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Bringing Care Within Reach

Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond

COVERED CALIFORNIA

Jan. 10, 2022

Prepared by Covered California

Bringing Care Within Reach

Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond

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Bringing Care Within Reach

Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond

Executive Summary

Marketplace Coverage, Covered California and Ongoing Efforts to Increase Affordability

The Patient Protection and Affordable Care Act reformed the individual health insurance market. It established marketplaces that offer comprehensive health plans with income-based financial help for individuals who do not have affordable coverage through an employer, Medicaid or Medicare. Covered California is California's insurance marketplace.

Under the original Affordable Care Act structure, premium support was available for consumers with income at or below 400 percent of the federal poverty level (FPL), and consumers with income at or below 250 percent of the FPL could receive support to lower their out-of-pocket costs through cost-sharing reduction (CSR) plans, which increase the richness of plan benefits at no cost to the consumer.[1] Currently, the majority of consumers eligible for the CSR plans select these benefits (about 71percent), while about 20 percent opt to enroll in Bronze plans – which have the lowest premiums but highest out-of-pocket costs of the plans offered through marketplaces.[2] [3] Currently, consumers earning more than 250 percent of the FPL are not eligible for federal support to lower their out-of-pocket costs, and they enroll in a mix plans ranging from Bronze plans through Platinum plans, with significant premium and out-of-pocket cost differences based on their selection.

Despite the financial support provided by the Affordable Care Act, many consumers still struggled to afford needed care. In response, California implemented a premium subsidy program in 2020 to reduce premium costs for low-income enrollees and expand eligibility to middle-income individuals who were not previously eligible for help under the Affordable Care Act. In 2021, the American Rescue Plan provided a significant increase in premium assistance through 2022, which superseded the state premium subsidy program. The Build Back Better Act (H.R. 5376), as passed by the House of Representatives on Nov. 19, 2021, would both extend American Rescue Plan premium subsidies through 2025 and provide $10 billion annually from 2023 to 2025 that would be allocated to states to reduce consumer costs, including out-of-pocket spending.

[1] In 2022, 400 percent of the FPL is $51,520 for an individual and $106,000 for a family of four, and 250 percent of FPL is $32,200 for an individual and $66,250 for a family of four.

[2] The Affordable Care Act defines four "metal tiers" of coverage that vary by actuarial value (AV), or the average amount of a member's health care cost that is paid by the health plan: Bronze (60 percent of cost paid by the plan), Silver (70 percent of cost paid by the plan), Gold (80 percent of cost paid by the plan) and Platinum (90 percent of cost paid by the plan). Plans with lower AV (e.g., Bronze with an AV of 60) generally have lower premiums but higher out-of-pocket costs. CSR plans are built on Silver-level coverage. For the lowest-income enrollees, CSR plans provide coverage near or above the Platinum level for highly subsidized Silver premium prices.

[3] The remaining nine percent of consumers eligible for CSR plans enroll in Gold or Platinum plans.

Potential State and Federal Funding to Reduce Cost-Sharing for Marketplace Enrollees

In response to the American Rescue Plan, the 2021-22 state budget (Assembly Bill 128) and health omnibus trailer bill (Assembly Bill 133) redirected $333.4 million from California's General Fund that would have been spent on state premium subsidies to a newly established California Health Care Affordability Reserve Fund. The fund would be used for affordability programs operated by Covered California starting in the plan year 2023. The legislation also called on Covered California to report on options for using the fund to reduce out-of-pocket costs for consumers. This report responds to that legislation.

Most of the analytic work conducted by Covered California for this report was performed in the context of how new state cost-sharing subsidies could complement the American Rescue Plan's enhanced premium subsidies. Covered California has also modeled, and presents here, additional cost-sharing reduction options for consideration in the context of new potential federal funding that could be used to reduce consumer cost sharing as proposed in the Build Back Better Act. The report begins, however, with modeling to show the significant loss of premium support that Californians would experience if the American Rescue Plan premium subsidies expire at the end of 2022, as would be the case under current law.

The options presented in this report can be used by policy makers under several possible scenarios:

> **The American Rescue Plan premium subsidies expire after 2022:** Under this scenario, the state would face a policy tradeoff between using state funding to reduce cost sharing or to address dramatic reductions in premium subsidies, which would take the state (and the nation) back to the original Affordable Care Act subsidy levels that were the basis of California's state-based premium support program instituted in 2020.
>
> **The American Rescue Plan premium subsidies are extended *with* additional federal cost-sharing support, through the Build Back Better Act or a similar policy:** Under this scenario, federal law would continue the expanded premium subsidies now in place under the American Rescue Plan, and California would receive a portion of the national $10 billion in funding per year from 2023 to 2025 to lower consumer cost sharing, which is included in the Build Back Better Act as passed by the House of Representatives on Nov. 19, 2021. While additional modeling would be needed, we have included in this report a preliminary set of options for lowering cost sharing using federal funding. Covered California has not modeled additional options that would combine state and federal funding to further reduce consumer cost sharing under this scenario.
>
> **The American Rescue Plan premium subsidies are extended *without* additional federal cost-sharing support:** Under this scenario, there would be continued federal support for the expanded premium subsidies now in place under the American Rescue Plan, but only state funding would be available for a cost-sharing reduction program. Many of the options in this report were developed for this scenario.

Potential State Options If American Rescue Plan Premium Subsidies Are Not Extended

The American Rescue Plan significantly increased and expanded premium assistance for marketplace enrollees nationwide for benefit years 2021 and 2022. It lowered premium contributions for marketplace enrollees with incomes under 400 percent of the federal poverty level (FPL), and for the first time, it expanded federal premium subsidies to individuals with incomes above 400 percent of the FPL so that no subsidy-eligible marketplace enrollee has to spend more than 8.5 percent of their income on their health insurance premiums. The American Rescue Plan significantly increased financial support for Covered California enrollees. Average household subsidies increased by more than $100 per month, bringing the average monthly premium subsidy to $704 and the average household net premium to $109. Notably, more than half of households that enrolled through Covered California in 2021 had a $1 per member, per month premium after implementation of the American Rescue Plan, compared to only 11 percent of households with only Affordable Care Act subsidies.

If federal action is not taken to extend American Rescue Plan premium subsidies beyond 2022, Californians will lose these enhanced benefits, which total approximately $1.6 billion annually in premium assistance. In that event, many thousands of the roughly 2.2 million Californians who receive coverage in the individual market could drop coverage.[4] Should this occur, California policy makers would need to consider whether the California Health Care Affordability Reserve Fund would be best used to partially address the shortfall by reinstating some form of a California premium subsidy program.

Options for a State Cost-Sharing Reduction Program That Complement Expanded Federal Premium Support

To produce this report, Covered California developed a variety of cost-sharing reduction options and commissioned the actuarial firm Milliman to estimate the cost of those options. Options were drawn from the AB 133 legislation, an extensive working-group process that engaged a variety of stakeholders (see Appendix I), other state-based cost-sharing reduction programs, and a cost-sharing reduction proposal modeled recently at the national level. This report presents Covered California's summary of the options and operational assessment for implementing a cost-sharing reduction program in 2023. Full details of the modeling developed by Milliman are available as a companion to this report.[5]

Options presented in this report would reduce out-of-pocket costs for low- and middle-income Californians enrolled through Covered California. Almost all options would expand eligibility for cost-sharing support above the current income limits and increase the actuarial value of plan designs for middle-income enrollees. Table 1 presents a selection of those options for federal or

[4] The Congressional Budget Office originally projected that approximately 1.3 million uninsured people (nationally) would temporarily take up new coverage under the American Rescue Plan, suggesting that roughly 8 percent of current nongroup enrollment may be at risk of returning to being uninsured. See Congressional Budget Office (2021). "CBO Cost Estimate: Reconciliation Recommendations of the House Committee on Ways & Means." February 2021. https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

[5] "Bringing Care Within Reach: Milliman Companion Report." Jan. 6, 2022. https://www.hbex.ca.gov/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Bringing-Care-Within-Reach-Milliman-Companion-Report-1-06-22.pdf

state funding. Under the option for a federally funded program shown in Table 1, eligibility for cost-sharing reductions would be expanded to all subsidy-eligible individuals up to 600 percent of the federal poverty level (FPL) and would significantly increase cost-sharing support for most income groups with plan generosity matching or exceeding the Gold or Platinum level. Several options for a state-funded program are also presented in Table 1, most of which would significantly expand eligibility and plan generosity to individuals up to 400 percent of the FPL. Details on these and other options are provided in the report that follows. Finally, we note that additional modeling will be needed to refine options depending on the availability and amount of federal funding for cost-sharing support in 2023 and beyond.

Table 1. Summary of Selected Cost-Sharing Reduction Options Under Federal- or State-Funded Scenarios

Selected Options	Up to 150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL	400-600% FPL	Annual Cost of Option Based on CSR Plan Enrollment Scenarios (millions of dollars)		
							Current	Some Switching to CSR Plans	More Switching to CSR Plans
Cost-Sharing Reduction Plans Under Current Law	*94*	*87*	*73*	*NA*	*NA*	*NA*			
Option for a federally funded cost-sharing reduction program as under the Build Back Better Act									
AV 95/90/85/80 with no deductibles	**95**	**95**	**90**	**90**	**85**	**80**	$475	$542	$626
Options for a state-funded cost-sharing reduction program building on American Rescue Plan premium subsidies									
ACA CSR plan upgrade with no deductibles and Gold AV for 250-400% FPL	**94**	**94**	**87**	**80**	**80**	**70**	$362	$403	$452
ACA CSR plans with no deductibles and Gold AV for 200-400% FPL	**94**	**87**	**80**	**80**	**80**	**70**	$128	$154	$189
ACA CSR plans with no deductibles	**94**	**87**	**73**	**73**	**73**	**70**	$37	$45	$55

Source: Table presents a selection of the 11 options modeled to show a range of options possible with federal or state funding. Detail on all options modeled is available in Table 6 and the Milliman companion report.

Notes: ACA = Affordable Care Act, AV = actuarial value, CSR = cost-sharing reduction, FPL = federal poverty level. Enrollment scenarios reflect a range of switching among current Covered California members into CSR plans to take advantage of enhanced benefits. Green shading indicates richer CSR plan provided in the option compared to the Affordable Care Act. For simplicity, ACA CSR plans with deductibles removed are displayed with their original actuarial values (i.e., 94, 87 and 73), even though their computed actuarial value would be higher due to the removal of the deductible. Individuals with income above 250 percent of the FPL are not eligible for ACA CSR plans.

Operational Assessment for Implementation of a State-Administered Cost-Sharing Reduction Program in 2023

Launching a state-administered cost-sharing reduction program in 2023 would require a significant amount of work on a compressed timeline. Program design and operations would need to closely follow the model of the federal cost-sharing reduction program, and decisions would be needed as early as possible in the calendar year 2022. The report provides detail on the following operational workstreams that would be required to launch a program:

1. **Benefit design** to incorporate new cost-sharing reduction funding into Covered California's Patient-Centered Benefit Designs.
2. **Payment methodology** to compensate qualified health plan issuers for reducing member cost sharing in accordance with the cost-sharing reduction program design.
3. **Enrollment forecasting and budgeting** to project enrollment and benefit costs for 2023.
4. **Eligibility-determination process** changes to CalHEERS, Covered California's eligibility and enrollment system, to define the income ranges and associated cost-sharing levels for the cost-sharing reduction program design.
5. **Enrollment process** changes to display the appropriate benefit plans under the cost-sharing reduction program design.
6. **Education and outreach** to applicants, members and certified enrollers.
7. **A carrier payment process** to make cost-sharing reduction payments to carriers.
8. **Risk adjustment** to consider whether or not to layer a state-specific risk-adjustment calculation on top the state cost-sharing reduction program.
9. **Plan renaming assessment** to determine the feasibility of renaming cost-sharing reduction plans as early as 2023 to reduce consumer confusion and better communicate the value of these plans.

Covered California made the following planning assumptions, which will need to hold true to minimize operational risk and prevent disruption for consumers:

1. State cost-sharing reduction plans would be offered to all renewing and newly applying members for a full benefit year, meaning that products would need to be available for shopping beginning Oct. 1, 2022.
2. Individuals would have to meet eligibility requirements for federal premium tax credits to be eligible for the state-administered cost-sharing reduction program.
3. Given the compressed timeframe, the program would need to leverage existing business processes wherever possible.
4. State cost-sharing reduction plans would be offered only at the Silver metal tier and would be developed by enhancing the actuarial value of the benefit plan consistent with the federal cost-sharing reduction program.
5. Payments for a state-administered cost-sharing reduction program would be made directly by the state to the carrier. The cost of enhanced benefits would not be "loaded" on premium rates, as it is now with the federal cost-sharing reduction program.

Introduction

Marketplace Coverage, Covered California and Ongoing Efforts to Increase Affordability

Section in Brief

- The Affordable Care Act **reformed the individual health insurance market** and established insurance marketplaces that offer comprehensive insurance plans with income-based financial help for individuals who do not have affordable coverage through an employer, Medicaid or Medicare. Covered California is California's insurance marketplace.
- Covered California uses the framework and tools of the Affordable Care Act to create standardized patient-centered benefit plans that **reduce financial barriers** to accessing health care.
- In recent years, state and federal efforts have improved the affordability of marketplace coverage by **increasing financial assistance** to reduce monthly premiums for marketplace coverage.
- While the affordability of premiums has improved significantly, federal support to reduce out-of-pocket costs such as copays and deductibles is limited to the lowest-income marketplace enrollees, and **some still struggle to afford care**.

Affordable Care Act Marketplaces

The Affordable Care Act, passed in 2010, dramatically changed the individual health insurance market by implementing key reforms such as banning coverage exclusions for preexisting conditions, standardizing benefits and coverage levels, and creating insurance marketplaces where eligible individuals can enroll in health plans with federal financial assistance to lower monthly premiums and out-of-pocket costs. Through Covered California, California's health insurance marketplace established under the Affordable Care Act, eligible individuals can buy qualified health plans (QHPs) from health insurance issuers that are certified by Covered California for meeting state and federal standards.

Marketplace Benefits and Coverage Levels

The Affordable Care Act requires that plans sold in the individual market cover 10 essential health benefit categories.[6] The Affordable Care Act defines four "metal tiers" of coverage for these benefits that vary by actuarial value, or the average amount of a member's health care cost that is paid by the health plan. The remaining cost is paid by the member in the form of deductibles, copays and coinsurance, which is referred to as member cost sharing. Plans with a lower actuarial value generally have lower monthly premiums but higher cost sharing.

[6] The essential health benefits are ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic-disease management; and pediatric services, including oral and vision care.

The four metal tiers are Bronze (60 percent of cost paid by the plan), Silver (70 percent of cost paid by the plan), Gold (80 percent of cost paid by the plan) and Platinum (90 percent of cost paid by the plan). Covered California takes an additional important step of standardizing its patient-centered benefit designs within each metal tier in order to simplify consumer plan choice and encourage the use of high-value services through a benefit-design process that is described in detail later on in this report (see Covered California's Patient-Centered Benefit Design Principles and Development Process). Health plans must offer the patient-centered benefit designs both through Covered California and, at the same price, in the off-exchange individual market.

Marketplace Eligibility and Financial Help

To purchase coverage through a marketplace, individuals must meet federal eligibility requirements for citizenship or immigration status and state residency. Eligible individuals who do not have affordable coverage through an employer, Medicaid, Medicare or another qualifying program receive income-based financial help to lower their monthly premiums and cost sharing.

Premium assistance: Marketplace premium assistance under the Affordable Care Act is available to individuals with incomes above Medicaid eligibility levels. Appendix II shows California's eligibility levels for Medi-Cal — California's Medicaid program — and marketplace coverage. Marketplace premium assistance takes the form of an income-based tax credit that can be taken in advance of tax filing to lower monthly premiums. Marketplace enrollees make a monthly required contribution toward their premium costs that ranges from 0 to 8.5 percent of their income based on their federal poverty level, and the premium tax credits covers the remaining cost of the premium for a benchmark plan.[7] [8] Recent state and federal policies described below have significantly increased premium assistance by expanding eligibility for assistance and reducing enrollee premium contributions.

Cost-sharing assistance: The Affordable Care Act requires qualified health plan issuers to reduce out-of-pocket maximums and cost-sharing amounts for consumers with incomes at or below 250 percent of the federal poverty level, which is $32,200 for an individual and $66,250 for a family of four.[9] Marketplace enrollees access these benefits by enrolling in what are known as cost-sharing reduction (CSR) plans built on Silver-level coverage. For the lowest-income enrollees, CSR plans provide coverage near or above the Platinum level for highly subsidized Silver premium prices.

[7] These required contributions were implemented with the American Rescue Plan, as discussed below. Under the Affordable Care Act, premium contributions ranged from approximately 2 to 10 percent of income, and individuals with income above 400 percent of the FPL were not eligible for premium assistance.

[8] The Affordable Care Act defines a benchmark plan as the second-lowest-cost Silver plan available to a marketplace enrollee.

[9] Until 2017, QHP issuers were compensated by the federal government for reducing member cost sharing in accordance with federal requirements. Since these payments were ended, issuers load the cost into Silver premiums. Payment processes are discussed in the Operational Assessment section. .

Cost-sharing reduction plans significantly reduce out-of-pocket costs at the point of care. For example, in Covered California's 2022 Silver 70 plan design, a primary care office visit costs $35, but in a Silver 94 plan the same visit costs $5. CSR plans also reduce the maximum-out-of-pocket (MOOP) limit on cost sharing for a benefit year. The MOOP limit and selected benefit information for an enrollee with income-based CSR plan eligibility are presented in Table 2. In 2021, about 71 percent of enrolled consumers who were eligible for the CSR plans enrolled in them. It is important to note that consumers forego their CSR benefits if they enroll in coverage tiers other than Silver.

Table 2. Eligibility for Cost-Sharing Reduction Plans and Selected 2022 Cost-Sharing Amounts

Cost-Sharing Reduction Plan	Income Eligibility by Federal Poverty Level	Deductibles (Individual/Family)			Maximum Out-of-Pocket Limit	Primary Care Office Visit	Generic Drugs
		Outpatient Care	Drugs	Inpatient Care			
Silver 94	Up to 150%	$0 / $0	$0 / $0	$75 / $150	$800 / $1,600	$5	$3
Silver 87	151-200%	$0 / $0	$0 / $0	$800 / $1,600	$2,850 / $5,700	$15	$5
Silver 73	201-250%	$0 / $0	$10 / $20	$3,700 / $7,400	$6,300 / $12,600	$35	$15*
N/A (Silver 70)	N/A	$0 / $0	$10 / $20	$3,700 / $7,400	$8,200 / $16,400	$35	$15*

*Price after drug deductible is met.

Notes: Individuals who are not eligible for cost-sharing reductions can buy a standard Silver 70, which we show here for comparison purposes.

Covered California's Patient-Centered Benefit Design Principles and Development Process

Two key Affordable Care Act market reforms — the requirement of essential health benefits and standardized coverage tiers — work in concert to ensure consumers can shop with confidence for comprehensive coverage with clear distinctions based on plan generosity. The addition of cost-sharing reductions is critical for low-income marketplace enrollees to afford the care they need. But these elements are not enough to ensure that consumers do not face an overwhelming number of benefit-design choices that are difficult to understand and create unnecessary financial risk and barriers to accessing care.

To address these issues, Covered California develops standard benefit designs, known as patient-centered benefit designs, for all metal tiers and cost-sharing reduction plans. These designs are crafted to remove as many financial barriers as possible to consumers' receiving needed care, to enable apples-to-apples comparisons between product offerings, and to incentivize insurers to compete on factors like network composition, service and quality rather than enrollee risk selection. (See Appendix III for Covered California's 2022 Patient-Centered

Benefit Designs.) Qualified health plan (QHP) issuers must offer the standardized patient-centered benefit designs through Covered California and — at the same price — off-exchange. Covered California has fostered innovation and has performed constant review of these designs. QHP issuers are invited to submit for approval alternate benefit designs that would be considered for offering, by both the proposing issuer and other QHPs. To date, California's 12 QHPs generally have not proposed alternate designs in the individual marketplace. In addition, each year, Covered California partners with consumer advocates, QHP issuers, providers, hospital associations and regulators to update the benefit designs to meet annual actuarial value requirements. In this process, Covered California incorporates the following benefit-design principles to reduce financial barriers to care:

1. Emphasize first-dollar coverage for most outpatient services in the Silver, Gold and Platinum metal tiers. Enrollees with Bronze coverage have a copay for the first three non-preventive care office visits before the deductible applies. With key primary care benefits not subject to the deductible, patient-centered benefit designs offer greater access to care.
2. Implement cost-sharing caps for expensive Tier 4 specialty drugs ($250 for Silver, Gold and Platinum; $500 for Bronze).
3. Use of copays versus coinsurance for several benefit categories and in particular to promote higher value care like primary care visits and generic medications.
4. Integrate the maximum out-of-pocket limit for health and pediatric dental benefits.

If a state cost-sharing reduction program were implemented, Covered California would use its existing benefit design process to ensure that additional funding would be applied in a way that maximizes consumer value. Considerations for this process are included in the Operational Assessment section of this report. If Covered California did not have its policies for standardized patient-centered designs, the process and options for providing additional cost-sharing reduction support would be far more complex and could lead to more consumer confusion or QHPs' having even greater variation among their offerings with regard to their relative value.

Remaining Affordability Challenges

Most efforts to address marketplace affordability have focused on increasing premium subsidies, as premiums represent the initial barrier to coverage take-up. However, consumers' perceptions of plan value include both premium and out-of-pocket costs, with enrollment and utilization decisions reflecting their perceived affordability of both.

Low-Income Enrollees Face High Costs With Higher Utilization

With enhanced premium subsidies available through the American Rescue Plan, individuals with incomes under 200 percent of the federal poverty level contribute up to 2 percent of their income to their benchmark cost-sharing reduction plan. Individuals with incomes under 150 percent of the federal poverty level are also eligible for $0 Silver 94 cost-sharing reduction plans. While enhanced subsidies increase affordability of premiums for these individuals, some low-income consumers can still face high cost sharing relative to their monthly incomes.

Evidence suggests that most individuals accrue their total out-of-pocket costs for the year in just one or two health encounters, which could create significant financial shocks for lower-income enrollees.[10] For example, an individual enrolled in a Silver 87 plan attending an annual check-up that results in a follow-up appointment, lab work and a prescription could spend almost 4 percent of their monthly income — nearly double their monthly premium cost — on the care resulting from the check-up.[11] While generally considered affordable for most enrollees, individuals with more complex health needs will face greater cost burdens to access needed care.

Little to No Cost-Sharing Support for Relatively Higher-Income Consumers

The federal cost-sharing program significantly increases the generosity of Silver plans for marketplace enrollees at the lowest income levels, but there is little to no cost-sharing support for those with incomes over 200 percent of the federal poverty level (FPL). While individuals with incomes between 200 and 250 percent of the FPL do qualify for Silver 73 cost-sharing reduction plans, these benefit designs are nearly identical to the standard Silver 70 plan and offer little cost-sharing support. In addition, while federally defined maximum out-of-pocket limits provide important financial protection for enrollees who need high-cost care like inpatient hospitalization and specialty drugs, those limits remain high as a percentage of income for groups who receive little to no federal cost-sharing support, as shown in Table 3.

Table 3. 2022 Maximum Out-of-Pocket Limits as a Percentage of Annual Household Income

Income Eligibility by Federal Poverty Level	Cost-Sharing Reduction Plan Actuarial Value	Maximum Out-of-Pocket Limit		Maximum Out-of-Pocket Limit as a Percent of Annual Income	
		Individual	Family	Individual	Family of Four
Up to 150%	Silver 94	$800	$1,600	4-6%*	4-6%*
151-200%	Silver 87	$2,850	$5,700	11-15%	11-14%
201-250%	Silver 73	$6,300	$12,600	20-24%	19-24%
251% and above	N/A (Silver 70)	$8,200	$16,400	16-25%	15-25%

*Range calculated for income at 100 and 150 percent of the federal poverty level.

Notes: Individuals who are not eligible for cost-sharing reductions can buy a standard Silver 70, which we show here for comparison purposes.

Implications for Take-Up and Utilization

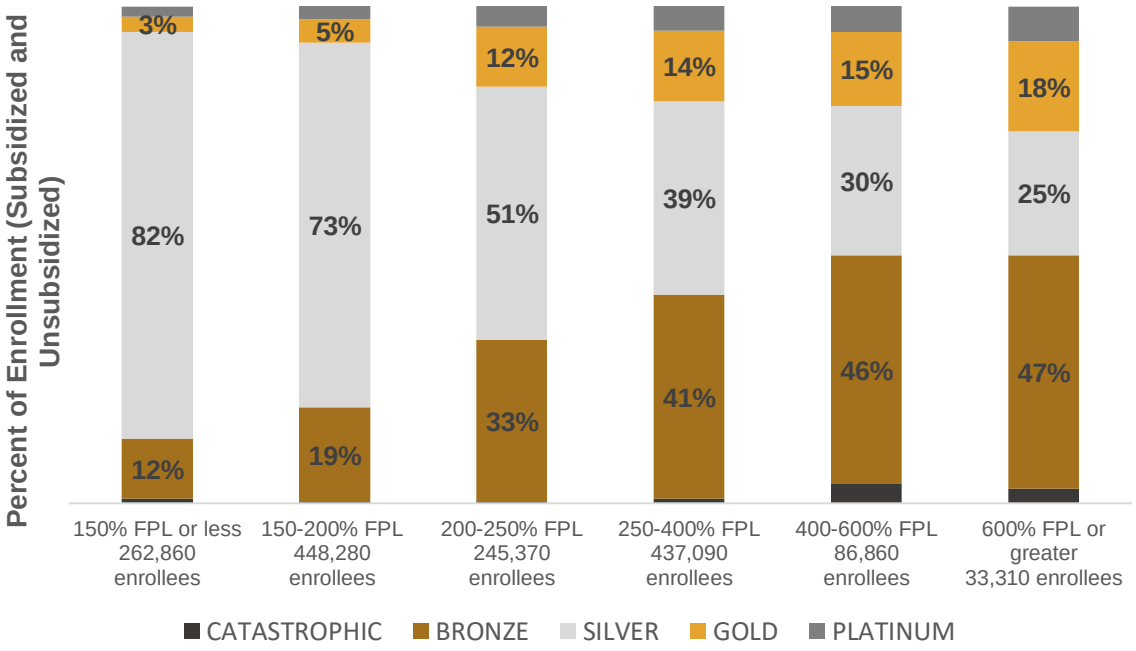
Affordability issues have implications for take-up, plan choice and enrollee health care utilization. As shown in Figure 1, take-up of Silver plans among Covered California enrollees

[10] Steven Chen et al. "Annual Out-of-Pocket Spending Clusters Within Short Time Intervals: Implications for Health Care Affordability." *Health Affairs* Volume 40, Number 2. February 2021.

[11] Covered California. AB 133 Health Care Affordability Working Group Meeting materials, Slide 10: Lucia L. Encounter scenario assumes out-of-pocket costs total $60 for an individual with an income of $1,620. Oct. 14, 2021 https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Final_10.14.21.pdf

decreases as income increase (and Silver actuarial value decreases), while enrollment in Bronze plans increases as income increases. While only 12 to 19 percent of enrollees choose Bronze plans when their income is below 200 percent of the FPL, the share of Bronze enrollees by income group jumps to 33 percent for those between 200 to 250 percent of the FPL and 46 percent for middle-income consumers. As enhanced cost-sharing support declines, consumers at higher incomes opt for the lower premiums of Bronze plans at higher rates.

Figure 1. Distribution of Metal Tier Choice, by Federal Poverty Level Bracket[12]



Perceptions of plan affordability also limit marketplace coverage take-up among the uninsured, with many unaware of financial assistance.[13] However, lack of awareness of subsidies and premium costs are not the only reasons individuals remain uninsured: Many uninsured individuals report preferring not to enroll in a plan with subsidized premiums if the plan comes with high out-of-pocket costs. National survey data indicate that 75 percent of uninsured individuals would not be interested in enrolling in a Bronze plan with a $0 monthly premium if it is accompanied by an annual deductible that exceeds $5,000.[14]

Covered California Bronze enrollees face much higher cost sharing, including a $6,300 individual medical deductible, which may influence enrollees' decisions to seek care. In 2018, three in 10 Bronze enrollees reported delaying care due to costs, compared to less than one in 10 enrollees

[12] Source: Covered California Active Member Profile, June 2021. Available at https://www.hbex.ca.gov/data-research/.

[13] Jennifer M. Haley et al. "Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage." Urban Institute. January 2021.

[14] Karen Pollitz et al. "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need." Henry J. Kaiser Family Foundation. August 2020.

in the Silver 94 cost-sharing reduction plan. The rate of delaying care due to costs for enrollees in Silver 70 plans was more than twice the rate of enrollees in Silver 94 plans.

Finally, implementation of the enhanced premium subsidies under the American Rescue Plan has highlighted the significant financial implications of foregoing cost-sharing reduction (CSR) plans in order to enroll in Platinum, Gold or Bronze plans. Individuals eligible for the richest CSR plans who instead choose Platinum or Gold plans pay higher monthly premiums and copays than they would in a CSR plan and have significantly higher maximum out-of-pocket limits.[15] Also, with the American Rescue Plan's premium subsidies, many low-income enrollees in Bronze plans could pay the same amount in monthly premiums for a generous CSR plan.

Measuring Affordability

In an effort to measure these affordability concerns, researchers at The Commonwealth Fund defined metrics of "underinsurance" in which an individual has health coverage but faces steep out-of-pocket costs that make care unaffordable. Based on out-of-pocket costs, an individual is considered underinsured if:

1. Deductibles equal 5 percent or more of a person's income, or
2. Out-of-pocket costs (excluding premiums) total 10 percent or more for an individual with an income greater than 200 percent of the federal poverty level or more than 5 percent for lower-income individuals (below 200 percent of the federal poverty level).

By these metrics, 42 percent of individual market enrollees nationally are considered underinsured.[16] One limitation of this underinsured metric is that Covered California's standard benefit designs maximize first dollar coverage for most outpatient services in the Silver metal tier, but a higher deductible is required for inpatient care and skilled nursing care to achieve this. Nevertheless, as California explores options to reduce cost sharing for Covered California enrollees, these or similar metrics may be helpful in evaluating policy options.

Efforts to Increase Affordability of Marketplace Coverage

State and federal efforts over the last several years have built on the foundation of the Affordable Care Act to increase affordability for marketplace enrollees:

In 2020, California established a state-funded premium subsidy program to complement the Affordable Care Act for low- and middle-income Californians. California established a three-year pilot program to provide new and enhanced premium subsidies to Covered California enrollees. The program was the first in the nation to provide premium subsidies to middle-income individuals with incomes between 400 and 600 percent of the federal

[15] For a discussion of such "choice errors" in California, see Feher, Andrew, and Isaac Menashe. "Using Email and Letters to Reduce Choice Errors Among ACA Marketplace Enrollees." Health Affairs 40, no. 5 (2021): 812-819.

[16] Sara R. Collins et al. "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability." The Commonwealth Fund. August 2020.

poverty level. The program took effect in in 2020, along with the state individual mandate to have coverage. As a result of these policies, Covered California saw a dramatic increase in new sign-ups during the open-enrollment period for 2020 compared to 2019.[17] Covered California has also seen record-low annual premium rate increases since the implementation of these policies, with a three-year average increase of 1.1 percent from 2020 to 2022.[18] While the program was authorized through 2022, it was superseded in 2021 with the enactment of the federal American Rescue Plan, meaning that state subsidy payments were discontinued when Covered California implemented the American Rescue Plan premium subsidy structure in early 2021.

In 2021, the American Rescue Plan significantly increased and expanded federal premium assistance for marketplace enrollees nationwide for 2021 and 2022. Among its many provisions, the American Rescue Plan lowered required premium contributions for marketplace enrollees earning less than 400 percent of the FPL and expanded premium subsidies to individuals earning more than 400 percent of the FPL, so that no subsidy-eligible marketplace enrollee has to spend more than 8.5 percent of their income on a benchmark plan. Appendix IV provides a comparison of premium subsidies under the Affordable Care Act and the American Rescue Plan.

The American Rescue Plan significantly increased financial support for Covered California enrollees. Average household subsidies increased by more than $100 per month, bringing the average monthly premium subsidy to $704 and the average household net premium to $109. Notably, more than half of households that enrolled through Covered California in 2021 had a $1 per member, per month premium after implementation of the American Rescue Plan, compared to only 11 percent of households with only Affordable Care Act subsidies. While the American Rescue Plan made significant increases in support for consumers' premiums, it did not increase cost-sharing support to lower consumers' out-of-pocket costs.

The Build Back Better Act would extend the American Rescue Plan premium subsidies through 2025 and provide states funding to further lower costs for marketplace enrollees. The act (H.R. 5376, as passed by the House of Representatives on Nov. 19, 2021) includes several provisions that would increase affordability of marketplace coverage. It would extend the American Rescue Plan premium subsidies through 2025; establish an affordability fund that would provide $10 billion per year between 2023 and 2025 for marketplaces to lower enrollee costs, including reducing cost sharing such as copays and deductibles; and it would enhance benefits for individuals with incomes at or below 138 percent of the federal poverty level who do not qualify for Medicaid coverage. These provisions are discussed below, along with a preliminary set of cost-sharing reduction options that could be considered if federal funding is made available.

[17] Covered California. "New California Policies Make Huge Difference, Increasing New Signups During Covered California's Open Enrollment by 41 Percent." Feb. 18, 2020. https://www.coveredca.com/newsroom/news-releases/2020/02/18/new-california-policies-make-huge-difference-increasing-new-signups-during-covered-californias-open-enrollment-by-41-percent/.

[18] Covered California. "Covered California Announces 2022 Plan: Full Year of American Rescue Plan Benefits, More Consumer Choice and Low Rate Change." July 28, 2021. https://www.coveredca.com/newsroom/news-releases/2021/07/28/covered-california-announces-2022-plans-full-year-of-american-rescue-plan-benefits-more-consumer-choice-and-low-rate-change/

Potential State Options If American Rescue Plan Premium Subsidies Are Not Extended

Section in Brief

- If federal action is not taken to extend American Rescue Plan premium subsidies beyond 2022, Covered California **enrollees will lose approximately $1.6 billion annually in premium assistance.**
- Should this occur, the California Health Care Affordability Reserve Fund could be used to **partially address the shortfall** by reinstating some form of a California premium subsidy program.

If enacted, the Build Back Better Act would extend the American Rescue Plan premium subsidy levels through 2025. These enhanced subsidies substantially reduced premiums both for those who were previously eligible for premium subsidies and middle-income members who became eligible for federal support for the first time under the American Rescue Plan. Figure 2 shows how the American Rescue Plan premium subsidies reduced net premiums for Covered California members at the household level in 2021.

Figure 2. Average 2021 Net Premium Before and After the American Rescue Plan (ARP) by Income Group

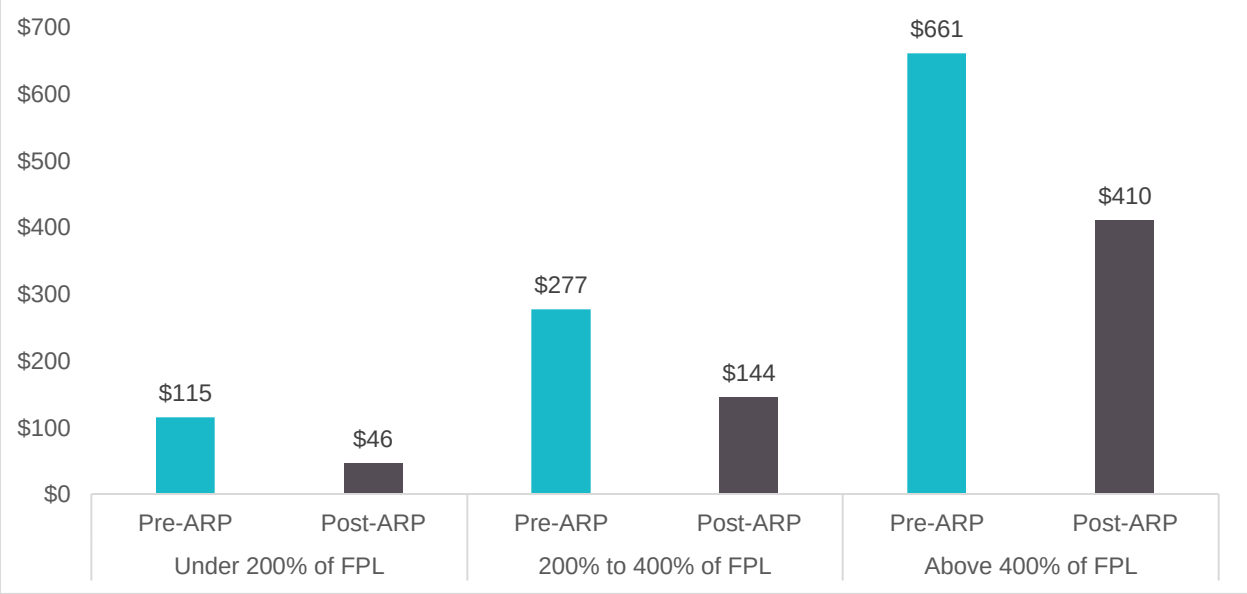


Table 4 shows the estimated premium assistance that Covered California enrollees will receive under the American Rescue Plan in 2022 by income group. We note that this estimate does not include the potential value of the American Rescue Plan subsidies for

eligible but unenrolled Californians. This group consists primarily of uninsured individuals and those enrolled in the individual market outside of Covered California.[19]

Table 4. Estimated 2022 American Rescue Plan Premium Subsidies for Covered California Enrollees by Income Group

Enrollee Income Group (by FPL Bracket)	Annual Value of American Rescue Plan Premium Subsidies in 2022	Count of Covered California Enrollees
0-150% FPL	$160,000,000	270,000
0-200% FPL	$565,000,000	706,000
0-250% FPL	$861,000,000	955,000
0-300% FPL	$1,098,000,000	1,171,000
0-400% FPL	$1,286,000,000	1,395,000
0-600% FPL	$1,575,000,000	1,484,000
All enrollees*	$ 1,617,000,000	1,519,000

*Includes the value of premium subsidies provided to individuals above 600 percent of the FPL who qualify for assistance under the American Rescue Plan if the cost of their benchmark plan exceeds 8.5 percent of their income.

If federal action is not taken to extend American Rescue Plan premium subsidies beyond 2022, Californians receiving these benefits through Covered California would lose approximately $1.6 billion annually in premium assistance. In that event, many thousands of the roughly 2.2 million Californians who receive coverage in the individual market could drop coverage.[20]

Under this scenario, California policy makers would need to consider whether the California Health Care Affordability Reserve Fund would be best used to partially address the shortfall by reinstating some form of the California premium subsidy program, though we note that the estimated annual value of the American Rescue Plan premium subsidies is more than four times the amount that was appropriated the state premium subsidy program for 2021.[21]

[19] An estimated 810,000 uninsured individuals and 270,000 individuals enrolled in the individual marketplace outside of Covered California could benefit from marketplace subsidies. See Covered California's April 8, 2021, Board Meeting Materials, Slide 3. "Covered California Policy and Action Items." https://board.coveredca.com/meetings/2021/april/meeting-materials/Policy-and-Action-April-2021-Final.pdf.

[20] The Congressional Budget Office originally projected that approximately 1.3 million uninsured (nationally) would temporarily take-up new coverage under the American Rescue Plan; suggesting that roughly eight percent of current nongroup enrollment might be at risk of returning to being uninsured. See Congressional Budget Office (2021). CBO Cost Estimate: Reconciliation Recommendations of the House Committee on Ways & Means, February 2021: https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

[21] For the plan years 2020 and 2021, $428,629,00 and $348,939,000, respectively, were appropriated for the state premium subsidy program.

Options for a State Cost-Sharing Reduction Program That Complement Expanded Federal Premium Support

Section in Brief

- Most of the analytic work presented here was developed for potential state funding, but federal funding through the **Build Back Better Act would significantly expand the range of options** that could be considered.
- Covered California developed a **variety of options** for a state cost-sharing reduction program that would reduce out-of-pocket costs for low- and middle-income Californians enrolled through Covered California.
- Several options would **expand eligibility for cost-sharing support** and increase the actuarial value of plan designs for middle-income enrollees to **match or exceed the generosity of Gold plans**.

Context for Reviewing Cost-Sharing Reduction Options

Most of the analytic work presented in this report was conducted in the context of how new state cost-sharing subsidies could complement the American Rescue Plan, which provided enhanced premium subsidies but did not provide additional cost-sharing support. Enactment of policies like those in the Build Back Better Act (H.R. 5376), as passed by the House of Representatives on Nov. 19, 2021, would significantly expand the range of options that could be considered for an enhanced cost-sharing reduction program relative to what would be possible with state funding. The Build Back Better Act would provide $10 billion in funding in each benefit year from 2023 through 2025 for marketplaces that could be used to reduce member cost-sharing.

While Covered California is still reviewing the allocation methodology in the proposed legislation, if funding were allocated proportionally based on recent CSR enrollment, California could receive $1.2 to $1.4 billion. [22] This potential funding for cost sharing would significantly exceed the $330 million in state funding in the California Health Care Affordability Reserve Fund.

The cost-sharing reduction options should be reviewed in the context of the following funding scenarios for 2023.

The American Rescue Plan premium subsidies are extended *with* additional federal support for cost-sharing as under the Build Back Better Act: Under this scenario, federal law would continue the expanded premium subsidies now in place under the

[22] In a recent effectuated enrollment snapshot (for the month of February 2021), California comprised 12.3 percent of all cost-sharing reduction plan effectuated enrollment, and 14.0 percent of total marketplace enrollment. See Centers for Medicare and Medicaid Services. "Effectuated Enrollment: Early 2021 Snapshot and Full Year 2020 Average." June 5, 2021. https://www.cms.gov/document/Early-2021-2020-Effectuated-Enrollment-Report.pdf.

American Rescue Plan, and California would receive a portion of the national $10 billion in funding per year from 2023 to 2025 to lower consumer cost sharing, which is included in the Build Back Better Act as passed by the House of Representatives on Nov. 19, 2021. We have included in this report a preliminary set of options for lowering cost sharing using federal funding, though additional modeling would be needed to refine options based on California's actual allocation. Covered California has not modeled additional options that would combine state and federal funding to further reduce consumer cost sharing under this scenario.

The American Rescue Plan premium subsidies are extended *without* additional federal support for cost-sharing: Under this scenario, there would be continued federal support for the expanded premium subsidies now in place under the American Rescue Plan, but only state funding would be available for a cost-sharing reduction program. Many of the options in this report were developed for this scenario.

Summary of Options Modeled

Covered California developed a variety of cost-sharing reduction options and commissioned Milliman to estimate the cost of those options. This section summarizes the options and key considerations for program design. Full details of the modeling developed by Milliman are available as a companion to this report.[23]

Options were modeled using the following steps:

1. **Developed plan designs.** Covered California provided Milliman with 12 plan designs to model: four existing and eight illustrative, for purposes of developing program cost estimates. Deductibles were eliminated in all illustrative plan designs, and copay and coinsurance amounts were significantly reduced in many designs. Plan design detail is displayed in Table 5 and can be summarized as follows:
    - Plans 1, 3, 7 and 10 are the existing Silver cost-sharing reduction plans for 2022.
    - Plans 2, 4, 8 and 11 are the existing Silver cost-sharing reduction plans for 2022, with the deductibles removed (e.g., eliminating the $3,700 inpatient deductible and $10 drug deductible from the Silver 73 plan design).
    - Plans 5, 6, 9 and 12 were chosen to target a desired actuarial value (e.g., Silver 80). Covered California provided the plan designs to use in order to achieve the target actuarial value.

    Note that plan details are provided for illustrative and modeling purposes, and actual 2023 plan designs will likely differ.

[23] "Bringing Care Within Reach: Milliman Companion Report." Dec. 6, 2021. https://www.hbex.ca.gov/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Attachment-1_Bringing-Care-Within-Reach_Milliman-Companion_Report-12-06-21.pdf

2. **Estimated per member, per month costs for each plan design.** Milliman modeled the marginal per member, per month (PMPM) cost that the state would have to pay to provide each of the modeled plan designs based on enrollee income group (e.g., it would cost approximately $48 PMPM to provide a Silver 94 plan to enrollees currently eligible for a Silver 87 plan). Average marginal PMPM costs are reported at a statewide level and separately for Northern and Southern California. See Tables 2, A1 and A2 of the Milliman report for full detail.

3. **Estimated the cost of several cost-sharing reduction program options.** At Covered California's direction, Milliman estimated the total costs of 11 program design options that differ by the plan design and enrollee income group. Options were drawn from the AB 133 legislation and working group process, which requires Covered California to "include options for all Covered California enrollees with income up to 400 percent of the FPL to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs" and "include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the FPL and upgrading those with income between 200 percent and 400 percent, inclusive, of the FPL to gold-tier cost sharing."

Additional options are based on other state-based cost-sharing reduction programs[24] and a cost-sharing reduction proposal modeled recently at the national level by researchers at the Urban Institute.[25]

Table 6 presents three preliminary options that could be considered if federal funding becomes available under H.R. 5376, and four options modeled for a state-funded cost-sharing reduction program. Detail for all 11 options modeled is available in the companion Milliman report.

For each option, at each income level, Table 6 shows the actuarial value for the Silver product proposed and denotes the combination of benefit and eligibility improvements proposed as follows:

- Improved cost-sharing relative to current eligibility under the Affordable Care Act, through either:
    - Cost-sharing reduction "upgrades" that further reduce cost sharing for those who are already eligible for some cost-sharing assistance at or below 250 percent of the federal poverty level.
    - New eligibility for a group with incomes above 250 percent of the federal poverty level, which is ineligible for a cost-sharing plan under the Affordable Care Act.

[24] Massachusetts, Vermont and Colorado operate cost-sharing reduction programs within their marketplace programs. See Appendix V for additional information.

[25] Linda J. Blumberg et al. "Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity." Urban Institute. February 2021. Accessed on Dec. 7, 2021. https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity_0.pdf

- Elimination of inpatient and drug deductibles in existing Silver and Silver cost-sharing reduction plans.

Table 6 also provides a cost range for each option based on one of three "tier switching" enrollment scenarios under which some percentage of Covered California members are assumed to switch from either the Platinum, Gold or Bronze tiers to take advantage of the enhanced cost-sharing subsidies at the Silver tier. See Tables 3, 4 and 6 of the Milliman report for full detail. All estimates use 2021 enrollment and would need to be updated in 2022 to reflect projected 2023 enrollment, including any changes in either Covered California's total enrollment or changes in metal tier choice.

Table 5: Summary of Key Components of Existing 2022 Covered California Plan Designs and Illustrative Plan Designs Used for Modeling Program Costs

		DEDUCTIBLE				COPAYS			
Plan Description	Existing or Illustrative	Inpatient*	Outpatient	Drug	MOOP	PCP	X-Ray	Drugs§	Federal Actuarial Value
Individual Silver 70	Existing	$3,700	$0	$10	$8,200	$35	$85	$15/55/85/20%	71.5%
Individual Silver 70 with deductibles removed	Illustrative†	$0	$0	$0	$8,200	$35	$85	$15/55/85/20%	74.3%
73 Silver	Existing	$3,700	$0	$10	$6,300	$35	$85	$15/55/85/20%	73.9%
73 Silver with deductibles removed	Illustrative†	$0	$0	$0	$6,300	$35	$85	$15/55/85/20%	76.3%
80 Silver	Illustrative	$0	$0	$0	$8,200	$35	$75	$15/55/85/20%	79.8%
85 Silver	Illustrative	$0	$0	$0	$5,200	$15	$40	$5/25/45/15%	85.0%
87 Silver	Existing	$800	$0	$0	$2,850	$15	$40	$5/25/45/15%	87.9%
87 Silver with deductibles removed	Illustrative†	$0	$0	$0	$2,850	$15	$40	$5/25/45/15%	88.3%
90 Silver	Illustrative	$0	$0	$0	$4,500	$15	$30	$5/15/25/10%	89.3%
94 Silver	Existing	$75	$0	$0	$800	$5	$8	$3/10/15/10%	94.7%
94 Silver with deductibles removed‡	Illustrative†	$0	$0	$0	$800	$5	$8	$3/10/15/10%	94.9%
99 Silver	Illustrative	$0	$0	$0	$250	$0	$0	$0/10/10/10	99.7%

Source: This table was reproduced from Table 1 in the companion Milliman report.

† Illustrative plans titled "with deductibles removed" are modified versions of existing plans (i.e., the inpatient and drug deductibles are removed from existing 2022 Silver and CSR plans). For simplicity, we used the parallel naming convention for these illustrative plans, however the AVs are different due to the changes made. For example, 73 Silver with deductibles removed (Illustrative) has an AV that is higher than 73 percent. Note that these plans are provided for illustrative purposes only. Actual 2023 plan designs will likely differ.

* The inpatient deductible applies to both inpatient facility and skilled nursing facilities.

‡ The plan 94 Silver with deductibles removed is also referred to as 95 Silver in this report.

§ Cost sharing for drugs is shown as Tier 1/Tier 2/Tier 3/Tier 4. Tier 1 is most generic drugs and low-cost preferred brands. Tier 2 is non-preferred generics and preferred brand drugs. Tier 3 is non-preferred brand drugs. Tier 4 is specialty drugs and biologics.

Table 6. Summary of Key Elements of Selected Cost-Sharing Reduction Options Modeled

✓ = *benefit or eligibility enhancement*

■ = *richer CSR support*

	Option	Summary	Description	Up to 150% FPL		150-200% FPL		200-250% FPL		250-300% FPL		300-400% FPL		400-600% FPL		Annual Cost by Tier Switching Scenarios 1, 2, and 3 (millions)		
				CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	New CSR Eligibility	CSR Upgrade	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	Current	Some Tier Switching	More Tier Switching
		Current CSR Eligibility		*CSR Eligible*						*CSR Ineligible*								
		AV of ACA Silver Products		*94*		*87*		*73*		*70*		*70*		*70*				
Options for Federally-funded Program	1	AV 95/90/85/80 with no deductibles	New eligibility for CSR up to 600% FPL. New products (min AV 80) under 600% FPL. No deductibles at any income below 600% FPL	95		95		90		90		85		80		$475	$542	$626
					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	2	AV 95/90/85 with no deductibles	New eligibility for CSR up to 400% FPL. New products (min AV 85) under 400% FPL. No deductibles at any income below 400% FPL	95		95		90		90		85		70		$463	$526	$604
					✓	✓	✓	✓	✓	✓	✓	✓	✓					
	3	ACA CSR plan upgrade with no deductibles and Gold AV for 300-400% FPL	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	94		94		87		87		80		70		$386	$433	$489
					✓	✓	✓	✓	✓	✓	✓	✓	✓					
Options for State-funded Program	4	ACA CSR plan upgrade with no deductibles and Gold AV for 250-400% FPL	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	94		94		87		80		80		70		$362	$403	$452
					✓	✓	✓	✓	✓	✓	✓	✓	✓					
	5	ACA CSR plan upgrade for 150-250% FPL	Richer CSR below 250% FPL, moving Silver 87 to Silver 94 and Silver 73 to Silver 87.	94		94		87		70		70		70		$278	$299	$322
						✓		✓										
	6	ACA CSR plans with no Deductibles and Gold AV for 200-400% FPL	New CSR product (AV 80) for 200% FPL. No deductibles at any income below 400% FPL.	94		87		80		80		80		70		$128	$154	$189
					✓		✓	✓	✓	✓	✓	✓	✓					
	7	ACA CSR plans with no Deductibles	Existing CSR products across the income spectrum. No deductibles at any income below 400% FPL.	94		87		73		73		73		70		$37	$45	$55
					✓		✓		✓		✓		✓					

Source: Adapted from Table 5 in the companion Milliman report. Table 5 in the Milliman report also includes modeling of cost-sharing reduction programs in Colorado, Massachusetts and Vermont (Options 8-11).

Notes: ACA = Affordable Care Act, AV = actuarial value, CSR = cost-sharing reduction, FPL = federal poverty level. Green shading indicates richer CSR plan provided in the option compared to the Affordable Care Act. For simplicity, ACA CSR plans with deductibles removed are displayed with their original actuarial values (i.e., 94, 87 and 73), even though their computed actuarial value would be higher due to the removal of the deductible as shown in Table 5.

Options for a Federally Funded Cost-Sharing Reduction Program, as Under the Build Back Better Act

These options could be considered if policies such as those under the Build Back Better Act are enacted to extend American Rescue Plan premium subsidies and provide new federal cost-sharing support. Under this scenario, California would receive a portion of the national $10 billion in funding per year from 2023 to 2025.

Option 1: AV 95/90/85/80 with no deductibles ($475 – $626 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 600 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90, 85 and 80. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option. Note that this is the only modeled option that incorporates CSR enhancements above 400 percent of FPL.

Option 2: AV 95/90/85 with no deductibles ($463 – $604 million). In this option, cost-sharing reduction (CSR) support would be expanded to all enrollees up to 400 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90 and 85. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option.

Option 3: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold actuarial value (AV) for individuals between 300 and 400 percent of the FPL ($386 – $489 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the federal poverty level (FPL). Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to a Silver 94 plan with no deductibles, and individuals between 200 and 300 percent of the FPL would be upgraded from a Silver 73 to a Silver 87 plan with no deductibles. Individuals between 300 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

Options for a State-Funded Cost-Sharing Reduction Program Building on the American Rescue Plan's Premium Subsidies

These options could be considered if American Rescue Plan premium subsidies are extended *without* new cost-sharing support. Under this scenario, only state funding would be available for a cost-sharing reduction program.

Option 4: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 250 and 400 percent of the FPL ($362 – $452 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Individuals between 250 and 400 percent of the FPL

would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

Option 5: Affordable Care Act cost-sharing reduction plan upgrade for individuals between 150 and 250 percent of the FPL ($278 – $322 million). In this option, eligibility for CSR plans would remain at 250 percent of the FPL, but individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Deductibles would not be eliminated in this option, which would potentially prevent the need for benefit-design changes in 2023.

Option 6: Affordable Care Act cost-sharing reduction plans with no deductibles and Gold AV for individuals between 200 and 400 percent of the FPL ($128 – $189 million). In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 200 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

Option 7: Affordable Care Act cost-sharing reduction plans with no deductibles ($37 – $55 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. State funding would be used to eliminate all deductibles in existing CSR plans and upgrade the Silver base plan to a Silver 73 for individuals between 250 and 400 percent of the FPL.

Benefit and Program Design Considerations

While Covered California will provide technical assistance during the development of any state cost-sharing reduction proposal, we offer several program design considerations to inform initial policy discussions.

1. **Integration of enhanced cost-sharing reduction funding into Covered California's program.** For this modeling effort, Covered California assumed that a state-administered cost-sharing reduction (CSR) program would operate similarly to the federal cost-sharing reduction program in which the statute defines both the income-based eligibility for CSR plans and the actuarial value that those plans would have to meet for each income group. We further assumed that Covered California would produce one standard CSR plan for each income group that would combine all available cost-sharing support. Actual plan designs developed for a state-administered cost-sharing reduction program could differ from those modeled for this report based on federal actuarial value requirements for the 2023 benefit year and benefit-design choices (e.g., requiring copays versus coinsurance for certain services). Once draft plan designs are available, additional analysis can be performed to assess member-level impacts of enhanced cost-sharing support under a state-administered program. To the extent federal or state support for expanded cost-sharing reductions were not framed and structured by standardized patient-centered designs, the process and options for providing

additional cost-sharing reduction support would be far more complex and could lead to more consumer confusion or qualified health plan issuers (QHPs) having even greater variation among their offerings with regard to their relative value.

Finally, we assumed that QHP issuers would be compensated for the cost-sharing reductions required under the Affordable Care Act through the existing Silver loading process and for the state-administered portion through a direct payment made by the state. Payment models are described in the Operational Assessment section below.

2. **Impact of deductibles.** The marginal cost of eliminating deductibles in Silver plans is small because deductibles are only applied to inpatient hospital and skilled nursing services, for which members very often hit their maximum out-of-pocket limit. While the direct financial impact of this option is relatively low, eliminating deductibles may have other important impacts on consumer take-up of coverage and access to and use of care, including:
   - Removing a potential enrollment barrier for consumers who are eligible for cost-sharing reduction plans but are deterred from enrolling based on real or perceived financial risk, or a judgement that a product with a deductible does not provide adequate value for the cost of the plan.
   - Removing a potential barrier for seeking care due to perceived cost for those who are enrolled, yet are not aware that their plan's medical deductible only applies to inpatient services.

   These secondary impacts were not modeled in the analysis by Milliman.

3. **Required updates to cost and enrollment estimates to develop state budget estimates.** As noted above, cost estimates presented in this report are preliminary and only address tier switching among current members. Costs will need to be updated in 2022 to reflect projected enrollment and benefit costs for 2023.

4. **Additional cost-sharing reduction elements related to the Build Back Better Act**. The provision of the Build Back Better Act that is intended to expand health care coverage in states that did not expand their Medicaid programs would provide special benefits for all individuals under 138 percent of the federal poverty level who qualify for marketplace coverage and do not qualify for Medicaid.[26] In addition to enhanced premium subsidies that would be available through 2025, these individuals would be eligible for a new cost-sharing reduction plan with an actuarial value of 99 percent for benefit years 2023 to 2025. Plan design and per member, per month costs for an illustrative Silver 99 plan design are available in the Milliman report.

[26] This generally includes individuals with household income under the federal poverty level who do not qualify for Medicaid for reasons other than immigration status.

5. **Actuarial value comparisons to employer-sponsored coverage.** Several options modeled would increase the actuarial value of plan designs for middle-income enrollees to match or exceed the generosity of Gold plans. For comparison purposes, the national average actuarial value of employer-sponsored coverage is 85 percent.[27] Recent research indicates that a growing share (85 percent) of individuals with employer-sponsored coverage nationally are enrolled in plans with a general annual deductible with an average amount of nearly $1,700 for single-coverage. Nearly all employer plans require additional cost sharing.

[27] See for example Rae, M., Copeland, R., and Cox, C. "Tracking the rise in premium contributions and cost-sharing for families with large employer coverage." Kaiser Family Foundation. 2019. https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/. See also Thomas G. Moehrle. "Measuring the generosity of employer-sponsored health plans: an actuarial-value approach." Monthly Labor Review, U.S. Bureau of Labor Statistics. June 2015. https://doi.org/10.21916/mlr.2015.16. Available at: https://www.bls.gov/opub/mlr/2015/article/measuring-the-generosity-of-employer-sponsored-health-plans.htm.

Operational Assessment for Implementation of a State-Administered Cost-Sharing Reduction Program in 2023

Section in Brief

- Launching a state-administered cost-sharing reduction program in 2023 would require a **significant workload on a compressed timeline**. Program design and operations will need to closely follow the federal model and **decisions will be needed as early as possible in the calendar year 2022**.
- The workload associated with implementing a state cost-sharing program would divert Covered California staff from other policy and consumer experience priorities. These **tradeoffs should be strongly considered if a multi-year state program cannot be financed**.

In addition to modeling options for enhanced cost-sharing support, AB 133 also requires Covered California to develop an operational assessment for implementing a state-administered cost-sharing reduction program for benefit year 2023. This section describes operational work streams and key activities that Covered California would need to undertake to launch a state-administered cost-sharing program in that timeframe.

Covered California Operational Work Streams

Described below are nine major operational work streams for implementing a state cost-sharing program with details about key activities and considerations within each.

1. **Benefit design**: As discussed above, state funding to reduce member cost sharing could be used to expand income-based eligibility for existing cost-sharing reduction (CSR) plans, increase the generosity of one or more of the existing income-based CSR plans, or both. Expanding income-based eligibility for one or more existing CSR plans would be simpler to operationalize because Covered California would not have to develop new CSR benefit designs. Modifying one or more of the existing CSR plans to increase generosity would require plan design changes and actuarial analysis that would have to be incorporated into the benefit-design approval process, which is described below.

   Benefit designs are developed between November and January for the next full benefit year (e.g., 2023 benefit designs will be developed between November 2021 and January 2022). Benefit designs are approved by the Covered California Board of Directors in a two-step process that usually occurs at the January and March board meetings. As such, the annual benefit-design process is completed several months before the statutory deadline for the adoption of the state budget. This creates significant operational risk that will have to be mitigated if a program is authorized for 2023. While timelines are far less clear, implementing a federally-funded program would almost certainly involve similar operational risks.

2. **Payment methodology**: Covered California would have to develop a payment methodology to compensate QHP issuers for reducing member cost sharing in accordance with the state program design. Covered California assessed two potential payment methodologies, which are summarized below. These options are based on those previously developed by the U.S. Department of Health and Human Services to make cost-sharing reduction payments to QHP issuers under the federal cost-sharing reduction program. Covered California will not direct QHP issuers to "load" the cost of a state program into plan premiums, a practice that is currently in use to fund the federal cost-sharing reduction program due to elimination of direct payments in 2017.[28]

    - A prospective per member, per month payment methodology in which the marginal cost to the QHP issuer to reduce member cost sharing in accordance with the state program design would be calculated as a per member, per month (PMPM) amount. The PMPM amount(s) would be set in advance of the benefit year (thus "prospective") and would be paid to QHP issuers throughout the benefit year for all eligible members. Modeling performed by Milliman assumed that a PMPM payment methodology would be used. This methodology is similar to the methodology that was in place for the federal cost-sharing reduction program between 2014 and 2017.
    - A claims-based reconciliation methodology in which QHP issuers would receive prospective payments throughout the benefit year similar to option one but would have to reconcile prospective payments to actual cost at the end of the benefit year. This methodology was required for benefit year 2017 and beyond for the federal program but was shortly thereafter negated due to the elimination of direct payments in the federal cost-sharing reduction program. A claims-based reconciliation methodology would require significant development time and resources for QHP issuers and Covered California, and QHP issuers may need to make modifications throughout the claims-processing workflow.

    Due to the complexity of the claims-based reconciliation methodology, Covered California could only support the prospective PMPM payment methodology for 2023. As noted by Milliman, the initial modeling assumed a PMPM payment methodology in which the marginal cost to the QHP issuer to administer a richer plan design would be set based on each member's income category, and that the program cost would be based on Northern versus Southern California average costs. Covered California would have to decide whether to include other factors in the methodology such as region, QHP issuer or enrollee risk.

[28] This elimination of direct payments resulted in "Silver loading," a response by health plan issuers to cost-sharing reduction payments' ending in 2017. The issuers raised Silver plans' premium costs to offset the uncompensated cost of continuing to provide cost-sharing reduction subsidies. Federal premium tax credit expenditures also rose due to the increase in Silver plan premiums.

3. **Enrollment forecasting and budgeting**: Estimates developed by Milliman for this report are preliminary and are intended to provide a reasonable estimate of program costs but will certainly vary based on enrollment and program design decisions. As noted above, costs will need to be updated in 2022 to reflect projected enrollment and benefit costs for 2023.

4. **Eligibility determination process**: Covered California would have to make system changes to CalHEERS, Covered California's eligibility and enrollment system, to define the income ranges and associated cost-sharing levels for the state program design. Cost-sharing levels are briefly explained in Appendix VI. Initial planning can begin prior to approval of a state-administered cost-sharing reduction program, but program design decisions will be needed by late spring 2022 in order to finalize system development and testing within and between Covered California and the QHP issuers' enrollment systems in time for the 2023 benefit year.

5. **Enrollment process**: Beginning on Oct. 1, 2022, Covered California would have to display the appropriate benefit plans to consumers based on the state-administered cost-sharing reduction program design. Consistent with current processes, Covered California would automatically move existing enrollees in the Silver metal tier to the appropriate cost-sharing reduction plan if they did not actively renew their coverage for 2023. Covered California could also consider various policies to encourage the selection of cost-sharing reduction plans among new and renewing members. For example, Covered California could consider adding decision-support information to the plan shopping experience in CalHEERS to encourage selection of cost-sharing reduction plans by new members and those who actively renew. Covered California could also consider automatically moving existing enrollees in the Bronze, Gold and Platinum coverage levels into cost-sharing reduction plans at renewal time to increase the number of consumers who take advantage of the benefits.[29]

6. **Education and outreach**: Covered California would have to develop plans for education and outreach to applicants, members and enrollment partners. These activities would take place throughout the summer of 2022 in preparation for open enrollment and renewal for the 2023 benefit year.

7. **Carrier payment process**: Covered California would have to work with the State Controller's Office to develop a process to make cost-sharing reduction payments to carriers. Covered California would likely make payments monthly but would have to determine whether payments would be made prospectively or retrospectively for the month. Regardless of that decision, payments to QHP issuers would be reconciled to actual membership through Covered California's regular issuer-reconciliation processes.

[29] Beginning in plan year 2022, Covered California will automatically move Bronze plan enrollees with incomes below 150 percent of federal poverty level to Enhanced Silver 94 plans with the same issuer in the same product, when available, to help them take advantage of significant cost-sharing support and $0 net premiums available through the American Rescue Plan.

8. **Risk adjustment**: Covered California would have to consider whether or not to layer a state-specific risk-adjustment calculation on top the state cost-sharing reduction program. Since risk adjustment is operated at the federal level, there is no built-in mechanism for making an adjustment for the impact of the state cost-sharing reduction program on risk selection. At least one other state, Colorado, has decided not to layer on a state-specific risk adjustment calculation with their state CSR program. An analysis has not yet been done to determine the potential relative impact of this on carriers.

9. **Plan renaming**: Covered California could assess the feasibility of renaming CSR plans as early as 2023 to reduce consumer confusion and better communicate the value of these plans. New plan names would likely be needed by March of 2022 to meet operational timeframes for the 2023 benefit year. Plan renaming would affect issuers' regulatory filings and development of member materials. Covered California would also have to assess the need for changes to the plan-shopping experience in CalHEERS to accommodate new names, particularly if the metal tier were eliminated from the plan name.

Key Planning Milestones for the 2023 Benefit Year

Planning for a benefit year begins approximately 12 months in advance of open enrollment for that benefit year. Key milestones and timeframes for the 2023 benefit year are listed in Table 7. While there is some flexibility to modify the timeframes below, Covered California, QHP issuers and the health insurance regulators will need parameters of a state cost-sharing reduction program as early in the planning process as possible to ensure that key milestones are met. As noted above, the annual state budget process lags behind Covered California's benefit year planning process by several months.

Table 7. Key Planning Milestones for the 2023 Benefit Year

Milestone	Estimated Timeframe
Plan Management Advisory: Benefit Design and Certification Policy Recommendation	January 2022
January Board Meeting: Discussion of Benefit Design and Certification Policy Recommendation	January 2022
Final Federal Actuarial Value Calculator Released*	February 2022
Qualified Health Plan and Qualified Dental Plan Issuer Applications Open	March 1, 2022
March Board Meeting: Anticipated Approval of 2022 Patient-Centered Benefit Plan Designs and Certification Policy	March 2022
Final CalHEERS Design Needed for State-Administered CSR Program	May 2022
May Board Meeting: Discussion of 2022-23 Covered California Budget	May 2022
June Board Meeting: Anticipated Approval of 2022-23 Covered California Budget	June 2022
Qualified Health Plan Negotiations	June 2022
Public Posting of Proposed Rates	July 2022
Carrier Integration Testing for the 2023 Plan Year	July – August 2022
CalHEERS Release for the 2023 Plan Year	September 2022
Public Posting of Final Rates	September – October 2022

*Tentative timing.

Operational Planning Assumptions

Launching a state cost-sharing reduction program in 2023 would require a significant workload on a compressed timeline. In developing this operational assessment, Covered California made the following planning assumptions that will need to hold true to minimize operational risk and prevent disruption for consumers:

1. State cost-sharing reduction plans would be offered to all renewing and newly applying members for a full benefit year, meaning that products would need to be available for shopping beginning Oct. 1, 2022.
2. Individuals would have to meet eligibility requirements for federal premium tax credits to be eligible for the state-administered cost-sharing reduction program. It would not be possible to make changes to eligibility rules to provide state cost-sharing reductions to individuals currently ineligible for premium assistance prior to the 2023 benefit year.
3. Given the compressed timeframe, the program would need to leverage existing business processes wherever possible.
4. State cost-sharing reduction plans would be offered only at the Silver metal tier and would be developed by enhancing the actuarial value of the benefit plan consistent with the federal cost-sharing reduction program.
5. Payments for a state-administered cost-sharing reduction program would be made directly by the state to the carrier. The cost of enhanced benefits would not be “loaded” on premium rates, as it is now with the federal cost-sharing reduction program.

Considerations for a Single-Year Versus a Multi-Year State Program

The statute that established the California Health Care Affordability Reserve Fund does not specify an ongoing funding source. The workload associated with implementing a state cost-sharing program would shift Covered California resources from other policy and consumer-experience priorities. These tradeoffs should be strongly considered if federal funding for cost-sharing support is not made available and a multi-year program cannot be financed with state funds. We also note that Covered California would have to tailor its member communication and marketing approach to be clear at the time of application or renewal that enhanced benefits would expire at the end of the 2023 benefit year.

Appendix I. Statutory Language of AB 133, Working Group Members and Meeting Material

Government Code: TITLE 22. California Health Benefit Exchange [100500 - 100522]

100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.
Government Code section 100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding any other law, the Controller may use the funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381.

(c) Upon the enactment of the Budget Act of 2021, and upon order of the Director of Finance, the Controller shall transfer three hundred thirty-three million four hundred thirty-nine thousand dollars ($333,439,000) from the General Fund to the Health Care Affordability Reserve Fund.

(d) Upon appropriation by the Legislature, the Health Care Affordability Reserve Fund shall be utilized, in addition to any other appropriations made by the Legislature for the same purpose, for the purpose of health care affordability programs operated by the California Health Benefit Exchange.

(e) (1) The California Health Benefit Exchange shall, in consultation with stakeholders and the Legislature, develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. On or before January 1, 2022, the Exchange shall report those developed options to the Legislature, Governor, and the Healthy California for All Commission, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2022–23 budget process.

(2) In developing the options, the Exchange shall do all of the following:

(A) Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs.

(B) Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent, inclusive, of the federal poverty level to gold-tier cost sharing.

(C) Address any operational issues that might impede implementation of enhanced cost-sharing reductions for the 2023 calendar year.

(D) Maximize federal funding and address interactions with federal law regarding federal cost-sharing reduction subsidies.

(3) The Exchange shall make the report publicly available on its internet website.

(4) The Exchange shall submit the report in compliance with Section 9795 of the Government Code.

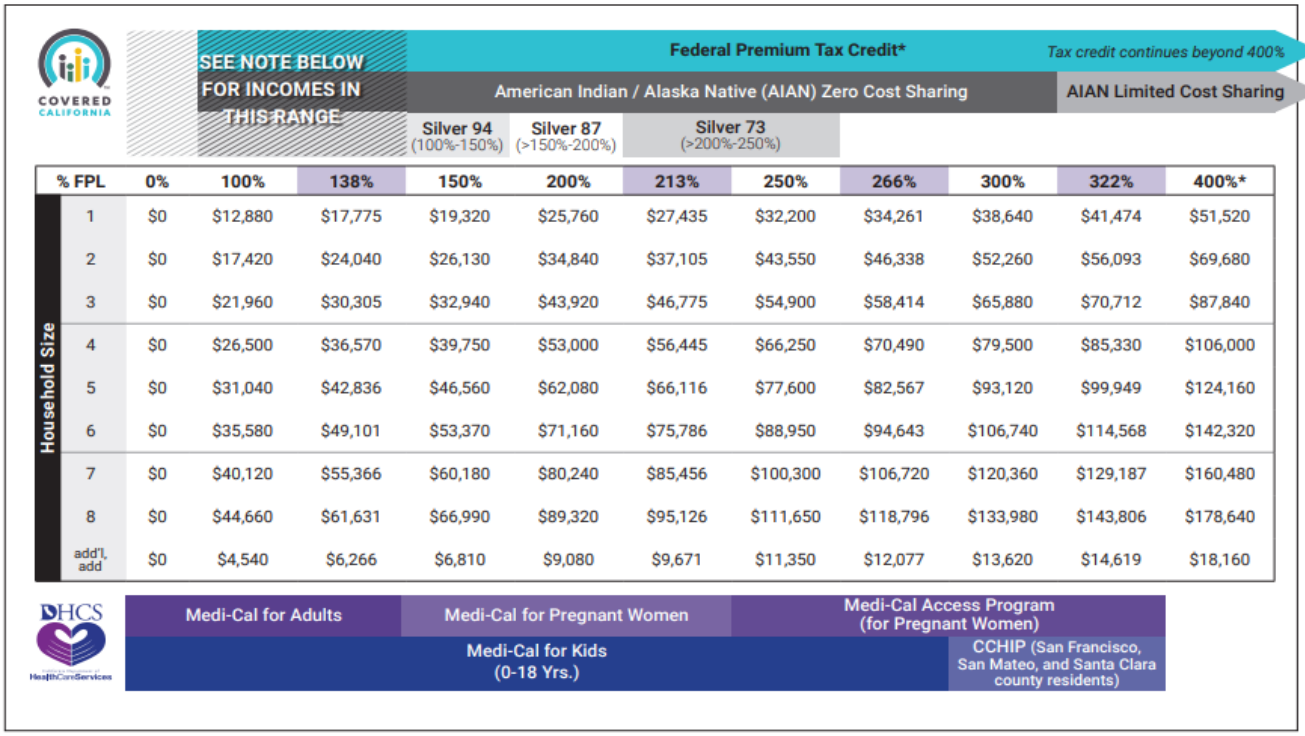
Covered California thanks the working groups for their valuable contributions to this project.

Working Group Member	Organization
Dawn McFarland	Agent
Rick Krum	Anthem Blue Cross Blue Shield
Robert Spector	Blue Shield of California
Anete Millers	California Association of Health Plans
Faith Borges	California Association of Health Underwriters
Stesha Hodges	California Department of Insurance
Janice Rocco	California Medical Association
Cary Sanders	California Pan-Ethnic Health Network
Mike Odeh	Children Now
Diana Douglas	Health Access
Amy Frith	Health Net of California
John Newman	Kaiser Permanente
Alicia Emanuel	National Health Law Program
Marjorie Swartz	Policy Consultant to Senate President Pro Tempore Toni Atkins at California State Senate
Cicely Rucker	Sharp HealthCare
Jen Flory	Western Center on Law and Poverty
Jerry Fleming	Covered California board member
Jarrett Tomás Barrios	Covered California board member
Teri Boughton	Senate Committee on Health
Ryan Witz	California Hospital Association
Doreena Wong	Asian Resources
Anika Lee	California Consortium of Urban Indian Health Consortium

AB 133 Working Group Website and Meeting Materials

Appendix II: Eligibility Limits for Medicaid and Marketplace Coverage in California in 2022

Medi-Cal, California's Medicaid program, provides coverage for adults with incomes at or below 138 percent of the federal poverty level. Medi-Cal eligibility limits are higher for pregnant women and children, as shown below. Eligibility for marketplace financial help through Covered California begins where Medi-Cal eligibility ends.



Household Size	% FPL	0%	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%*
	1	$0	$12,880	$17,775	$19,320	$25,760	$27,435	$32,200	$34,261	$38,640	$41,474	$51,520
	2	$0	$17,420	$24,040	$26,130	$34,840	$37,105	$43,550	$46,338	$52,260	$56,093	$69,680
	3	$0	$21,960	$30,305	$32,940	$43,920	$46,775	$54,900	$58,414	$65,880	$70,712	$87,840
	4	$0	$26,500	$36,570	$39,750	$53,000	$56,445	$66,250	$70,490	$79,500	$85,330	$106,000
	5	$0	$31,040	$42,836	$46,560	$62,080	$66,116	$77,600	$82,567	$93,120	$99,949	$124,160
	6	$0	$35,580	$49,101	$53,370	$71,160	$75,786	$88,950	$94,643	$106,740	$114,568	$142,320
	7	$0	$40,120	$55,366	$60,180	$80,240	$85,456	$100,300	$106,720	$120,360	$129,187	$160,480
	8	$0	$44,660	$61,631	$66,990	$89,320	$95,126	$111,650	$118,796	$133,980	$143,806	$178,640
	add'l. add	$0	$4,540	$6,266	$6,810	$9,080	$9,671	$11,350	$12,077	$13,620	$14,619	$18,160

Note: Most consumers up to 138% FPL will be eligible for Medi-Cal. If ineligible for Medi-Cal, consumers may qualify for a Covered California health plan with financial help including: federal premium tax credit, Silver (94, 87, 73) plans and Zero Cost Sharing and Limited Cost Sharing AIAN plans.

Silver 94, 87 and 73 plans provide lower deductibles, co-pays, and out-of-pocket maximum costs.

* Consumers at 400% FPL or higher may receive a federal premium tax credit to lower their premium to a maximum of 8.5 percent of their income based on the second-lowest-cost Silver plan in their area. See the chart on page 2 for more information.

2022 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **73%** average annual cost	Covers **87%** average annual cost	Covers **94%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	**$25,761 to $32,200 (>200% to ≤250% FPL)**	**$19,321 to $25,760 (>150% to ≤200% FPL)**	**up to $19,320 (100% to ≤150% FPL)**	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care or Urgent Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$35	$35	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$70	$70	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Hospital Stay			20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	15% coinsurance after medical deductible is met	10% coinsurance after medical deductible is met	$600 copay/day up to 5 days or 20% coinsurance	$250 copay/day up to 5 days or 10% coinsurance
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$150 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$15**	$15**	$5	$3	$15	$5
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$55**	$55**	$25	$10	$55	$15
Tier 3 (Non-preferred Drugs)			$85**	$85**	$45	$15	$80	$25
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150 per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $3,700 Family: $7,400	Individual: $3,700 Family: $7,400	Individual: $800 Family: $1,600	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $10 Family: $20	Individual: $10 Family: $20	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,700 individual $17,400 family	$8,200 individual $16,400 family	$8,200 individual $16,400 family	$6,300 individual $12,600 family	$2,850 individual $5,700 family	$800 individual $1,600 family	$8,200 individual $16,400 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

Appendix IV: Comparison of Percentage of Income Paid for a Marketplace Benchmark Plan Under the Affordable Care Act, the California Premium Subsidy Program, and the American Rescue Plan

Income Range		Required Premium Contribution		
Income As Percent FPL	**Income** for Single Household[30]	Affordable Care Act	California State Subsidy Program	American Rescue Plan
Under 138%	$0 to $17,609	2.07%	0%	0%
138% – 150%	$17,609 to $19,140	3.10% – 4.14%	N/A	0%
150% – 200%	$19,140 to $25,520	4.14% – 6.52%	N/A	0% – 2.0%
200% – 250%	$25,520 to $31,900	6.52% – 8.33%	6.24% – 7.80%	2.0% – 4.0%
250% – 300%	$31,900 to $38,280	8.33% – 9.83%	7.80% – 8.90%	4.0% – 6.0%
300% – 400%	$38,280 to $51,040	9.83%	8.90% – 9.68%	6.0% – 8.5%
Over 400%	$51,040 and up	Not eligible for subsidies	9.68% – 18.0%	8.5%

[30] Income limits for additional household sizes can be found www.coveredca.com/pdfs/FPL-chart.pdf.

Appendix V. Information About Cost-Sharing Reduction Programs Operated by Other State Exchanges

	Actuarial Value of State Cost-Sharing Reduction Plans					
	Enrollee Income Range					
	<100% FPL*	100-150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL
AV of ACA Silver Products	*94%*	*94%*	*87%*	*73%*	N/A (70%)	N/A (70%)
Massachusetts	99.7%	95%	95%	92%	92%	N/A (70%)
Colorado	N/A (94%)	94%	94%	73%	N/A (70%)	N/A (70%)
Vermont	N/A (94%)	94%	87%	77%	73%	N/A (70%)

Source: Adapted from "Introduction to State Cost-Sharing Subsidies" presentation by Jason Levitis to the AB 133 working group.

*Individuals under 100 percent of the federal poverty level are generally eligible for cost-sharing reduction plans only if they are "lawfully present" immigrants subject to the so-called five-year bar from accessing Medicaid benefits.

State Resources

Massachusetts Health Connector, 2021. https://www.mahealthconnector.org/wp-content/uploads/MA-Cost-Sharing-Subsidies-in-ConnectorCare-Brief-083021.pdf

Oliver Wyman, 2021. https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Colorado-Enhanced-Support-Payment-Options-Final.pdf

Vermont General Assembly, 2021. https://legislature.vermont.gov/statutes/section/33/018/01812

Appendix VI. Marketplace Qualified Health Plan Identifiers

HIOS ID and cost-sharing levels: Each marketplace plan has a Centers for Medicare and Medicaid Services-approved 14-digit Health Insurance Oversight System (HIOS) identification number with a 2-digit extension, or CS level, to identify the cost-sharing variation from the baseline plan. Below are the definitions for the CS levels and eligible populations.

CS Level	Cost-Sharing Reduction Plan	Eligible Population
01	Standard plan with no cost-sharing reduction (all metal tiers and catastrophic)	All consumers
02	Zero cost-sharing American Indian/Alaska Native (AI/AN)	AI/AN below 300% FPL: Bronze tier only
03	Limited cost-sharing AI/AN	AI/AN above 300% FPL: all tiers
04	CSR 73%	200 to 250% FPL: Silver tier only
05	CSR 87%	150 to 200% FPL: Silver tier only
06	CSR 94%	Up to 150% FPL: Silver tier only

By Rebecca Myerson, Nicholas Tilipman, Andrew Feher, Honglin Li, Wesley Yin, and Isaac Menashe

Personalized Telephone Outreach Increased Health Insurance Take-Up For Hard-To-Reach Populations, But Challenges Remain

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ABSTRACT **We tested the impact of personalized telephone calls from service center representatives on health plan enrollment in California's Affordable Care Act Marketplace, Covered California, using a randomized controlled trial. The study sample included 79,522 consumers who had applied but not selected a plan. Receiving a call increased enrollment by 2.7 percentage points (22.5 percent) overall. Among subgroups, receiving a call significantly increased enrollment among consumers with income below 200 percent of the federal poverty level (4.0 percentage points or 47.6 percent for consumers with incomes below 150 percent of poverty and 4.0 percentage points or 36.4 percent for consumers with incomes of 150–199 of poverty), as well as those who were referred from Medicaid (2.9 percentage points or 53.7 percent), those ages 30–50 (2.4 percentage points or 23.3 percent) or older than age 50 (5.1 percentage points or 34.2 percent), those who were Hispanic (2.3 percentage points or 31.1 percent), and those whose preferred spoken language was Spanish (3.2 percentage points or 74.4 percent) or English (2.6 percentage points or 18.6 percent). The intervention provided a two-to-one return on investment. Yet absolute enrollment in the target population remained low; persistent enrollment barriers may have limited the intervention's impact. These findings inform implementation of the American Rescue Plan Act of 2021, which expands eligibility for subsidized coverage.**

The Affordable Care Act (ACA) has helped raise health insurance coverage rates in the US to record highs, in part by establishing regulated health insurance Marketplaces that provide new coverage options.[1–3] Yet important gaps in coverage remain; nationally, more than fourteen million people remained uninsured as of 2019 despite eligibility for Marketplace coverage.[4] Reducing barriers to Marketplace enrollment is a priority for policy makers, as evidenced by new efforts from state-based Marketplaces during the COVID-19 pandemic and new funding to expand Marketplace coverage subsidies under the American Rescue Plan Act of 2021.[5–7]

One potential barrier to enrollment in Marketplace coverage is the complexity of the plan selection process.[8–14] Selecting a plan can be made more difficult by limited awareness of the availability of subsidies, the complexity of income-based subsidies and contribution caps, a lack of understanding about insurance terminology (for example, deductible and copayment), the variability of plan architecture and provider networks, and administrative or time-related burdens.[15–18] These barriers can result in people remaining uninsured or choosing a suboptimal plan.[11,19,20]

Several prior interventions sought to improve

health insurance decisions via "low-touch" outreach methods, such as presenting information in an automated online choice environment, in an advertisement, or by mail.[21–28] Although these approaches are effective for many consumers, they might not be sufficient to overcome certain barriers to obtaining coverage, such as gaps in health insurance literacy, computer literacy, or internet access.[8,11,12,26,29–33] Further, consumers in non-English-speaking communities may face language and informational barriers that limit the effectiveness of traditional passive outreach.[34] These concerns have led to increasing interest among policy makers, navigators, and consumer organizations in developing novel outreach methods to address diverse barriers to enrollment.[5,6]

This study evaluates the impacts of one such intervention—personalized, live outbound telephone calls from service center representatives—on enrollment in California's ACA Marketplace, Covered California, which accounts for 13.5 percent of national ACA Marketplace enrollment.[35] The intervention targeted consumers who had initiated the enrollment process by submitting an application but had yet to select a plan.

Consumers apply for, shop for, and purchase Marketplace insurance plans during an open enrollment period at the end of the year for coverage that begins in the subsequent calendar year. Typically, consumers in California apply directly through CoveredCA.com or through insurance brokers, navigators, or others who are certified by the exchange. For the 2019 coverage year, 38 percent of enrollees were unassisted, and the remainder received assistance.[36]

Enrollees in the Medicaid program who become ineligible for Medicaid (for example, because of an increase in income) make up a substantial portion of potential enrollees in Covered California. In some cases, a social services office will apply to Covered California directly for these consumers. All households that are referred to Covered California in this way are sent a formal notice (letter) informing them that they are no longer eligible for Medicaid but are newly eligible to enroll in a health insurance plan through Covered California. All applicants, including those referred from Medicaid, are given the contact information of the service center in case of any questions.

At the time of the study, households earning less than 400 percent of the federal poverty level (that is, less than $100,400 for a family of four)[37] were eligible to receive premium subsidies to defray the cost of purchasing coverage. To simplify plan comparisons, California has taken the step of standardizing all benefit designs, effectively resulting in a single benefit design for each level of coverage (or actuarial value).[38] On the nationwide Marketplace website, HealthCare.gov, which does not have standardized benefit designs, consumers had, on average, from thirty to forty-seven plan choices during 2016–17.[39]

Toward the end of the Covered California open enrollment period, tens of thousands of people begin but do not complete the enrollment process. Although many factors affect take-up of Marketplace coverage, information-related barriers and hassle costs may be important barriers to enrollment.

The intervention in this study provided personalized assistance to consumers with the goal of addressing these barriers. When a consumer was reached for a one-on-one telephone conversation, the service center representative had detailed information on the consumer's available options. Representatives were able to describe to consumers the subsidies and cost-sharing reduction options for which they were eligible, clarify the parameters of specific plans available to them (including the costs and benefits of each plan, provider networks, and quality ratings), and walk them through the enrollment process if desired. Assistance was available in Spanish and other languages. This intervention could address enrollment barriers such as lack of awareness of health insurance options, low health insurance literacy or computer literacy, preference for in-language assistance, and the time and cognitive costs of sifting through options.

Our study exploited random assignment to receive a personalized call from a service center representative during open enrollment. The number of consumers eligible to receive a call exceeded the capacity of the outbound call service center, and random assignment provided a fair way to select call recipients. The goal of the study was to assess the extent to which outbound calls increased enrollment, both overall and among subgroups by application source, income, language preference, race and ethnicity, and age.[40] We hypothesized that receiving a personalized telephone call would address enrollment barriers, thereby helping a diverse set of consumers complete the enrollment process.

Study Data And Methods

STUDY POPULATION AND INTERVENTION During the 2019 open enrollment period, Covered California identified 79,522 people who had applied to obtain Covered California health insurance coverage for the 2019 coverage year but had neither selected and enrolled in a plan nor delegated their case to an insurance agent or navigator.

Households in the study population were randomly assigned to one of two groups at the outset

of the intervention period: a treatment group that was assigned to receive a phone call (hereafter referred to as an "outbound call") from a service center representative and a control group that was assigned to not receive an outbound call. Those in the control group, similar to any other consumers, could contact the Covered California service center by calling the publicly available number that had been provided to them.

Approximately 70 percent of households in the study sample were assigned to the treatment group ($n = 55{,}519$) and about 30 percent to the control group ($n = 24{,}003$). Randomization was conducted using the last digit of a system-generated case ID (1, 2, or 3 versus all other digits). This randomization scheme was chosen because Covered California wanted to reach as many consumers as possible before the open enrollment period ended, while also learning about the effects of telephone-based outreach at scale.

The intervention was conducted over the course of several weeks during the open enrollment period. Nine hundred four service center representatives reviewed prospective Covered California enrollees' files to ensure that they were still eligible for the intervention—that is, that they were not Medicaid eligible and not already enrolled in Marketplace coverage. Because of constraints in service center capacity, this step was completed for only 39,309 of the 55,519 households. After review, service center representatives called the eligible households. If the representative and consumer were able to connect by telephone, the representative provided personalized information about Covered California plan options and provided live assistance in choosing a plan, as described above. If the call went to voicemail, the representative left a message instructing the recipient to call the service center hotline if they would like further assistance. In total, 27,123 households received an outbound call before the end of open enrollment, with about one-quarter (6,732) answering or returning the call. All 79,522 households randomly assigned to a study group were included in the analysis, following recommended practices for reporting randomized controlled trials.[41]

The preanalysis plan for this study was registered in the AEA RCT Registry (Trial No. AEARCTR-0006391). The data analysis project was approved by the State of California Health and Human Services Agency Institutional Review Board.

DATA SOURCE We used administrative data from Covered California. These data provide information about each household's take-up of insurance from the Covered California Marketplace, service center tracking information, and each household's demographic composition and income information (before randomization).

OUTCOME The outcome of interest was enrollment in Covered California health insurance, defined as selecting a plan before the end of the 2019 open enrollment period and paying at least one month's premium.

STRATIFICATION VARIABLES We stratified the data to test the impact of an outbound phone call on enrollment by application source (referral from the Medicaid eligibility system versus CoveredCA.com), by income group (less than 150 percent, 150–199 percent, 200–249 percent, 250–400 percent, or more than 400 percent of the federal poverty level), by English or Spanish spoken language preference, by race and ethnicity (non-Hispanic white, Hispanic, non-Hispanic Black, Asian, or other race or ethnicity), and by age (younger than 30, 30–50, or older than 50).

COVARIATES USED IN MULTIVARIABLE MODELING Although not required to obtain unbiased treatment effects in models using randomized controlled trial data, we adjusted for prespecified covariates including county fixed effects, age of the household head, household income, preferred language, and race and ethnicity.

STATISTICAL ANALYSIS We measured the effects of assignment to the treatment group (the "intent-to-treat" effect) using a regression model in which enrollment was modeled as a function of treatment assignment. Although the main specification included the prespecified covariates noted above, we also present estimates from unadjusted models.[42] Next, we employed a two-stage least squares strategy, using random assignment to the treatment group as an instrument for receiving an outbound call. The two-stage least squares model estimates the causal effect of receiving an outbound call from the service center among people who received an outbound call because of random assignment. Because treatment effects may differ for other groups of people, we interpreted the two-stage least squares estimates as a local average treatment effect for "compliers" to treatment—that is, people who received treatment only because of assignment to the treatment group.[43] We used robust standard errors to account for heteroscedasticity. We accounted for multiple hypothesis tests in the subgroups analysis, using Bonferroni-adjusted cutoffs for statistical significance. Additional details are in online appendix 1.[44]

SENSITIVITY ANALYSES We conducted supplemental analyses to assess the validity of the findings. First, we sought to verify random assignment by comparing the treatment and control groups on observable variables and using a sim-

ulation analysis. See appendix 1 for details.[44] Next, we assessed the sensitivity of estimates to alternative model specifications, including the use of logit or probit models, dropping covariates, and including people with missing data on covariates.

RETURN ON INVESTMENT We calculated the intervention's return on investment from the Marketplace perspective by comparing the costs (financial outlays to support service center representatives' time) and revenues (issuer user fees received by the Marketplace resulting from additional members recruited) attributable to the intervention. See appendix 2 for additional details.[44]

LIMITATIONS The study had several limitations. First, because service center representatives did not reach every person in the treatment group, we could not estimate the causal effect on enrollment of having had a conversation with a representative (as opposed to having been called). Second, if the effect of an outbound call varied across individuals, the local average treatment effect we measured would not reflect the effect of an outbound call across the full population. Instead, it would reflect the treatment effect only in the population that met our inclusion criteria—that is, those who had applied for Marketplace coverage but not picked a plan—and that received an outbound call because of random assignment to the treatment group. Third, we could not observe coverage outcomes other than enrollment in Covered California insurance. Finally, the estimates were specific to the set of consumers we studied and might not generalize to the broader uninsured population or to consumers seeking other types of health insurance.

EXHIBIT 1

Characteristics of consumers in the sample of prospective Covered California enrollees, 2018–19

Characteristics	Treatment group ($n = 55,519$)	Control group ($n = 24,003$)
Referred from Medicaid[a] (%)		
Yes	61.7	62.0
Household income as percent of FPL (%)		
<150%	13.2	13.2
150%–199%	30.6	30.8
200%–249%	19.4	19.1
250%–400%	17.7	17.6
>400%	18.5	18.7
Characteristics of head of household		
Sex (%)		
Female	36.9	37.0
Male	63.1	63.0
Age (mean years)	38.3	38.6
Language preference, spoken (%)		
Prefer English	76.4	76.2
Prefer Spanish	19.1	19.3
Race and ethnicity (%)		
Non-Hispanic white	23.4	23.6
Hispanic	48.2	48.1
Non-Hispanic Black	4.8	5.0
Asian	9.5	9.3
Any other group	13.5	13.5

SOURCE Authors' analysis of Covered California administrative data, 2018–19. **NOTES** There were no statistically significant differences between the treatment and control groups, with the exception of age ($p = 0.007$). The difference in age across the groups is small (mean age, 38.3 in the treatment group versus 38.6 in the control group). The pooled *F*-test *p* value was 0.383, indicating that groups were balanced overall. [a]Consumers who had recently disenrolled from Medicaid and were referred to Covered California from the Medicaid eligibility system.

Study Results

BALANCE TESTS Balance checks indicated that the randomization procedure successfully created comparable treatment and control groups. Exhibit 1 reports the mean baseline characteristics of consumers in the treatment and control groups. Characteristics were balanced overall across households in the treatment and control groups, according to an *F*-test ($p = 0.383$). *T*-test comparisons for each variable were also nonsignificant except for age; the age difference between the groups was small (mean age was 38.3 years in the treatment group versus 38.6 years in the control group). Findings from a simulation test supported the validity of the randomization; see exhibit S1 in appendix 3.[44]

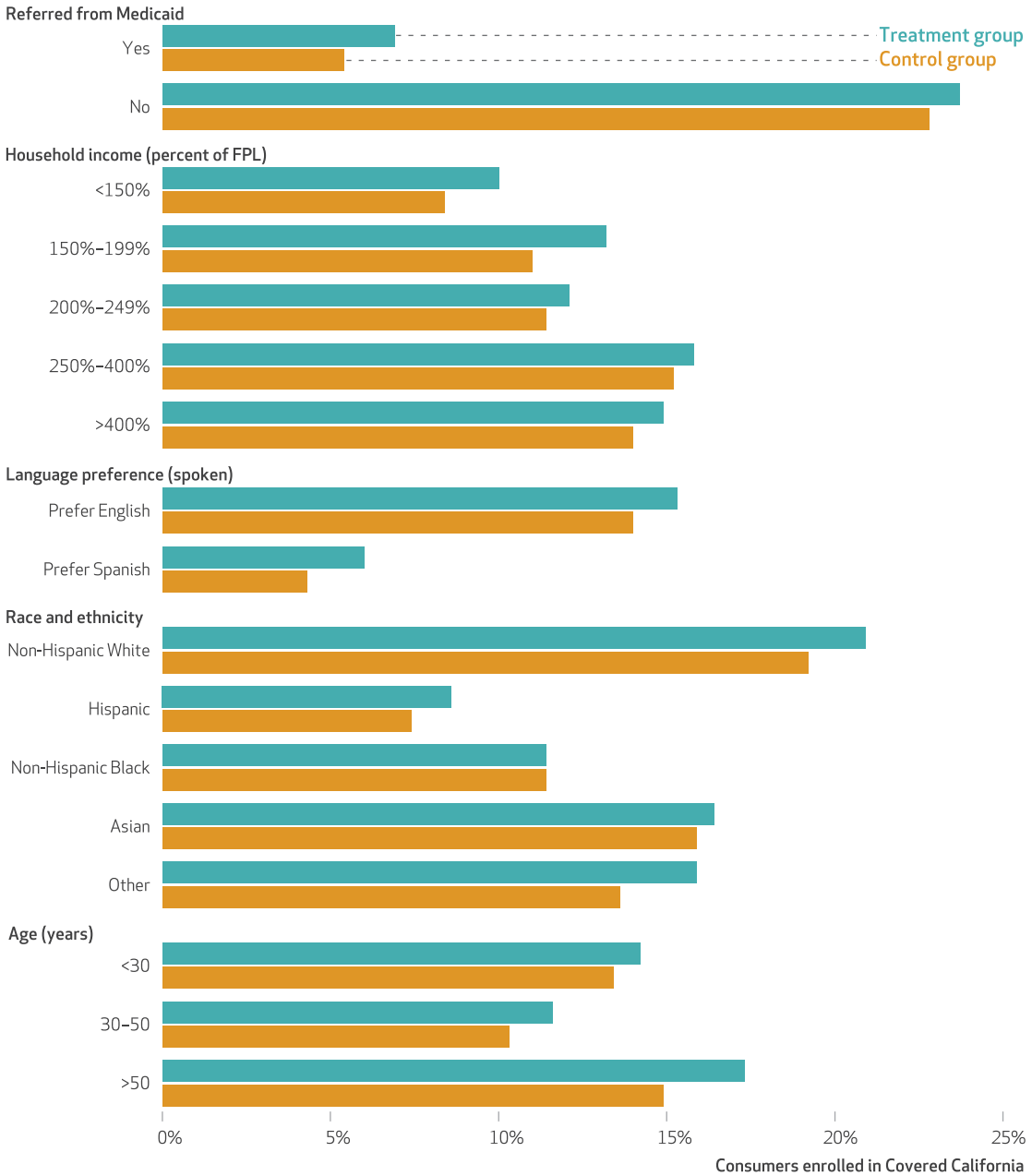
ENROLLMENT IMPACTS The intervention significantly increased take-up of Covered California insurance. By the end of the open enrollment period, 12 percent of the control group had enrolled in Covered California insurance. Assignment to the treatment group increased take-up by 1.3 percentage points ($p < 0.001$)—a 10.8 percent increase over the control-group rate.

Outbound calls were placed to 27,123 households in the treatment group (49 percent). Receiving an outbound call increased Marketplace health insurance take-up by 2.7 percentage points ($p < 0.001$) for consumers who received a call because of random assignment—a 22.5 percent increase over the control-group rate.

HETEROGENEITY ANALYSES Exhibit 2 shows the unadjusted data from people in each subgroup who had been randomly assigned to the treatment and control groups. Data from the control group show that in the absence of intervention, take-up was highest among non-Hispanic White consumers and consumers who were not referred from the Medicaid system (19.2 percent and 22.8 percent, respectively) and was lowest among consumers who preferred Spanish and consumers referred by the Medicaid system (4.3 percent and 5.4 percent, respectively). These data also show that despite higher enrollment rates in the treatment group for

EXHIBIT 2

Enrollment in Covered California among consumers who were randomly assigned to treatment and control groups, by consumer characteristics (unadjusted data), 2018–19



SOURCE Authors' analysis of Covered California administrative data, 2018–19. **NOTES** The exhibit shows unadjusted data from people in each subgroup. Randomization into the treatment group significantly increased enrollment in Covered California among consumers whose applications were initiated by the Medicaid system, whose incomes were either less than 150 percent or 150–199 percent of the federal poverty level (FPL), who preferred spoken English or who preferred spoken Spanish, who identified as Hispanic, or who were ages 30–50 or older than age 50, based on *p* values lower than the Bonferroni threshold of 0.003.

many subgroups, overall enrollment in the study population remained low.

Exhibit 3 depicts adjusted data for each subgroup for our main outcome of interest: the impact of receiving an outbound call from the service center on enrollment. Outbound calls had the largest absolute impact on enrollment for consumers older than age 50 (a 5.1-percentage-point increase, or a 34.2 percent increase, over the control group mean). Outbound calls increased enrollment by 2.9 percentage points (or 53.7 percent) among consumers whose ap-

EXHIBIT 3

Enrollment in Covered California among consumers who did and did not receive an outbound call from service center representatives, by consumer characteristics (adjusted data), 2018–19

Subgroups	Sample sizes[a]	Control-group enrollment rate (%)	Enrollment increase due to outbound call (percentage points)	Change in enrollment[b] (%)
Referred from Medicaid[c]				
Yes	49,020	5.4	2.9****[d]	53.7
No	29,981	22.8	2.1	9.2
Household income as percent of FPL				
<150%	10,437	8.4	4.0****[d]	47.6
150%–199%	24,194	11.0	4.0****[d]	36.4
200%–249%	15,266	11.4	1.3	11.4
250%–400%	13,974	15.2	1.7	11.2
>400%	14,687	14.0	1.7	12.1
Language preference, spoken				
Prefer English	60,672	14.0	2.6****[d]	18.6
Prefer Spanish	15,210	4.3	3.2****[d]	74.4
Race and ethnicity				
Non-Hispanic White	18,611	19.2	3.4	17.7
Hispanic	38,277	7.4	2.3****[d]	31.1
Non-Hispanic Black	3,853	11.4	0.1	0.9
Asian	7,509	15.9	1.0	6.3
Other race and ethnicity	10,751	13.6	4.5	33.1
Age, years				
<30	22,461	13.4	1.7	12.7
30–50	42,406	10.3	2.4****[d]	23.3
>50	14,134	14.9	5.1****[d]	34.2

SOURCE Authors' analysis of Covered California administrative data, 2018–19. **NOTES** Data are adjusted for the covariates mentioned in the text. Significance is determined based on a threshold of $p < 0.003$ under the Bonferroni correction. We did not detect significant differences in the effect size across groups (p value > 0.10). FPL is federal poverty level. [a]The sample sizes in each category vary and do not all sum to 79,522 (treatment plus control groups). This occurs because of missing data or because categories are not exhaustive (for example, some consumers prefer a spoken language other than English or Spanish). [b]Percent change in enrollment among consumers receiving outbound calls. [c]Consumers who had recently disenrolled from Medicaid and were referred to Covered California from the Medicaid eligibility system. [d]Enrollment impact significantly different from zero (that is, p value below the Bonferroni threshold of 0.003). ****$p < 0.001$.

plications were initiated by the Medicaid system, 4.0 percentage points (47.6 percent) among consumers with income less than 150 percent of the federal poverty level, 4.0 percentage points (36.4 percent) among consumers with incomes of 150–199 percent of the federal poverty level, 2.3 percentage points (31.1 percent) among Hispanic consumers, 2.6 percentage points (18.6 percent) among consumers who preferred spoken English, 3.2 percentage points (74.4 percent) among consumers who preferred spoken Spanish, and 2.4 percentage points (23.3 percent) among consumers ages 30–50. Because of the small sample sizes for non-Hispanic Black and Asian consumers, the study was not powered to detect effects of the size found in other subgroups.

The data above indicate which groups experienced any positive enrollment effects; when comparing the size of enrollment effects across groups, we did not detect differences by referral source, income, Spanish spoken language preference, race and ethnicity, or age.

SENSITIVITY ANALYSES Findings were similar when we used alternative modeling approaches (that is, logit and probit models); when we dropped covariates in a prespecified order, first location fixed effects and then all covariates; and when we included people with missing data on covariates. See exhibit S2 in appendix 3.[44]

RETURN ON INVESTMENT The total intervention cost to Covered California was approximately $243,000, or approximately $224 per new member acquired. Our calculations suggested that the return on investment was 102 percent. See appendix 2 for details.[44]

Discussion

Personalized telephone calls from service center representatives increased take-up of Covered California health insurance. Receiving an outbound call from the service center because of random assignment increased enrollment by

2.7 percentage points—a 22.5 percent increase over the control-group rate. Enrollment impacts were statistically significant for lower-income households (below 200 percent of the federal poverty level) but not for higher-income households.

The intervention increased enrollment in Marketplace insurance among adults older than age fifty by 5.1 percentage points. This finding has important policy implications because older adults are more likely than younger adults to have chronic conditions that require ongoing medical attention.[45,46] This finding also contrasts with findings from studies of computer- or mail-based information interventions, which showed impacts to be concentrated among younger and healthier populations.[21,22,29]

In the absence of intervention, enrollment in Marketplace insurance was particularly low (below 6 percent) among consumers who preferred spoken Spanish and among consumers disenrolled from Medicaid. This finding is consistent with prior data suggesting that people with low English proficiency disproportionately experience gaps in insurance and access to care[34,47] and that consumers disenrolled from Medicaid are at high risk of remaining uninsured and losing access to care.[48,49] Receipt of an outbound call increased Marketplace enrollment by 3.2 percentage points (74.4 percent) for consumers who preferred spoken Spanish and by 2.9 percentage points (53.7 percent) for consumers disenrolled from Medicaid.

Despite these increases, enrollment in Covered California insurance remained low for our study population. There are many reasons why the intervention might not have resulted in Marketplace enrollment for certain consumers. First, for the three-quarters of the treated group that likely only received a voicemail message, the intervention represented a modest nudge. Second, some consumers may perceive that their Marketplace coverage options are not a good value.[50] Also, some consumers may have taken up insurance elsewhere. A prior administrative survey of the population from which our study sample was drawn found that 19 percent of this group ultimately obtained Medicaid coverage and that 26 percent obtained employer-sponsored coverage.[51] The low postintervention enrollment rate may also indicate the persistence of enrollment frictions. Nonetheless, the reported treatment effects are larger than those generated by comparatively passive nudges for similar study samples.[22,24,26]

A longer service center representative intervention or one paired with passive nudges and reminders might generate further modest effects, given that some consumers may have lacked the time to talk with the representative. More far-reaching strategies that reduce frictions, such as automatic enrollment, may achieve much higher enrollment levels.[52]

In the absence of structural enrollment reforms such as auto-enrollment, our study indicates that personalized outbound call interventions may still induce modest but meaningful enrollment gains in certain populations while yielding a positive return on investment. We estimated that the intervention has yielded a positive expected return on investment for the state-based Marketplace of 102 percent, or roughly two to one. Our estimated cost per new member acquired, $224, is similar to Covered California's average lifetime commission per member for broker-assisted consumers; other reported acquisition costs in the individual market range from less than $100 to $1,000.[53,54]

Our findings inform current policy debates about how to invest in outreach to boost Marketplace enrollment. The Government Accountability Office has recommended enhancing the management of the consumer experience to improve the performance of the Marketplaces.[5] Furthermore, the American Rescue Plan Act of 2021 expanded eligibility for subsidized Marketplace coverage for households with incomes below 150 percent of poverty; our findings suggest that personalized outreach increases enrollment in this income group. Similar to prior studies, we found that information interventions do not fully overcome barriers to enrollment for many consumers.[22,24,26,28,34] Nonetheless, informational interventions may induce modest gains in enrollment among certain segments of the population while yielding a positive return on investment. ■

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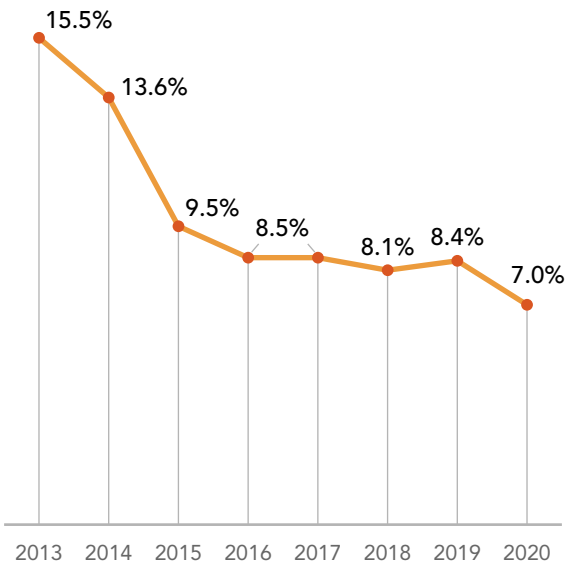
CHCF Issue Brief

Coverage During a Crisis: Insured Rate for Californians Hits Historic High in First Year of COVID-19 Pandemic

Despite widespread concern that economic fallout from the pandemic could slow California's progress toward covering the uninsured, more Californians had health insurance coverage than ever before in 2020, according to results from the latest California Health Interview Survey (CHIS). The uninsured rate among the total nonelderly California population declined significantly, from 8.4% in 2019 to 7.0% in 2020. The rate in 2020 was less than half the rate of 15.5% in 2013, before the coverage expansions of the Affordable Care Act (ACA) (Figure 1).[1]

Figure 1. Uninsured Nonelderly Californians, 2013–20



* Due to changes in California Health Interview Survey (CHIS) design in 2019, comparisons to prior years should be interpreted with caution.

Sources: State Health Access Data Assistance Center (SHADAC) analysis of CHIS data. "A New Design for CHIS 2019–2020," UCLA Center for Health Policy Research.

With full implementation of the ACA in 2014, many Californians obtained health insurance through expanded eligibility for Medicaid (called Medi-Cal in California). The ACA also provided federal government subsidies to make individual coverage purchased through Covered California more affordable for Californians with moderate incomes.

Since then, California has enacted policies beyond the ACA to expand access to coverage. The state extended Medi-Cal coverage to undocumented children and young adults up to 26 in families with low incomes, and increased state-funded premium subsidies for some Covered California enrollees. The state also instituted a tax penalty for being uninsured, in effect reviving an ACA policy that was nullified by Congress in 2017.

In 2020, the federal government enacted provisions that helped protect health insurance coverage during the pandemic. For example, the Families First Coronavirus Response Act (FFCRA) limited the ability of states to disenroll people from Medicaid through its "continuous coverage" provision, which went into effect in March 2020. There were also multiple stimulus checks, providing direct payments to millions of Californians. These cash infusions may have helped consumers continue to pay premiums despite job losses and reduced wages resulting from broad shutdowns targeted at slowing the spread of the virus.

Key Coverage Supports in 2021

There were also important coverage supports enacted in 2021. Although the impacts of these policies are not reflected in the 2020 data discussed here, the policies provide important context for understanding trends that emerge in 2021 and beyond. For example, the American Rescue Plan of 2021 increased premium subsidies available for those purchasing their own coverage through Covered California and other state marketplaces. Researchers have estimated[2] that this policy provides an additional $91 per month to those Californians already enrolled. The federal government also provided 100% premium subsidies for COBRA coverage from April through September 2021, allowing people who lost their jobs during the COVID-19 crisis to keep their work-based health insurance.

The combination of prepandemic state and federal policies that expanded health insurance coverage, along with quick action by policymakers in 2020 to bolster those policies with additional crisis stopgaps, helped protect coverage for many Californians during the pandemic. Below, more detailed information is provided about the coverage landscape in California in 2020, highlighting both encouraging trends and persistent disparities that warrant attention, particularly as federal policies that protect coverage connected to the pandemic end or wind down.

Rates of Uninsured Dropped Across Several Population Subgroups from 2019 to 2020

In addition to the statewide trend toward expanded coverage from 2019 to 2020, the rates of uninsured also declined for several key subgroups in this time period (Table 2, page 3):

- Californians with incomes up to 138% of the federal poverty guidelines (FPG), dropping from 12.1% in 2019 to 9.6% in 2020. These are people whose income would make them eligible for Medi-Cal, many through the ACA expansion of the program.
- Californians who identify as Latinx, from 12.9% in 2019 to 10.5% in 2020.
- Those residing in rural areas of the state, from 9.6% to 6.4%.
- Adults age 18 to 64, from 10.8% to 9.1%.

There were no statistically significant changes in uninsured rates by citizenship, for urban Californians, children, or for other categories by income or race/ethnicity.

Statistical significance is a mathematical test of whether differences are real or the result of random chance. A confidence level of 95% means that researchers are 95% confident that the results were not due to random chance.

Table 1. Annual Income, by FPG (family of four)

	2019	2020
100% FPG	$25,750	$26,200
138% FPG	$35,535	$36,156
250% FPG	$64,375	$65,500
400% FPG	$103,000	$104,800

Source: Office of the Assistant Secretary for Planning and Evaluation, 2019-poverty-guidelines and 2020-poverty-guidelines.

Table 2. Uninsured Rates Among Nonelderly Californians, 2019–20

	2020	2019	PERCENTAGE POINT CHANGE, 2019–20	SIGNIFICANCE
Overall	**7.0%**	**8.4%**	**–1.4**	*
AGE				
▶ 0 to 17	1.8%	2.0%	–0.2	
▶ 18 to 64	9.1%	10.8%	–1.8	*
GEOGRAPHY				
▶ Urban	7.1%	8.2%	–1.1	
▶ Rural	6.4%	9.6%	–3.2	*
INCOME, BY FEDERAL POVERTY GUIDELINES				
▶ 0% to 138% FPG	9.6%	12.1%	–2.5	*
▶ 139% to 249% FPG	11.7%	14.2%	–2.4	
▶ 250% to 399% FPG	8.3%	9.1%	–0.7	
▶ 400%+ FPG	4.1%	4.7%	–0.6	
RACE AND ETHNICITY				
▶ Latinx	10.5%	12.9%	–2.4	*
▶ Asian	5.4%	6.4%	–1.0	
▶ Black	5.3%	4.1%	1.2	
▶ Other / Multiple Races	5.1%	4.6%	0.5	
▶ White	3.8%	4.5%	–0.7	
▶ American Indian / Alaska Native	†	†	N/A	
CITIZENSHIP				
▶ Citizen	5.6%	6.4%	–0.8	
▶ Noncitizen	18.4%	22.8%	–4.4	

* Statistically significant difference between 2019 and 2020 at the 95% confidence level. See the box on page 2 for a definition of statistical significance.

† Estimate suppressed due to insufficient sample and/or unstable estimate.

Notes: Source uses *African American* instead of *Black*. *N/A* is not available. Percentage point difference shown may differ from calculations in the table due to rounding.

Source: SHADAC analysis of CHIS data.

Employer and Individual Coverage Held Steady Statewide, and Increased for Some Groups

There was concern that the deep job losses associated with the pandemic would result in loss of employer-sponsored insurance, which covers the majority of Californians. However, the overall statewide rate of employer coverage among the nonelderly was statistically unchanged from 58.8% in 2019 to 60.1% in 2020. Employer coverage increased significantly from 59.2% to 60.9% among nonelderly adults, from 62.6% to 64.9% among citizens, and from 20.5% to 24.0% among those with incomes 0% to 138% FPG (Table A1, page 8).

The increased rate of employer coverage among those with very low incomes is unusual, and it's likely that the unique circumstances of the pandemic and government supports to help people weather the situation influenced those changes, but the exact mechanisms by which that may have happened are not yet clear. It is possible that the increase in employer coverage among people with lower incomes might be explained by a shift in the composition of the population with low incomes during the pandemic. For example, pandemic-driven job losses may have pushed a larger number of people into this income category temporarily, and these people may have been more likely to have had and kept employer coverage than other Californians with low incomes.

There were no statistically significant changes in employer-sponsored insurance from 2019 to 2020 for Californians in other income categories, children, or noncitizens, or by race/ethnicity or geography.

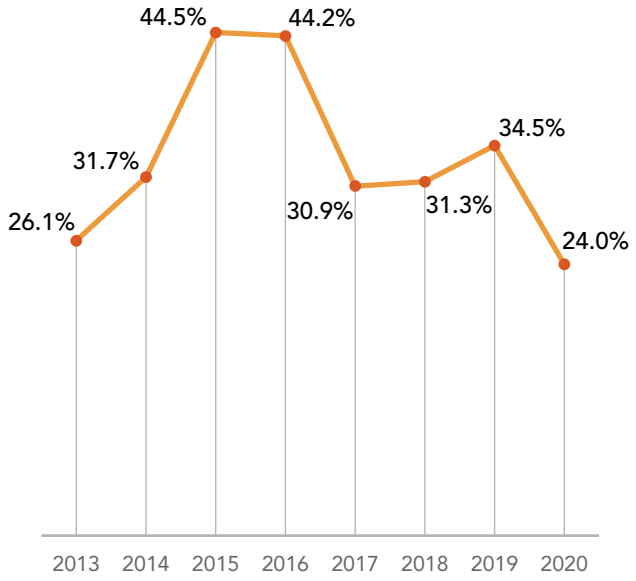
The share of Californians purchasing their own health insurance coverage, either directly from insurers or through Covered California, also held steady from 2019 to 2020, at 5.6%. Changes among subgroups were also limited. Individually purchased coverage increased significantly among Asians from 4.9% to 7.6%, but decreased from 8.1% to 6.8% among White people. There were no statistically significant changes for other racial/ethnic groups, or by age, citizenship, geography, or income (Table A2, page 9).

Medi-Cal Coverage Held Steady Statewide, but Declined Significantly Among Black Californians

Medi-Cal coverage held steady between 2019 and 2020, covering roughly one quarter of the nonelderly population (Table A3, page 10).[3] Changes by subpopulation were also limited, with the notable exception that the share of Black Californians with Medi-Cal declined from 34.5% in 2019 to 24.0% in 2020, a difference that was statistically significant, and is a continuation of recent trends. The share of Black Californians covered by Medi-Cal increased for the first few years following implementation of the ACA, but has declined since its peak in 2015 (Figure 2, page 5). As noted above, the percentage of Black Californians without insurance increased from 4.1% to 5.3% between 2019 and 2020. This difference was not statistically significant, but merits continued monitoring.

There were no statistically significant changes in Medi-Cal coverage for other racial/ethnic groups, or by age, citizenship, or geography.

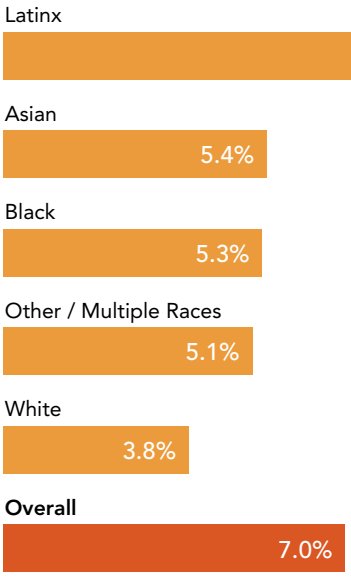
Figure 2. Medi-Cal Among Black Californians, 2013–20



Note: Due to changes in CHIS design in 2019, comparisons to prior years should be interpreted with caution.

Sources: SHADAC analysis of CHIS data. "A New Design for CHIS 2019–2020," UCLA Center for Health Policy Research.

Figure 3. Nonelderly Uninsured, by Race/Ethnicity, 2020



Uninsured rate among Latinx Californians remains almost **THREE TIMES** as high as that of their White counterparts.

* Statistically significant difference from White at the 95% level of confidence.

Notes: *American Indian / Alaska Native* suppressed due to unstable estimate. Source uses *African American* instead of *Black*.

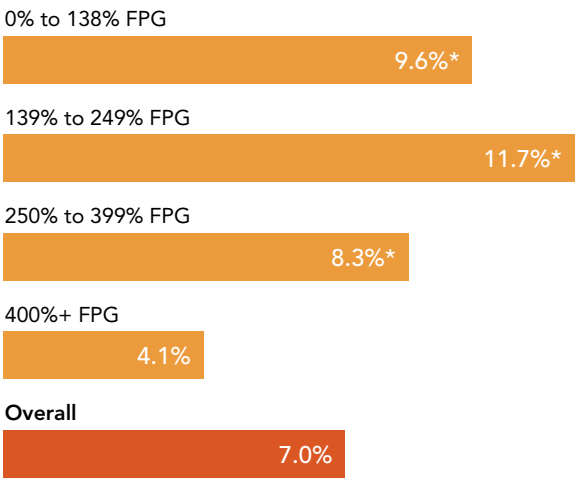
Source: SHADAC analysis of CHIS data.

Despite Measurable Progress, Critical Disparities in Coverage Persist

Despite considerable progress in expanding coverage and historic narrowing of disparities[4] that CHCF has reported on previously, there remain substantial inequities in the extent to which certain groups remain uninsured in California.

- The uninsured rate among Latinx Californians remains almost three times as high as that of their White counterparts (10.5% compared to 3.8%), a difference that was statistically significant (Figure 3).
- Noncitizen adults are uninsured at more than three times the rate of their citizen counterparts (18.4% compared to 5.6%) (Table 2, page 3).
- Californians with lower incomes are more likely to be uninsured than those with incomes above 400% FPG (Figure 4).

Figure 4. Nonelderly Uninsured, by Income, 2020



* Statistically significant difference from 400%+ at the 95% level of confidence.

Source: SHADAC analysis of CHIS data.

Conclusion

California has made remarkable progress in expanding access to health coverage since the passage of the Affordable Care Act in 2013. The state's robust implementation of the ACA and additional state policies over the years, in combination with recent state and federal policies designed to protect against coverage losses during the pandemic, has enabled the rate of coverage among Californians to rise to historic levels, even during a massive public health and economic crisis.

However, there is potential for coverage expansion to slow or even reverse as policies that provided robust protection during the pandemic unwind or scale back. For example, the American Rescue Plan Act subsidies for those purchasing coverage through Covered California are set to expire in 2023 without additional legislative action. The COBRA subsidies will end in 2022. The FFCRA continuous coverage provision for Medicaid will end with the federally declared public health emergency, potentially leading to large numbers of Californians with low incomes losing coverage if flexibilities and consumer-friendly enrollment policies are not embraced.

The sunsetting of these policies could also reverse or stall California's progress on closing disparities in coverage. Researchers have pointed out[5] that the end of the continuous coverage provision for Medicaid, in particular, has the potential to disproportionately impact communities of color. Given that disparities have persisted even during a time with considerable policy action to promote coverage, it will be critical to continue to monitor the impacts of these provisions phasing out in California and to take policy action to protect consumers.

The state is also planning additional provisions to bolster coverage in the coming year, including expanding Medi-Cal coverage to Californians with low incomes age 50 and above regardless of immigration status as well as implementing other Medi-Cal enrollment and eligibility improvements. These interventions should help many Californians get and maintain coverage.

As the pandemic abates, it will be important to monitor not only whether health insurance coverage rates hold steady, continue to improve, or regress — and for whom — but also how coverage translates into tangible benefits for Californians. Ultimately, the value of health insurance is found in enhancing people's access to health care services and insulating them against unaffordable costs, which can sometimes be financially ruinous. Further research in subsequent years should investigate the extent to which and for whom the state's steadily improving health coverage landscape is resulting in improvements to Californians' ability to get and afford health care.

About the Author

Lacey Hartman, MPP, is a senior research fellow at the State Health Access Data Assistance Center (SHADAC), where she leads a range of projects aimed at helping states use data to inform policy.

About the Foundation

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

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

Endnotes

1. The survey data reported here rely on self-reported insurance status. When asked by survey researchers about health coverage, some immigrants who are undocumented and who have used restricted scope Medi-Cal may respond that they have Medi-Cal coverage. Restricted-scope Medi-Cal, which covers only emergency and pregnancy-related services, is not comprehensive coverage. If survey respondents with restricted-scope Medi-Cal were instead reported as uninsured, the number of Californians without insurance would be higher.
2. Miranda Deitz et al., *American Rescue Plan Improvements to Covered California Affordability: Who Gains?*, California Health Care Foundation (CHCF), April 2021.
3. This estimate differs from administrative data from the California Department of Health Care Services, which put Medi-Cal enrollment at 13.1 million in 2020 (or about a third of the California population), because surveys tend to undercount Medicaid. DHCS data as cited in Finocchio et al., *Medi-Cal Facts and Figures, 2021 Edition*, CHCF, August 2021.
4. Tara Becker, *ACA Reduces Racial/Ethnic Disparities in Health Coverage*, CHCF, October 2018.
5. Patricia Boozang and Adam Striar, "The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage," State Health and Value Strategies, September 17, 2021.

Appendix. Supplemental Data Tables

Table A1. Employer Coverage Rates Among Nonelderly Californians, 2019–20

	2020	2019	PERCENTAGE POINT CHANGE, 2019–20	SIGNIFICANCE
Overall	**60.1%**	**58.8%**	**1.4**	
AGE				
▶ 0 to 17	58.1%	57.7%	0.4	
▶ 18 to 64	60.9%	59.2%	1.7	*
GEOGRAPHY				
▶ Urban	59.4%	60.6%	–1.2	
▶ Rural	52.6%	56.5%	–3.9	
INCOME, BY FEDERAL POVERTY GUIDELINES				
▶ 0% to 138% FPG	24.0%	20.5%	3.6	*
▶ 139% to 249% FPG	42.8%	39.4%	3.4	
▶ 250% to 399% FPG	64.2%	63.5%	0.7	
▶ 400%+ FPG	82.0%	82.0%	0.1	
RACE AND ETHNICITY				
▶ White	72.8%	70.4%	2.4	
▶ Asian	66.0%	70.5%	–4.5	
▶ Black	60.0%	53.8%	6.2	
▶ American Indian / Alaska Native	48.5%	†	N/A	
▶ Latinx	47.4%	45.5%	1.9	
▶ Other / Multiple Races	70.7%	74.2%	–3.5	
CITIZENSHIP				
▶ Citizen	64.9%	62.6%	2.3	*
▶ Noncitizen	38.4%	40.5%	–2.2	

* Statistically significant difference from reference category at 95% confidence level. See the box on page 2 for a definition of statistical significance.

† Estimate suppressed due to insufficient sample and/or unstable estimate.

Notes: Source uses *African American* instead of *Black*. *N/A* is not available. Percentage point difference shown may differ from calculations in the table due to rounding.

Source: SHADAC analysis of CHIS data.

Table A2. Individual Market Coverage Rates Among Nonelderly Californians, 2019–20

	2020	2019	PERCENTAGE POINT CHANGE, 2019–20	SIGNIFICANCE
Overall	**5.6%**	**5.6%**	**0.0**	
AGE				
▶ 0 to 17	3.4%	3.1%	0.3	
▶ 18 to 64	6.4%	6.6%	–0.2	
GEOGRAPHY				
▶ Urban	5.3%	5.5%	–0.2	
▶ Rural	7.4%	6.9%	–0.5	
INCOME, BY FEDERAL POVERTY GUIDELINES				
▶ 0% to 138% FPG	4.5%	4.1%	0.5	
▶ 139% to 249% FPG	7.1%	6.2%	0.8	
▶ 250% to 399% FPG	6.7%	8.1%	–1.4	
▶ 400%+ FPG	5.3%	5.0%	0.3	
RACE AND ETHNICITY				
▶ Asian	7.6%	4.9%	2.8	*
▶ White	6.8%	8.1%	–1.3	*
▶ Latinx	4.0%	4.2%	–0.1	
▶ Black	3.8%	2.9%	0.9	
▶ American Indian / Alaska Native	†	†	N/A	
▶ Other / Multiple Races	7.1%	6.0%	1.1	
CITIZENSHIP				
▶ Citizen	5.5%	5.7%	–0.2	
▶ Noncitizen	6.2%	4.7%	1.5	

* Statistically significant difference from reference category at 95% confidence level. See the box on page 2 for a definition of statistical significance.

† Estimate suppressed due to insufficient sample and/or unstable estimate.

Notes: Source uses *African American* instead of *Black*. *N/A* is not available. Percentage point difference shown may differ from calculations in the table due to rounding.

Source: SHADAC analysis of CHIS data.

Table A3. Medi-Cal Rates Among Nonelderly Californians, 2019–20

	2020	2019	PERCENTAGE POINT CHANGE, 2019–20	SIGNIFICANCE
Overall	**24.8%**	**24.7%**	**0.1**	
AGE				
▶ 0 to 17	35.3%	36.7%	–1.4	
▶ 18 to 64	20.8%	20.1%	0.7	
GEOGRAPHY				
▶ Urban	24.6%	24.5%	0.1	
▶ Rural	26.8%	27.3%	–0.5	
INCOME, BY FEDERAL POVERTY GUIDELINES				
▶ 0% to 138% FPG	58.2%	59.7%	–1.5	
▶ 139% to 249% FPG	34.7%	36.3%	–1.6	
▶ 250% to 399% FPG	18.1%	16.2%	1.9	
▶ 400%+ FPG	7.2%	7.0%	0.2	
RACE AND ETHNICITY				
▶ Latinx	35.7%	35.1%	0.6	
▶ Black	24.0%	34.5%	–10.5	*
▶ Asian	20.1%	17.0%	3.1	
▶ White	14.1%	14.1%	0.0	
▶ American Indian / Alaska Native	†	51.1%	N/A	
▶ Other / Multiple Races	14.7%	12.7%	2.0	
CITIZENSHIP				
▶ Citizen	24.3%	25.0%	–0.7	
▶ Noncitizen	34.7%	29.8%	4.9	

* Statistically significant difference from reference category at 95% confidence level. See the box on page 2 for a definition of statistical significance.

† Estimate suppressed due to insufficient sample and/or unstable estimate.

Notes: Source uses *African American* instead of *Black*. *N/A* is not available. Percentage point difference shown may differ from calculations in the table due to rounding.

Source: SHADAC analysis of CHIS data.

Table A4. Uninsured Rates Among Nonelderly Californians, 2020

	2020	PERCENTAGE POINT DIFFERENCE FROM REFERENCE	SIGNIFICANCE
Overall	**7.0%**	**N/A**	*****
AGE			
▶ 0 to 17	1.8%	–7.2	*
▶ 18 to 64	9.1%	Reference	
GEOGRAPHY			
▶ Urban	7.1%	Reference	
▶ Rural	6.4%	–0.7	
INCOME, BY FEDERAL POVERTY GUIDELINES			
▶ 0% to 138% FPG	9.6%	5.5	*
▶ 139% to 249% FPG	11.7%	7.6	*
▶ 250% to 399% FPG	8.3%	4.2	*
▶ 400%+ FPG	4.1%	Reference	
RACE AND ETHNICITY			
▶ Latinx	10.5%	6.7	*
▶ Asian	5.4%	1.6	
▶ Black	5.3%	1.5	
▶ White	3.8%	Reference	
▶ American Indian / Alaska Native	†	N/A	
▶ Other / Multiple Races	5.1%	1.2	
CITIZENSHIP			
▶ Citizen	5.6%	Reference	
▶ Noncitizen	18.4%	12.8	*

* Statistically significant difference from reference category at 95% confidence level. See the box on page 2 for a definition of statistical significance.

† Estimate suppressed due to insufficient sample and/or unstable estimate.

Notes: Source uses *African American* instead of *Black*. *N/A* is not available. Percentage point difference shown may differ from calculations in the table due to rounding.

Source: SHADAC analysis of CHIS data.

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

ISSUE BRIEF

January 11, 2022

HP-2022-01

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

Research examining the impact of the Affordable Care Act suggests that millions of individuals have benefitted from increased access to care and coverage of clinical preventive services without cost-sharing.

KEY POINTS

- The Affordable Care Act (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.

BACKGROUND

Preventive services can help people avoid acute illness, identify and treat chronic conditions, prevent cancer or lead to earlier detection, and improve health. The Affordable Care Act (ACA) reduced financial barriers to accessing preventive services by requiring that most private health plans cover certain recommended preventive services without cost-sharing. This requirement became effective for new health coverage beginning on or after September 23, 2010, except for a requirement concerning women's preventive services, which became effective for plan years beginning on or after August 1, 2012.

Under the ACA, in most instances group health plans and individual health coverage plans cannot charge a patient a copayment, co-insurance, or deductible for these services when they are delivered by an in-network provider.* One exception are so-called "grandfathered" plans, which are plans that were in existence prior to 2010 and are allowed to continue offering benefit designs other than those generally required by the ACA. By eliminating cost-sharing for these services, the ACA was designed to increase access and use of preventive care, especially among individuals for whom affordability was a key barrier.

This issue brief summarizes the ACA'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.

POLICY OVERVIEW

Private Health Coverage

Under the ACA, most private insurance plans are required to cover four categories of preventive services in-network without cost-sharing, including:

1. evidence-based preventive services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF), which indicates moderate to high certainty that the net benefits of those services are moderate to substantial;[1]
2. routine vaccines for adults and children that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) and which has been adopted by the Director of the Centers for Disease Control and Prevention (CDC);[2]
3. evidence-informed preventive services for infants, children, and adolescents provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);[†,3] and
4. preventive care and screenings for women, other than those that have in effect a rating of A or B in the current recommendations of the USPSTF, that are provided for in comprehensive guidelines supported by HRSA.[4]

These requirements do not apply to grandfathered plans, which are plans that existed on March 23, 2010, before the law was enacted, that meet certain requirements, and that are exempt from certain provisions of the ACA.[‡]

The range of preventive services covered without cost-sharing includes services such as alcohol misuse screening and counseling, blood pressure screening, depression screening, immunizations, and obesity screening and counseling. Certain covered preventive services recommended by the USPSTF are specific to people in certain age groups or individuals at increased risk; for example, screening for latent tuberculosis in populations at increased risk of infection, and colorectal cancer screening for adults aged 45 to 75.[5,6,7] The USPSTF defers to the ACIP on recommendations concerning the use of vaccines.[§]

[†] The guidelines implemented by HRSA are commonly referred to as Bright Futures and the Women's Preventive Services Guidelines.

[‡] These requirements also do not apply to coverage of certain services when a religious exemption applies.

[§] The Centers for Disease Control and Prevention (CDC) sets the U.S. adult and childhood immunization schedules based on recommendations from the ACIP.

Most health plans also generally must cover a set of preventive services for children without cost-sharing (i.e., those plans that are not grandfathered as discussed above) including those providing coverage in the group, individual, and Medicaid markets.[8] Preventive services benefits for children include, but are not limited to, alcohol, tobacco, and drug use assessments for adolescents; universal newborn hearing screening; developmental and autism screening for children at 18 and 24 months; bilirubin concentration screening for newborns; blood pressure screening for children ages 0 to 17 years; developmental screening for children under age 3; and routine immunization for children from birth to age 18 (doses, recommended ages, and recommended populations vary).

In most instances, non-grandfathered group and individual health coverage plans are required to cover certain preventive benefits for women, including well-woman visits, screening and counseling for domestic violence, U.S. Food and Drug Administration (FDA)-approved contraceptive methods, and other services specified in the Women's Preventive Services Guidelines, which initially went into effect August 2012.[9] These guidelines are updated periodically to reflect the latest evidence-based recommendations including, for example, a recommendation that adolescent and adult women have access to the full range of FDA-approved contraceptive products, effective family planning practices, and sterilization procedures for women to prevent unintended pregnancy and improve health outcomes.

Estimated Population Size with Private Health Coverage Benefitting from ACA Provisions

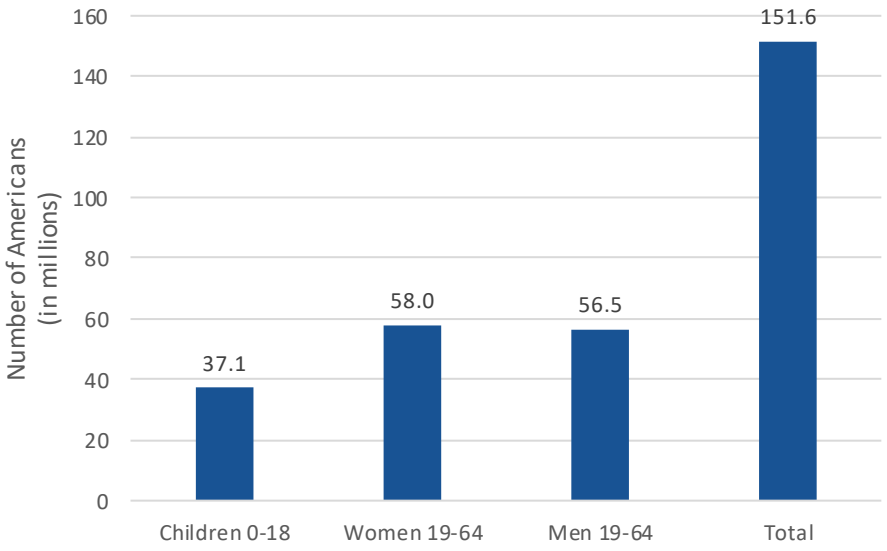
Previous analyses by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated that approximately 137 million Americans with private insurance had access to preventive services without cost sharing in 2015.[10,**] Using the same method, ASPE estimates that about 151.6 million had such coverage in 2020. The increase is due in part to growth in the number of people enrolled in private health coverage and a decrease in the share of such people enrolled in grandfathered plans.

In 2020, the most recent year of data available, 175.9 million people under age 65 had private health coverage, mainly through an employer, but also including coverage purchased through a state or federal Marketplace.[11] The 2020 Kaiser Family Foundation Employer Health Benefits survey found that 14 percent of individuals with employer-based health plans were enrolled in grandfathered plans, which are not required to provide preventive service coverage with zero cost-sharing (we assume that these individuals are subject to some level of cost sharing for preventive services). Data from the 2020 Final Rule on Grandfathered Health Plans and from the 2020 National Health Expenditures Accounts suggest that at most 12 percent of people with individual market coverage are enrolled in grandfathered health plans.[††] Using these statistics, we estimate that a total of approximately 151.6 million individuals[12] currently have private health coverage that covers preventive services with zero cost-sharing (Figure 1).[13] This includes approximately 58 million women, 57 million men, and 37 million children. Table 1 presents state-level estimates.

[**] ASPE released a different estimate in 2012 focused on the number of people *newly* gaining coverage for free preventive services, based on how many people with private coverage already had access to preventive care vs. how many were gaining it for the first time, with an estimate of 54 million. The more recent reports, including this report, provide estimates of how many *total* people have private coverage without cost-sharing for these services, whether or not some may have had similar coverage prior to the ACA.

[††] See Figure 1 sources for more information on this estimate.

Figure 1. Estimated Number of Individuals with Private Health Coverage, by Age and Gender, with Preventive Services Coverage without Cost-Sharing, 2020 (in millions)



Note: ASPE subtracted estimated 14% and 12% of grandfathered plan enrollees from the total number of individuals with employee sponsored health insurance and the total number of individuals with nongroup insurance, respectively, to estimate the number of privately covered individuals with preventive services coverage without cost-sharing.

Sources: Privately insured individuals, by age and gender: 2020 Kaiser Family Foundation State Health Facts on Health Coverage and the Uninsured, developed from the 2017-2021 Current Population Survey (CPS) Annual Social and Economic Supplements: https://www.kff.org/state-category/health-coverage-uninsured/

Grandfathered plan estimates: 2020 Kaiser Family Foundation Employer Health Benefits Survey: https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/

Non group estimate calculated from 2020 Final Rule on Grandfathered Health Plans and 2020 National Health Expenditures Table 22 on coverage:
https://www.govinfo.gov/content/pkg/FR-2020-12-15/pdf/2020-27498.pdf
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

Table 1. State-level Estimates of Individuals with Private Health Coverage with Preventive Services Coverage without Cost-Sharing, 2020 (in thousands)

	Children (<19)	Women (ages 19-64)	Men (ages 19-64)	Total
United States	37,077	58,019	56,483	151,579
Alabama	513	813	757	2,084
Alaska	60	95	91	246
Arizona	758	1,121	1,163	3,042
Arkansas	274	480	460	1,214
California	4,411	6,718	6,860	17,988
Colorado	625	1,032	1,055	2,712
Connecticut	341	615	587	1,543
Delaware	92	174	153	420
District of Columbia	53	157	156	367
Florida	1,872	3,606	3,566	9,045
Georgia	1,081	1,871	1,706	4,658
Hawaii	134	229	236	599
Idaho	227	315	320	862
Illinois	1,656	2,429	2,433	6,518
Indiana	946	1,241	1,220	3,407
Iowa	406	588	593	1,587
Kansas	402	523	517	1,441
Kentucky	414	712	713	1,840
Louisiana	417	663	644	1,724
Maine	105	248	220	573
Maryland	800	1,195	1,118	3,113
Massachusetts	767	1,326	1,249	3,343
Michigan	1,203	1,759	1,697	4,659
Minnesota	817	1,145	1,135	3,097
Mississippi	294	513	445	1,252
Missouri	741	1,152	1,070	2,964
Montana	116	171	166	453
Nebraska	278	364	388	1,030
Nevada	316	524	529	1,369
New Hampshire	162	261	279	702
New Jersey	1,143	1,673	1,693	4,509
New Mexico	131	257	251	640
New York	2,073	3,452	3,067	8,592
North Carolina	959	1,908	1,783	4,650
North Dakota	114	141	156	411
Ohio	1,302	1,983	1,950	5,235
Oklahoma	379	578	579	1,537
Oregon	510	803	740	2,053
Pennsylvania	1,432	2,441	2,348	6,220
Rhode Island	127	206	191	524
South Carolina	483	887	905	2,275
South Dakota	113	163	174	450
Tennessee	685	1,118	1,093	2,895
Texas	3,472	4,884	4,583	12,939
Utah	617	620	591	1,829
Vermont	64	114	115	292
Virginia	1,115	1,680	1,596	4,392
Washington	896	1,502	1,477	3,875
West Virginia	172	277	294	743
Wisconsin	704	1,191	1,276	3,171
Wyoming	62	101	93	256

Note: ASPE subtracted the estimated 14% and 12% of grandfathered plan enrollees from the total number of individuals with employee sponsored health insurance and the total number of individuals with nongroup insurance, respectively, to estimate the number of privately covered individuals with preventive services coverage without cost-sharing. Numbers of individual children, women, and men may not sum to total due to rounding.

Sources: Privately insured individuals, by age and gender: 2020 Kaiser Family Foundation State Health Facts on Health Coverage and the Uninsured, developed from the 2017-2021 Current Population Survey (CPS) Annual Social and Economic Supplements: https://www.kff.org/state-category/health-coverage-uninsured/

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Medicaid and Children's Health Insurance Program

In addition to the 151.6 million individuals with non-grandfathered group health plans and non-grandfathered group and individual health coverage who benefit from preventive services coverage under the ACA, the ACA provisions also address coverage of preventive services in both Medicare and Medicaid. Medicaid coverage offered by states (and the District of Columbia) that have expanded Medicaid eligibility to non-elderly adults with family incomes at or below 133 percent of the federal poverty level must cover the full range of preventive services required by the essential health benefits (EHB) regulations, which includes recommended preventive services coverage without cost-sharing.

In Medicaid, the ACA requirement for coverage of preventive services without cost-sharing applies only to Medicaid expansion enrollees and other Medicaid enrollees in Alternative Benefit Plans. As of October 2021, 38 states and the District of Columbia have expanded Medicaid.[14] Under Medicaid expansion, approximately 20 million adults had coverage for preventive services without cost-sharing as of September 2021.[15]

Unrelated to the ACA, all children in Medicaid (31 million in December 2020)[16] are covered without cost-sharing for Early and Periodic Screening, Diagnostics and Treatment (EPSDT), created in 1967, which includes well-child visits and ACIP-recommended vaccines,[17] and other essential preventive health benefits for children.

Medicaid coverage of preventive services for adults in states that have not expanded Medicaid is a state option, but most states provided some level of coverage of these services before the ACA.[18] Tobacco cessation for pregnant women is the only preventive service listed under mandatory Medicaid benefits.[19] Optional benefits include "other diagnostic, screening, preventive and rehabilitative services." In traditional Medicaid, states that opt to cover all USPSTF Grade "A" or "B" recommended preventive services and ACIP-recommended vaccines and their administration without cost-sharing receive a one percentage point increase in the federal medical assistance percentage (FMAP) for those services.[20] State Medicaid Agencies are encouraged to consider this option to ensure access to preventive services without cost-sharing to additional Medicaid beneficiaries without mandatory coverage.

A total of 33 states covered well-adult exams in FFS and in managed care, and five states covered well-adult exams in managed care in 2012.[21] Half the states charged co-pays in 2012. Three states did not cover screening mammograms at all, and two states did not cover Pap testing while some states covered Pap testing only as part of family planning visits. A 2018-19 study showed that only 24 out of 49 Medicaid state programs responding to a survey covered all 13 ACIP-recommended adult vaccines.[22] A total of 48 Medicaid state FFS programs covered hepatitis B and meningococcal ACWY[‡‡] vaccines and 47 Medicaid state FFS programs covered influenza; tetanus, diphtheria, and pertussis (Tdap); measles, mumps, and rubella (MMR); varicella; and pneumococcal vaccines. A total of 29 states out of 34 states responding to the survey required their Medicaid managed care plans to cover Tdap, hepatitis B, and meningococcal ACWY vaccines, and 28 states required their Medicaid Managed plans to cover influenza, MMR, varicella, pneumococcal conjugate, and meningococcal B vaccines.

The Children's Health Insurance Program (CHIP) is a program funded by the Federal government and states to cover children up to age 19 in households with income too high to qualify for Medicaid. Ten states and the District of Columbia cover all of their CHIP beneficiaries under Medicaid and provide them with the same Medicaid benefits, including EPSDT.[23] Thirty-eight states cover some CHIP beneficiaries under Medicaid and some under a separate CHIP program. Two states only have separate CHIP programs. All CHIP programs are required to cover well-child visits without cost-sharing.[24] CHIP programs are also required to cover vaccines

[‡‡] Meningococcal ACWY vaccine can help protect against meningococcal disease caused by serogroups A, C, W, and Y.

and vaccine administration for children without cost-sharing. Fifteen states cover pregnant women under CHIP.[25] The American Rescue Plan Act (ARP) requires CHIP programs to cover COVID-19 vaccines for children and pregnant women without cost-sharing through the last day of the quarter of the end of the public health emergency.[26] Other preventive services may be covered with or without cost-sharing by separate state CHIP programs, but there are no studies on this. All children enrolled in CHIP (6.7 million in December 2020)[27] are covered for vaccines and well-child visits without cost-sharing and may be covered for other preventive services with or without cost-sharing.

Medicare

Under the ACA, services recommended by the USPSTF with a Grade "A" or "B" must be covered by Medicare without cost-sharing if the Secretary of the U.S. Department of Health and Human Services (HHS) determines through the national coverage determination process that they are reasonable and necessary for the prevention or early detection of an illness or disability, and appropriate for individuals entitled to the program's Part A benefits or who are enrolled in Part B.[28] There are approximately 61.5 million individuals enrolled in Medicare, all of whom potentially benefit from this provision of the ACA.[29]

After the ACA was enacted, HHS issued new rules on November 29, 2010, to eliminate Medicare cost-sharing for USPSTF recommended preventive services and to provide Medicare coverage for an annual wellness visit that includes a comprehensive health risk assessment and a 5- to 10-year personalized prevention plan. Medicare Part B provides coverage without cost-sharing for certain USPSTF-recommended services and four vaccinations: COVID-19, influenza, hepatitis B, and pneumococcus. Medicare Part B does not currently cover preventive shingles and tetanus, diphtheria, and pertussis (Tdap) vaccinations.[30] Optional Medicare Part D plans generally cover these other vaccinations, though they may include cost-sharing.[§§,31] The Build Back Better Act (BBB), being considered in the Congress, proposes covering these vaccinations without cost-sharing in Medicare Part D.

EVIDENCE ON CHANGES IN UTILIZATION AND OUTCOMES

Research shows that the ACA reduced health coverage disparities across racial groups and expanded access to a range of clinical services including preventive services.[32,33] Gains in access to services were due in large part to uninsured individuals obtaining health coverage. For example, people who became newly covered under Medicaid and the Marketplace through the ACA in 2014 were much less likely than uninsured people to report being unable to get care or delaying needed care because of cost.[34] There have been fewer studies specifically examining the effects of eliminating cost-sharing for preventive services among individuals who already had health coverage. In this section, we describe the effects of the ACA on utilization of several types of preventive services; these effects are likely a combined result of the provisions expanding coverage to the uninsured and the provisions increasing access to preventive services without cost-sharing.

Cancer Screening

Overall, Americans utilize recommended clinical preventive services at low rates, and utilization of preventive services such as cancer screening differs across racial and ethnic populations.[35,36,37] ACA provisions to eliminate cost-sharing for recommended clinical preventive services, such as cancer screenings, presented an opportunity to increase early diagnosis of cancer. Studies examining changes in cancer screening among privately insured individuals after the ACA eliminated cost-sharing show an overall increase in colorectal cancer screening tests, while breast cancer screening rates were stable; rates of Pap testing decreased, though

[§§] Generally, Medicare prescription drug plans (Part D) cover all commercially available vaccines (e.g., shingles) needed to prevent illness.

this time period coincided with revised cervical cancer screening recommendations that include less frequent testing for many patients.[38,39] An analysis of 2013-2016 national survey data indicated utilization rates among newly insured immigrants increased for colon cancer screenings but did not change for Pap testing or mammography.[40] Some research also shows that patient navigation interventions have helped increase cervical cancer screening rates among Latinas and Chinese-American women.[41] While the studies reviewed show some evidence of improved use of cancer screening since enactment of the ACA, disparities remain.[42,43]

The USPSTF announced a new recommendation in May 2021 that colon cancer screening start at age 45 instead of 50.[44] We estimate that this means an additional 15.0 million to 17.5 million individuals will be able to benefit from the ACA's provisions for preventive services without cost-sharing for colon cancer screening.[45] An analysis of data from 2009 and 2014 suggest that the elimination of cost-sharing under the ACA positively affected colorectal cancer screening among men and women with private health coverage, and among men and Hispanic beneficiaries with Medicare coverage.[46] While data show that colon cancer mortality among men and women was decreasing prior to the ACA, colon cancer remains one of the leading causes of cancer deaths, and increased screening – which can result in identification and removal of precancerous growths – has resulted in a decrease in colorectal cancer incidence.[47]

Health coverage is important for individuals with cancer because access to care can affect health outcomes. Annual out-of-pocket costs among recently diagnosed survivors of cancers like breast, prostate, colorectal, and lung cancers average more than $1,000 for medical care costs, depending on age.[48] Some research suggests that increased access to preventive services and increased affordability of care since the ACA has helped cancer survivors obtain the care they needed.[49,50] However, decreases in cancer screenings during 2020 as a result of the COVID-19 pandemic indicate the need to monitor post-pandemic changes in cancer incidence, later-stage cancer diagnosis, and cancer mortality.[51,52]

Vaccinations

One ACA provision with particular relevance for young adults is the dependent coverage provision, which generally allows young adults to stay on their parents' health care plans until age 26. With the ACA dependent coverage provision and the provision for preventive services without cost-sharing, an estimated 854,000 young women completed the human papillomavirus (HPV) vaccine series from 2010 to 2012, an increase of 5.8 percentage points compared to a control group of women who were not eligible for dependent coverage.[53] Coverage without cost-sharing was associated with a 4.3 percentage point increase in HPV vaccine completion for females aged 9 to 26 who were privately insured and a 5.7 percentage point increase for Medicaid enrollees in three states (Massachusetts, New Hampshire, and Maine) in a study of 2009-2015 claims.[54]

Influenza vaccinations showed a small but significant increase from 2009 to 2011/2012 after the elimination of cost-sharing among adults with private health coverage.[55] National survey data from 2016 showed that among adults 65 and older, 70.4 percent received an influenza vaccine and 66.9 percent had been vaccinated against pneumococcal disease; Tdap vaccination of adults 19 years and older was just 26.6 percent.[56] Thus, many adults do not receive all of the recommended vaccinations, sometimes for reasons other than cost, and there is still potential for greater uptake and utilization of routine vaccination among adults who have private health coverage, Medicare, and Medicaid.[57]

Medicare Wellness Visits

The percentage of Medicare beneficiaries utilizing annual wellness visits increased 14.9 percentage points between 2011 (the first year when such visits were covered) and 2016, rising from 8.1 percent to 23.0 percent.[58] This trend suggests that it may take time for beneficiaries and providers to use a new service when it becomes available. However, the utilization of this new service was characterized by disparities, with

utilization 10.2 percentage points lower for non-Hispanic Black Medicare beneficiaries and 11.6 percentage points lower for Hispanic beneficiaries than non-Hispanic White beneficiaries in 2016.

Women's Health and Contraception

Provisions in the ACA addressed a range of women's health needs by increasing health coverage – which increased access to medical and mental health care – and by establishing HRSA-supported Women's Preventive Services Guidelines specifying certain services that must be covered without cost-sharing by non-grandfathered group and individual health coverage. Services included in the Women's Preventive Services Guidelines are: screening for anxiety, breast cancer screening for average-risk women, breastfeeding services and supplies, screening for cervical cancer, contraception (including contraceptive counseling), screening for gestational diabetes mellitus, screening for diabetes after pregnancy, screening for human immunodeficiency virus infection, screening for interpersonal and domestic violence, counseling for sexually transmitted infections, well-woman preventive visits, and screening for urinary incontinence.

Most recently in January 2022, the Guidelines incorporated new, updated evidence-based recommendations for breastfeeding services and supplies, contraception, screening for human immunodeficiency virus (HIV) infection, counseling for sexually transmitted infections, and well-woman preventive visits, and added a new recommendation for preventing obesity in midlife women.

Access to contraceptives has been shown to improve a variety of women's health and economic outcomes, including reduced rates of entry into poverty, increased rates of entry into professional school, or the labor force, and increases in wages.[59,60] Access has also had intergenerational effects. Children of women who have access to contraceptives have been shown to achieve higher rates of college graduation and higher incomes than children of women who did not have access to contraceptives.[61] Contraceptives include a wide array of products. Long-acting reversible contraceptives (LARCs) – which include intrauterine devices (IUDs), intrauterine systems (IUSs), and subdermal implants – are among the most effective methods of contraception, while the birth control pill is among the most popular. Other types of contraception include the hormone patch, the vaginal ring, and emergency contraceptive medication. The ACA provision requiring coverage of contraceptives without cost-sharing mitigated a major barrier to contraceptive use: cost. High cost-sharing has been shown to be associated with contraceptive nonadherence and discontinuation, as well as lower use of LARCs, which often have high one-time costs even though they can be less expensive over time than methods that must be purchased periodically such as the birth control pill.[62,63,64,65]

A comparison of out-of-pocket costs for contraception before and after the implementation of the ACA found that average costs for every category of contraception decreased. The mean out-of-pocket cost for an IUD fell from $262.38 in the first half of 2012 to $84.30 in the first half of 2013. The ACA provision saved an average of $255 annually per user of birth control pills between 2012 and 2013.[66] After the implementation of the ACA's preventive service zero-cost sharing requirements, the median out-of-pocket spending for all categories except the vaginal ring and the subdermal patch was $0. The estimated out-of-pocket savings to women totaled approximately $1.4 billion in 2013.

Research also demonstrates that the reduction in cost-sharing led to increased use of LARCs. One study found that the reduction in cost-sharing was associated with increases in prescription contraceptive usage, with a shift toward longer-term methods (including non-reversible options such as sterilization).[67] A later study found that women enrolled in high deductible health plans (HDHPs) initiated LARC use at rates more than twice as high than women in non-high deductible health plans (non-HDHPs) beginning after the implementation of the ACA. This study is consistent with the idea that women in HDHPs were hesitant to access IUDs/LARCs because they would have had higher cost-sharing due to their high deductibles, until the ACA provision removed that barrier.[68]

An analysis of data through 2018 showed that ACA Medicaid expansion was associated with greater preconception health counseling and postpartum use of effective birth control methods among low-income women, and another study found that expanded Medicaid coverage under the ACA was associated with decreases in the proportion of pregnancies that were unintended among individuals with a high-school degree or less, but was not associated with any significant change in the overall birth rate.[69,70] The overall national rate of intended pregnancy decreased from 67 percent of births to 62 percent of births between 2011 and 2019.[***,71]

Chronic Conditions

Gaining access to health coverage and preventive services can allow earlier detection and treatment of chronic health conditions such as hypertension and diabetes. Several studies have found that the ACA resulted in improvements in affordability of care, regular care for chronic conditions, medication adherence, and self-reported health.[72,73] During 2012-2015, the percentage of adults aged 18 to 64 with two or more chronic health conditions who delayed or did not obtain needed medical care due to cost decreased.[74]

More adults with private insurance received blood pressure and cholesterol screening in 2011-12, compared to pre-ACA screening rates in 2009.[75] An analysis of 2012-2018 data showed that ACA Medicaid expansion was associated with sustained increases in improvements in blood pressure and glucose control over a five-year period among individuals receiving care at Federally Qualified Health Centers, especially Black and Hispanic patients.[76] Preventive services and chronic disease management contribute to improvements in cardiovascular health, blood pressure control,[77] and both the incidence and care for diabetes; increasing access to such services is an important factor in improving health outcomes over time and addressing health disparities. ACA implementation has also contributed to improved health outcomes among people living with HIV in terms of viral suppression and retention in care.[78]

CONCLUSIONS

The implementation of the ACA increased health coverage, especially among Black Americans, Latinos, Asian Americans and Pacific Islanders, American Indians/Alaska Natives, and individuals living in states that expanded Medicaid.[79,80,81,82] We estimate that more than 150 million people with private health coverage are now benefitting from the ACA's coverage of preventive services without cost-sharing, across a range of services and conditions. In addition, tens of millions of Medicare and Medicaid beneficiaries are also benefitting from the ACA provisions regarding preventive services without cost-sharing. Studies demonstrate increases in access to preventive services, including colon cancer screening, HPV vaccination, Medicare annual wellness visits, and contraceptive use. Investments in prevention in the early and middle decades of life, when people are more likely to be covered by private health coverage including Marketplace insurance and Medicaid, may also help people enter the Medicare program at age 65 in better health. Ongoing research can help monitor the impact of the ACA on access to care, use of preventive services, health disparities, and long-term health outcomes.

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Fact sheet

HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule Fact Sheet

Dec 28, 2021 Affordable Care Act, Coverage

In the HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule released today, the Centers for Medicare & Medicaid Services (CMS) proposed standards for issuers and Marketplaces, as well as requirements for agents, brokers, web brokers, and issuers assisting consumers with enrollment through Marketplaces that use the federal platform.

Overall, the proposed rule minimizes the number of significant regulatory changes to provide states and issuers with a more stable and predictable regulatory framework that facilitates a more efficient and competitive market. These changes would further the Biden-Harris Administration's goal of advancing health equity by addressing the health disparities that underlie our health system. They also build on the Affordable Care Act (ACA) to expand access to quality, affordable health coverage and care by lowering premiums, strengthening markets, and enhancing the consumer experience.

Enhancing Consumer Options & Choice

Network Adequacy

CMS proposes to conduct network adequacy reviews in all Federally-facilitated Marketplace (FFM) states except for states performing plan management functions that adhere to a standard as stringent as the federal standard and elect to perform their own reviews. The federal standard would be based on quantitative time and distance standards and appointment wait time standards, and reviews would occur prospectively during the Qualified Health Plan (QHP) certification process. Issuers that are unable to meet the specified standards would be able to submit a justification to explain why they are not meeting the standards, what they are doing to work towards meeting them, and how they are protecting consumers in the meantime. CMS also proposes to collect data from issuers on which of their in-network providers offer telehealth services.

Standardized Plan Options

CMS proposes to require issuers in the FFMs and State-based Marketplaces on the Federal Platform (SBM-FPs) to offer standardized plan options at every product network type, metal level, and throughout every service area that they offer non-standardized options in plan year (PY) 2023. For example, if an issuer offers a non-standardized gold plan in a particular service area, that issuer must also offer a standardized gold plan in that same service area. CMS is not proposing to require issuers to offer standardized plan options at product network types, metal levels, and throughout services areas in which they do not offer non-standardized options. CMS has designed two sets of standardized plan options at each of the bronze, expanded bronze, silver, silver cost-sharing reduction (CSR) variations, gold, and platinum metal levels of coverage, with each set being tailored to the unique cost-sharing laws in different sets of states. CMS also proposes to display these standardized options differentially on HealthCare.gov and to resume enforcement of the existing standardized plan option differential display requirements for web brokers and QHP issuers utilizing a Classic Direct Enrollment or Enhanced Direct Enrollment pathway.

Advancing Health Equity

Prohibit Discrimination Based on Sexual Orientation and Gender Identity

CMS proposes to prohibit Marketplaces, issuers, agents, and brokers from discriminating against consumers based on sexual orientation and gender identity. CMS rules previously prohibited discrimination based on "race, color, national origin, disability, age, sex, gender identity or sexual orientation," but in 2020 the HHS final rule on Section 1557 removed gender identity and sexual orientation from these non-discrimination protections by revising CMS regulations. Prohibiting discrimination based on sexual orientation and gender identity would increase access to health care, decrease health disparities, and align with the Executive Order on *Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation.*

Refine Essential Health Benefits (EHBs) Nondiscrimination Policy for Health Plan Designs

CMS proposes to refine the EHB nondiscrimination policy to ensure that benefit designs, and particularly benefit limitations and plan coverage requirements, are based on clinical evidence. CMS proposes refining CMS regulations and providing examples that illustrate presumptive discriminatory plan designs, such as discrimination based on age, health conditions, and sociodemographic factors. CMS current rules provide that an issuer does not provide EHB "if its benefit design, or the implementation of its benefit design, discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."

Special Enrollment Period (SEP) Verification

Special Enrollment Period (SEP) Verification

CMS proposes scaling back pre-enrollment SEP verification in the FFMs and SBM-FPs to include only the SEP for loss of minimum essential coverage—the SEP type that comprises the majority of all SEP enrollments on the Marketplaces on the federal platform—and to clarify that Marketplaces maintain the option to verify eligibility for any SEP types and may provide an exception to pre-enrollment SEP verification for circumstances that could include natural disasters or public health emergencies impacting consumers or the Marketplace. The FFM currently conducts verification for five SEP types (loss of minimum essential coverage, Medicaid/Children's Health Insurance Program (CHIP) denial, permanent move, marriage, and dependent addition); 90% of applications successfully verify. While pre-enrollment SEP verification can decrease the risk for adverse selection and improve program integrity, it can also deter eligible consumers from enrolling in coverage through a SEP because of the barrier of document verification. Our experience operating the FFMs and the federal platform shows that pre-enrollment SEP verification disproportionately negatively impacts Black and African American consumers who submit acceptable documentation to verify their SEP eligibility at much lower rates than white consumers. We have also found that younger, often healthier consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older, often less healthy consumers, which can negatively impact the risk pool. Scaling back SEP verification would mitigate the negative impacts of pre-enrollment SEP verification on populations that have historically faced barriers to accessing health care, and would decrease overall consumer burden without substantially sacrificing program integrity.

Updating Quality Improvement Strategy (QIS) Standards to Require Issuers to Address Health and Health Care Disparities

CMS proposes to update the QIS standards beginning in PY2023 to require QHP issuers to address health and health care disparities as a specific topic area within their QIS. Currently, QHP issuers participating in a Marketplace for two or more consecutive years are required to implement and report on a QIS that includes at least one topic area defined in section 1311(g)(1) of the ACA (activities to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, promote wellness and health and reduce health and health care disparities). In PY2020, an estimated 60% of QHP issuer QIS submissions across the FFM did address health care disparities. CMS is now proposing to require QHP issuers to address the topic of reducing health and health care disparities in their QIS submissions in addition to at least one other topic area described in section 1311(g)(1) of the ACA beginning in 2023.

Raise the Essential Community Provider (ECP) Threshold from 20 to 35 percent

For PY2023 and beyond, we propose increasing the ECP threshold from 20 to 35 percent of

available ECPs in each plan's service area. For PY2021, the percentages of medical and

dental FFM issuers that could have satisfied a 35 percent ECP threshold were 80 and 74 percent, respectively. CMS anticipates that issuers will be able to meet the 35 percent threshold with only minimal reliance on our ECP write-in and justification processes, if needed. CMS does not anticipate any meaningful premium impact, and believes that raising the ECP threshold will help ensure greater access to health care for vulnerable populations.

Lowering Premiums and Strengthening Markets

FFM and SBM-FP User Fees

For the 2023 benefit year, CMS proposes to maintain the FFM user fee rate of 2.75% of premium and the SBM-FP user fee rate of 2.25% of premium based on the portion of FFM user fee-eligible costs allocated to SBM-FP activities.

Risk Adjustment

CMS proposes a number of changes to the risk adjustment models that would improve prediction in the adult and child models for the lowest-risk enrollees, the highest-risk enrollees, and partial-year enrollees, whose plan liabilities are underpredicted in the current models. Beginning with the 2023 benefit year, CMS proposes the following risk adjustment model changes: (1) adding a two-stage weighted approach to the adult and child models; (2) removing the current severity illness factors from the adult models and adding an interacted hierarchical condition category (HCC) count model specification to the adult and child models; and (3) replacing the current enrollment duration factors in the adult models with HCC-contingent enrollment duration factors.

CMS also proposes the following changes to model recalibration for the 2023 benefit year risk adjustment models: (1) using the 2017, 2018, and 2019 enrollee-level EDGE data for model recalibration; (2) applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs; and (3) using the fourth quarter (Q4) prescription drug categories (RXC) mapping document for each benefit year of recalibration data, with the exception of 2017 enrollee-level EDGE data. In addition, CMS discusses considerations of the targeted removal of the mapping of hydroxychloroquine sulfate to Immune Suppressants and Immunomodulators (RXC 09) in the 2018 and 2019 benefit year enrollee-level EDGE data used for the 2023 benefit year model recalibration, as well as the targeted removal of Descovy® from mapping to Anti-HIV Agents (RXC 01) in all three benefit year enrollee-level EDGE datasets used for the 2023 benefit year model recalibration.

CMS also proposes to collect and extract through issuers' EDGE servers five new data elements including ZIP code, race, ethnicity, individual coverage health reimbursement arrangement (ICHRA) indicator, and a subsidy indicator as part of the required risk

arrangement (ICHRA) indicator, and a subsidy indicator as part of the required risk adjustment data that issuers must make accessible to HHS in states where HHS is operating the risk adjustment program. CMS also proposes to extract three new data elements issuers already provide through their EDGE servers as part of the required risk adjustment data submissions (plan ID, rating area, and subscriber indicator), and to expand the permitted uses of the risk adjustment data and reports. CMS also proposes a risk adjustment user fee for the 2023 benefit year of $0.22 per member per month.

Finally, CMS proposes to repeal the ability for states to request a reduction in risk adjustment state transfers starting with the 2024 benefit year, while proposing to provide an exception for states that previously requested such flexibility. CMS also solicits comments on the requests submitted by Alabama to reduce risk adjustment state transfers in the individual (catastrophic and non-catastrophic risk pools) and small group markets for the 2023 benefit year.

HHS Risk Adjustment Data Validation (HHS-RADV)

CMS proposes further refinements to the HHS-RADV error rate calculation methodology beginning with the 2021 benefit year and beyond to: (1) extend the application of Super HCCs to also apply coefficient estimation groups throughout the HHS-RADV error rate calculation processes; (2) specify that the Super HCCs will be defined separately according to the age group model to which an enrollee is subject; and (3) constrain to zero any outlier negative failure rate in a failure rate group, regardless of whether the outlier issuer has a negative or positive error rate. We believe that these proposed changes will better align the calculation and application of error rates with the intent of the HHS-RADV program, thereby enhancing the integrity of HHS-RADV and the HHS-operated risk adjustment program.

Premium Adjustment Percentage and Payment Parameters

CMS will issue the 2023 benefit year premium adjustment percentage, the maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and the required contribution percentage (payment parameters) in guidance by January 2022, consistent with policy finalized in the 2022 Payment Notice (86 FR 24140).

Prohibit Inclusion of Indirect Quality Improvement Activity (QIA) Expenses in Medical Loss Ratio (MLR)

CMS proposes to specify that QIA expenses that may be included for MLR reporting and rebate calculation purposes are only those expenses that are directly related to activities that improve health care quality. Some issuers appropriately include only direct QIA expenses, such as salaries of the staff actually performing QIA functions, while others additionally allocate indirect expenses, such as a portion of overhead (including holding

additionally allocate indirect expenses, such as a portion of overhead (including holding group overhead), marketing, office space, IT infrastructure (such as IT mainframes, which are primarily used to process claims), and vendor profits that have no traceable or quantifiable connection to QIA.

Enhancing the Consumer Experience

Advanced Payments of the Premium Tax Credit (APTC) Proration

CMS proposes that beginning in the 2024 benefit year, all Marketplaces, specifically certain State-based Marketplaces that have not done so, would be required to prorate APTC due to issuers when an enrollee is enrolled in a particular policy for less than the full coverage month. This method of administering APTC would help prevent APTC overpayment that exceeds an enrollee's premium tax credit, and thus protect the enrollee from potentially incurring additional income tax liability.

Require the Display of Explanations for QHP Recommendations on Web Broker Websites

CMS proposes to require web broker websites to display a prominent and clear explanation of the rationale for explicit QHP recommendations and the methodology for default display of QHPs on their websites (for example, alphabetically based on plan name, from lowest to highest premium, etc.) to ensure consumers are better able to make informed decisions and shop for and select QHPs that best fit their needs.

Prohibit QHP Advertising on Web Broker Websites

CMS proposes prohibiting QHP advertising, or otherwise providing favored or "preferred placement" in the display of QHPs on web broker websites based on compensation an agent, broker, or web-broker receives from QHP issuers.

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HHS to Make Coverage More Accessible and Affordable for Millions of Americans in 2023

Proposed rule would make it easier for consumers to shop for coverage

The Biden-Harris Administration today released the Notice of Benefit and Payment Parameters 2023 Proposed Rule, which would make it easier for millions of consumers to find affordable, comprehensive health coverage in 2023. Among the many policies it advances, the proposed rule aims to improve shopping for health care coverage, establish rules to ensure people can access care, and advance health equity for consumers purchasing Marketplace coverage. Collectively, these proposals build on the Biden-Harris Administration's priority to build on the Affordable Care Act (ACA), lower health care costs, and make coverage options more equitable.

"Today's rule is part of the Biden-Harris Administration's ongoing efforts to ensure an equitable health care system as we continue to make coverage more accessible and affordable," said Health and Human Services Secretary Xavier Becerra. "We are building a more competitive, transparent and affordable health care market. At the end of the day, health care should be a right for everyone, not a privilege for some."

"This year, we've implemented changes that have helped connect millions of people to health care coverage," said CMS Administrator Chiquita Brooks-LaSure. "With this proposed rule, we are working to ensure the Marketplaces are a model for accessible, affordable, inclusive coverage—particularly for eligible individuals who have thought comprehensive coverage was out of reach."

Advancing Standardized Plan Options

Supporting a direct call to action in President Joe Biden's Executive Order on Promoting Competition in the American Economy (https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/), the 2023 Payment Notice proposed rule would require all issuers in the Federally-facilitated

Marketplace and State-based Marketplaces on the Federal Platform to offer standardized plan options for every product network type, metal type, and plan classification, as well as in every service area where the issuer will offer Marketplace plans.

Because standardized plan options have a uniform cost-sharing structure, they help consumers to make simple and easy-to-understand comparisons across plans to select a plan that meets their needs. A report (https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces) released by the Office of the Assistant Secretary for Planning & Evaluation, for example, detailed how standardized plans can improve competition and coverage choice.

Implementing Network Adequacy Reviews

To help ensure consumers have better access to the right type of provider or facility at the right time and in an accessible location, CMS proposes to reestablish federal network adequacy reviews in states utilizing the Federally-facilitated Marketplace. The standards used for these reviews would highlight key characteristics like time and distance to care, as well as appointment wait times.

Strengthening Access to Essential Community Providers

The proposed rule would help improve access to health care for low-income and medically underserved consumers, particularly through essential community providers (ECPs). Issuers would need to include 35 percent of available ECPs in their network for each plan's service area. The rule would also add Substance Use Disorder Treatment Centers as eligible ECPs.

Prohibiting Discriminatory Practices & Refining Health Plan Designs with Clinical Evidence

The 2023 Payment Notice proposed rule also would explicitly prohibit health insurance issuers from discriminating on the basis of sexual orientation and gender identity. Restoring these protections for covered services—previously removed from the list of non-discrimination protections in 2020—can lead to improved health outcomes in the LGBTQI+ community.

Additionally, this proposal refines the Essential Health Benefits nondiscrimination policy by requiring issuers to rely on clinical evidence as a basis of the health plan design. For example, plans could not be designed to burden people managing chronic conditions with inordinately high prescription costs, absent a clinical rationale.

Reducing Health Care Costs and Further Streamlining HealthCare.gov Operations

The annual payment notice proposed rule also includes a variety of other provisions to streamline Marketplace operations and reduce health care costs. These include scaling back pre-enrollment verification for special enrollment periods (SEPs) to include only the SEP for loss of minimum essential

coverage. Additionally, changes to certain individual market plan variants mean subsidized enrollees would see even lower premiums in 2023 and beyond.

For more information on these and other proposals, consult CMS's fact sheet (https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-proposed-rule-fact-sheet) .

The comment period on the proposed rule will be open for 30 days. To view the proposed rule in its entirety, visit the Federal Register (https://www.federalregister.gov/public-inspection/current) .

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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Date: December 28, 2021

Subject: Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2023 Benefit Year

I. Purpose

As finalized in the HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards (2022 Payment Notice Part 2),[1] beginning with the 2023 benefit year, the Department of Health and Human Services (HHS) will publish the premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and required contribution percentage (payment parameters) in guidance by January of the year preceding the applicable benefit year using the most recent National Health Expenditure Accounts (NHEA) income and premium data that is available at the time of publication. HHS is issuing this guidance to provide these payment parameters for the 2023 benefit year. [2]

II. Background

Section 1302(c)(4) of the Patient Protection and Affordable Care Act (ACA) directs the Secretary of HHS to determine an annual premium adjustment percentage, a measure of premium growth that is used to set three other parameters detailed in the ACA: (1) the maximum annual limitation on cost sharing (defined at 45 CFR 156.130(a)); (2) the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Internal Revenue Code (the Code) (defined at 45 CFR 155.605(d)(2)); and (3) the employer shared responsibility payment amounts under section 4980H(a) and (b) of the Code (see section 4980H(c)(5) of the Code).

[1] 86 FR 24140 (May 5, 2021).

[2] Pursuant to the policy finalized in the 2022 Payment Notice and codified at 45 CFR 156.130(e), HHS may publish the premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing and required contribution percentage in guidance by January of the year preceding the applicable benefit year. The Good Guidance Practices Final Rule, (85 FR 78,770 (Dec. 7, 2020)) took effect on January 6, 2021, and specifies limitations on and requirements for HHS issuance of guidance. Because the payment parameters are being published in this guidance document, HHS has included the appropriate citations to the statutes and regulations that direct the calculations of these parameters, and that provide authority for the calculations that this guidance implements. In addition. HHS includes the following disclaimer to achieve compliance with Good Guidance standards: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under law.

Section 1302(c)(4) of the ACA and 45 CFR 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013.

In the 2022 Payment Notice Part 2, HHS established that the average per capita premium will be based on NHEA estimates of employer-sponsored insurance (ESI) premiums and finalized that, beginning with the 2023 benefit year, HHS would release the payment parameters in guidance by January of the year preceding the applicable benefit year.[3] HHS also established that the premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and required contribution percentage would be calculated using the most recent NHEA income and premium data that is available at the time these values are published in guidance or, if applicable, rulemaking.

For the 2023 benefit year, HHS is not proposing changes to the methodology to calculate the premium adjustment percentage or related parameters. As such, we are releasing these parameters in this guidance.

III. NHEA Data Years

For the calculation of the 2023 benefit year payment parameters, we are using the NHEA Projections 2019-2028.[4] This data source, which reflects the most recent projections available, is the same as that used for the 2022 benefit year calculations, because more recent NHEA projections have not yet been published as of the date this document is being issued.

IV. Premium Adjustment Percentage for 2023

Using the NHEA Projections 2019-2028, the premium adjustment percentage for 2023 is the percentage (if any) by which the NHEA Projections 2019-2028 value for per enrollee ESI premiums for 2022 ($7,292) exceeds the NHEA Projections 2019-2028 value for per enrollee ESI premiums for 2013 ($5,061) carried out to ten significant digits. Using this formula, the premium adjustment percentage for the 2023 benefit year is 1.4408219719 ($7,292/$5,061), which represents an increase in ESI premiums of approximately 44.1 percent over the period from 2013 to 2022. This premium adjustment percentage will be used to index the maximum annual limitation on cost sharing and the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code. It will also be used to index the employer shared responsibility payment amounts under section 4980H(a) and (b) of the Code.

V. Maximum Annual Limitation on Cost Sharing for 2023

Under 45 CFR 156.130(a)(2), for the 2023 calendar year, cost sharing for self-only coverage may not exceed the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage for 2023. For other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded down to the next

[3] We note that if HHS proposes changes to the methodology used to calculate these values for a future benefit year, we would publish the annual premium adjustment percentage in rulemaking and then would resume publication in guidance for subsequent benefit years when no methodological changes are proposed.

[4] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

lowest multiple of $50. Using the premium adjustment percentage for 2023 of 1.4408219719, and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage, which was published by the Internal Revenue Service on May 2, 2013,[5] the 2023 maximum annual limitation on cost sharing is $9,100 for self-only coverage and $18,200 for other than self-only coverage. This represents an approximately 4.6 percent increase above the 2022 parameters of $8,700 for self-only coverage and $17,400 for other than self-only coverage.

VI. Reduced Maximum Annual Limitation on Cost Sharing for 2023

The reduced maximum annual limitations on cost sharing for cost-sharing plan variations are determined by the methodology we established beginning with the 2014 benefit year. In the 2014 Payment Notice,[6] we established standards related to the provision of these cost-sharing reductions (CSRs). Specifically, in 45 CFR part 156, subpart E, we specified that qualified health plan (QHP) issuers must provide CSRs by developing plan variations, which are separate cost-sharing structures for each eligibility category that change how the cost sharing required under the QHP is to be shared between the enrollee and the federal government. At 45 CFR 156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver plan variation has an annual limitation on cost sharing no greater than the applicable reduced maximum annual limitation on cost sharing specified in the annual HHS guidance or HHS notice of benefit and payment parameters. Although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the ACA, section 1402(c)(1)(B)(ii) of the ACA states that the Secretary may adjust the cost sharing limits to ensure that the resulting limits do not cause the actuarial value (AV) of the health plans to exceed the levels specified in section 1402(c)(1)(B)(i) of the ACA (that is, 70 percent, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee).

We note that for the 2023 benefit year, as described in 45 CFR 156.135(d), states are permitted to request HHS's approval for state-specific datasets for use as the standard population to calculate AV. No state submitted a dataset by the September 1, 2021 deadline.

As indicated in Table 1, we are finalizing the values of the reduced maximum annual limitation on cost sharing at $3,000 for enrollees with household income greater than or equal to 100 percent of the federal poverty level (FPL) and less than or equal to 150 percent FPL, $3,000 for enrollees with household income greater than 150 percent FPL and less than or equal to 200 percent FPL, and $7,250 for enrollees with household income greater than 200 and less than or equal to 250 percent FPL, as calculated using the 2023 premium adjustment percentage and maximum annual limitation on cost sharing.

[5] See Revenue Procedure 2013-25, 2013-21 IRB 1110. http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.
[6] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; 78 FR 15409 (Mar. 11, 2013).

TABLE 1: Reductions in Maximum Annual Limitation on Cost Sharing for 2023

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for 2023	Reduced Maximum Annual Limitation on Cost Sharing for Other than Self-only Coverage for 2023
Individuals eligible for CSRs under § 155.305(g)(2)(i) (household income greater than or equal to 100 and less than or equal to 150 percent of FPL)	$3,000	$6,000
Individuals eligible for CSRs under § 155.305(g)(2)(ii) (household income greater than 150 and less than or equal to-200 percent of FPL)	$3,000	$6,000
Individuals eligible for CSRs under § 155.305(g)(2)(iii) (household income greater than 200 and less than or equal to-250 percent of FPL)	$7,250	$14,500

To confirm consistency with past results of the analysis for the reduced maximum annual limitation on cost sharing, we tested the updated reductions to the 2023 maximum annual limitation for cost sharing ($9,100) that we are publishing in this guidance and we analyzed the impact of the reductions specified in the ACA on the AV levels of the test plans. For 2023, the test silver level QHPs included a preferred provider organization (PPO) with typical cost sharing structure ($9,100 annual limitation on cost sharing, $2,650 deductible, and 25 percent in-network coinsurance rate); a PPO with a lower annual limitation on cost sharing ($8,600 annual limitation on cost sharing, $2,800 deductible, and 25 percent in-network coinsurance rate); and a health maintenance organization (HMO) ($9,100 annual limitation on cost sharing, $4,200 deductible, 30 percent in-network coinsurance rate, and the following services with copayments that are not subject to the deductible or coinsurance: $1,500 inpatient stay per day, $600 emergency department visit, $40 primary care office visit, and $80 specialist office visit). All three test QHPs meet the AV requirements for silver level health plans based on the parameters that we are publishing here.

We then entered these test plans into a draft version of the 2023 benefit year AV Calculator and observed how the reductions in the maximum annual limitation on cost sharing specified in the ACA affected the AVs of the plans. We found that the reduction in the maximum annual limitation on cost sharing specified in the ACA for enrollees with a household income greater than or equal to 100 percent FPL and less than or equal to 150 percent of FPL (2/3 reduction in the maximum annual limitation on cost sharing), and greater than 150 percent FPL and less than or equal to 200 percent of FPL (2/3 reduction), would not cause the AV of any of the model QHPs to exceed the statutorily specified AV levels.

As with prior years, we continue to find that the reduction in the maximum annual limitation on cost sharing specified in the ACA for enrollees with a household income greater than 200 percent FPL and less than or equal to 250 percent of FPL (1/2 reduction) would cause the AVs of two of the three test QHPs to exceed the specified AV level of 73 percent. Furthermore, as with prior years, for individuals with household incomes greater than 250 and less than or equal to 400 percent of FPL, without any change in other forms of cost sharing, the statutory reductions in the maximum annual limitation on cost sharing would cause an increase in AV that exceeds the maximum 70 percent level set forth in the statute.

Therefore, we continue to reduce the maximum annual limitation on cost sharing by 2/3 for enrollees with a household income greater than or equal to 100 percent FPL and less than or equal to 200 percent of FPL, 1/5 for enrollees with a household income greater than 200 percent FPL and less than or equal to 250 percent of FPL, and no reduction for individuals with household incomes greater than 250 percent FPL and less than or equal to 400 percent of FPL for the 2023 benefit year. The resulting final 2023 reduced maximum annual limitations on cost sharing are displayed in Table 1 above.

VII. Required Contribution Percentage for 2023

HHS calculates the required contribution percentage for each benefit year using the most recent projections and estimates of premium growth and income growth over the period from 2013 to the preceding calendar year. Accordingly, we are establishing the required contribution percentage for the 2023 benefit year, calculated using income and premium growth data for the 2013 and 2022 calendar years.

Section 5000A of the Code imposes a tax in the form of an individual shared responsibility payment, on non-exempt individuals without minimum essential coverage (MEC) each month. Under 45 CFR 155.605(d)(2), an individual is allowed a coverage exemption (the affordability exemption) for months in which the amount the individual would pay for MEC exceeds a percentage, called the required contribution percentage, of the individual's household income. Although the Tax Cuts and Jobs Act[7] reduced the individual shared responsibility payment to $0 for months beginning after December 31, 2018, the required contribution percentage is still used to determine whether individuals above the age of 30 qualify for an affordability exemption that would enable them to enroll in catastrophic coverage under 45 CFR 155.305(h).

The initial 2014 required contribution percentage under section 5000A of the Code was 8 percent. For plan years after 2014, section 5000A(e)(1)(D) of the Code and Treasury regulations at 26 CFR 1.5000A-3(e)(2)(ii) provide that the required contribution percentage is the percentage determined by the Secretary of HHS that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period. The excess of the rate of premium growth over the rate of income growth is also used for determining the applicable percentage in section 36B(b)(3)(A)[8] of the Code and the required contribution percentage in section 36B(c)(2)(C) of the Code.

As the measure of income growth for a calendar year, we established in the 2017 Payment Notice[9] that we would use NHEA projections of per capita personal income (PI). The rate of income growth for 2023 is the percentage (if any) by which the NHEA Projections 2019–2028 value for per capita PI for the preceding calendar year ($63,427 for 2022) exceeds the NHEA Projections 2019–2028 value for per capita PI for 2013 ($44,948), carried out to ten significant digits. Using the 2023 premium adjustment percentage established in this guidance, the excess of the rate of premium growth over the rate of income

[7] Pub. L. 115-97. (Dec. 22, 2017)
[8] Section 36B(b)(3)(A)(ii) of the Code generally provides that the applicable percentages are to be adjusted after 2014 to reflect the excess of the rate of premium growth for the preceding year over the rate of income growth for the preceding year. The American Rescue Plan Act of 2021 (Pub. L. 117-2 (Dec. 27, 2020)) amended the Code to temporarily suspend indexing of the applicable percentage table in section 36B(b)(3)(A) for the 2021 and 2022 tax years.
[9] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 FR 12203 (Mar. 8, 2016).

growth for 2013 to 2022 is 1.4408219719 ÷ 1.4111195159, or 1.0210488592. This results in the 2023 required contribution percentage under section 5000A of the Code of 8.00 ×1.0210488592 or 8.17 percent, when rounded to the nearest one-hundredth of one percent, an increase of approximately 0.08 percentage points from 2022 (8.16839-8.09066).

Table 2: Payment Parameters for the 2023 Benefit Year

Area	Metric	Value
Premium Adjustment Percentage	NHEA Projections 2019-2028 value for per enrollee ESI premiums for 2013	$5,061
	NHEA Projections 2019-2028 value for per enrollee ESI premiums for 2022	$7,292
	2023 Premium Adjustment Percentage	1.4408219719
Required Contribution	NHEA Projections 2019-2028 value for of per capita personal income for 2013	$44,948
	NHEA Projections 2019-2028 value for of per capita personal income for 2022	$63,427
	Income Growth	1.4111195159
	Premium Growth over Income Growth Index	1.0210488592
	2023 Required Contribution Percentage	8.17%
Maximum Annual Limitation on Cost Sharing	2023 Maximum Annual Limitation on Cost Sharing	$9,100
	2023 Reduced Maximum Annual Limitation on Cost Sharing – household income greater than or equal to 100% and less than or equal to 150% FPL	$3,000
	2023 Reduced Maximum Annual Limitation on Cost Sharing – household income greater than 150% and less than or equal to 200% FPL	$3,000
	2023 Reduced Maximum Annual Limitation on Cost Sharing – household income greater than 200% and less than or equal to 250% FPL	$7,250

Note: NHEA Data Available as of March 24, 2020.[10]

[10] For the calculation of the 2023 benefit year premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and required contribution percentage, we are using the NHEA Projections 2019-2028, which are the most recent projections that have been released. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

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

RESEARCH REPORT

December 17, 2021

HP-2021-26

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

Many immigrants face obstacles in accessing health care services and health insurance coverage, and immigrant communities have been heavily affected by the COVID-19 pandemic. Policy changes are needed to improve health equity for this 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.

INTRODUCTION

As of 2019, approximately 44.9 million immigrants (including both naturalized citizens and noncitizens) were living in the United States (U.S.), representing 13.7 percent of the nation's population. Immigrant communities are diverse across a range of dimensions, with widely varying demographic characteristics, income, types of employment, country of origin, immigration status, and reasons for seeking residence in the U.S. Immigration status plays an important role in how immigrants interact with the health care system, as it affects what health care coverage options are available to them, and how they may be treated when obtaining care. Of particular concern are the 21.7 million non-citizen immigrants living in the U.S. who often experience lower socioeconomic status, health insurance coverage, and utilization of services, in addition to worse health

outcomes, compared to U.S. citizens.* The barriers immigrant communities experience accessing health coverage and health care, combined with the effects of social determinants of health, make this an important area for policy attention to improve health equity. This paper describes some of these key disparities, analyzes trends in health insurance coverage among immigrants over the past decade, and identifies potential policy interventions to address gaps in health care access and social determinants of health for members of foreign-born and immigrant communities.

OVERVIEW OF THE IMMIGRANT POPULATION IN THE UNITED STATES

Immigration Status

The 44.9 million foreign-born people residing in the U.S. in 2019 come from all over the world. Over half (22.5 million) are from Latin America, with the largest numbers from Mexico (10.9 million), El Salvador (1.4 million), Cuba (1.3 million), Guatemala (1.1 million) and the Dominican Republic (1.1 million). The Philippines, China, Korea, and India each account for more than one million immigrants living in the U.S., and Asian countries represent the largest source of newly arriving immigrants in the U.S. In terms of race and ethnicity, 44 percent of all immigrants currently living in the U.S. report Latino ethnicity, while 27 percent describe themselves as Asian.[1]

The majority of foreign-born individuals have obtained legal status in the U.S by means of family relationships, sponsored employment, asylee or refugee status, or through the Diversity Visa lottery. More than half (approximately 23.2 million) are naturalized American citizens.[2] The Department of Homeland Security (DHS) estimates that in 2019, 13.6 million immigrants were lawful permanent residents (LPRs, also known as "green card holders"), of whom 9.1 million were eligible for naturalization.[3]

The immigration status of refugees and asylees is granted on humanitarian grounds to people who have been persecuted or fear persecution on the basis of race, religion, nationality, membership in a particular social group, or political opinion. Refugees are generally outside of their home country and unwilling or unable to return home. They apply for this status before they enter the U.S. Asylees meet the definition of refugees but are already in the U.S. One year after they have been granted refugee and or asylum status, individuals can file for lawful permanent resident status.[4] In 2019, 29,916 refugees were admitted to the U.S., with the largest numbers coming from the Democratic Republic of the Congo, Myanmar, and Ukraine, which collectively accounted for 75 percent of the total.[5] That same year were 46,508 people were granted asylum, with the largest numbers coming from the People's Republic of China, Venezuela, El Salvador, and Guatemala (accounting for slightly less than half of asylees).[6]

The Migration Policy Institute estimated that there were approximately 11 million undocumented immigrants in the U.S. in 2018.[7] California and Texas are states with the highest proportion of undocumented immigrants, accounting for 40 percent of the U.S.'s undocumented immigrants, followed by Florida and New York. Six countries of origin account for roughly 75 percent of undocumented immigration: nearly half of undocumented immigrants come from Mexico (approximately 5.42 million people); the next five countries – El Salvador (730,000 people), Guatemala (620,000), Honduras (450,000), India (540,000) and the People's Republic China (410,000) – together account for an additional 25 percent of the total undocumented population in 2018.[8]

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* Documentation status refers to whether an immigrant possesses valid paperwork allowing them to reside in the United States, and if so, they are officially referred to by the Department of Homeland Security as "lawfully present." Immigrants who have become naturalized citizens are eligible for the same programs as native-born citizens and have very different patterns of health care use compared to non-citizens; accordingly, this Issue Brief primarily focuses on non-citizen immigrants.

As of the end of 2020, the Department of Homeland Security reported, there were over 636,000 active Deferred Action on Childhood Arrival (DACA) recipients in the U.S.[9] This status, established in 2012, grants temporary deportation relief and authority to work to young people at least 15 years old who meet specified requirements.

Socioeconomic Circumstances of Immigrant Populations

The U.S. Census Bureau collects information on education, employment, and income of all people living in the U.S., including the foreign-born, but it does not collect data on the documentation status of immigrants.*

According to the most recently available Community Population data from 2020,[10] foreign-born persons:

- Are more likely to participate in the workforce than nonimmigrants in the prime working ages of 25-54 (71.8 percent versus 62.2 percent)
- Are more likely to be employed in service (20.6 percent versus 14.4 percent) and maintenance occupations (13.6 percent versus 8.1 percent)
- Had lower median weekly earnings ($885 versus $1,000) than native-born workers, among those without a college degree
- Had modestly higher median weekly earnings ($1,492 versus $1,409) than native-born workers, among those with a college degree.

The COVID-19 pandemic had a greater effect on employment for the foreign born than the native born. The unemployment rate for foreign-born persons in the U.S. was 9.2 percent in 2020, compared to 3.1 percent in 2019. The jobless rate for native-born persons also increased, but less sharply from 3.8 percent in 2019, to 7.8 percent in 2020.

HEALTH STATUS AND BARRIERS TO CARE AMONG IMMIGRANTS

Health Status of Immigrant Populations

Prior studies comparing health status of foreign-born individuals versus those born in the U.S., most of which focused on Hispanic immigrants, found that on average immigrant populations were healthier and had lower mortality rates compared to their non-immigrant peers with similar demographic and socioeconomic profiles.[11,12] Consistent with this research, a recent examination of National Health Information Survey (NHIS) data found that self-reported health status of naturalized immigrants was similar to that of the native born (27.1 percent versus 27.9 percent reported excellent health); however, noncitizens, whether here for less than five years (41.6 percent) or more than five years (30.1 percent), were more likely to report their health as excellent.[13] Immigrant populations have also been found to be less likely to die from cardiovascular disease or cancer, had fewer chronic health conditions, lower rates of obesity, and had lower prevalence of depression and alcohol abuse, compared to the U.S.-born populations[14] Collectively, these generally favorable health indicators among immigrants – despite lower incomes on average – has sometimes been called "the immigrant health paradox."[15] One important exception is occupational injuries, in which immigrants experience higher rates of injury compared to the overall U.S. population, like in part due to the different types of jobs disproportionately performed by immigrants; furthermore, such rates may be underestimated to the extent that certain injuries go unreported due to concerns about immigration enforcement.[16]

However, the health status and prevalence of various conditions varies by specific immigrant populations. For example, an analysis of the NHIS Linked Mortality Files estimated differences in adult mortality among 12

* Information on how the U.S. Census Bureau defines "foreign born," and what related information they collect, is available here: https://www.census.gov/topics/population/foreign-born/about/faq.html.

Hispanic subgroups by region of origin and nativity, adjusting for socioeconomic and demographic characteristics, and found variation in mortality rates of people of Hispanic origin. The analysis indicated that all subgroups of Hispanic immigrant adults ages 65 and over have lower mortality rates than non-Hispanic Whites; however, immigrant Mexicans between ages 25 and 64 had higher mortality compared to non-Hispanic Whites.[17] Factors like the concentration of certain immigrants in low-income neighborhoods and low-wage occupations or unsafe working conditions may contribute to worse health outcomes in some populations.[18] The health status of immigrant populations as a whole is also affected by the characteristics of those who choose to migrate to the U.S., as well as health behaviors including diet, level of physical activity, and smoking.

Different patterns exist in the area of behavioral health. Studies of substance use disorders suggest better outcomes among first generation immigrants do not persist into the second or third generation.[19,20] While immigrants overall have a lower prevalence of mental health conditions compared to those born in the U.S., those coming from countries involved in wars or other forms of conflict have a higher reported prevalence of mental health conditions.[21]

Barriers to Care and Impacts of Social Determinants of Health among Immigrant Populations

Many immigrants, whether they are undocumented, naturalized citizens, or lawfully present immigrants, face obstacles when seeking health care services. Lack of health insurance coverage is a common challenge, discussed at more length later in this report. Other barriers include cultural and language challenges, such as providers who are frequently not adequately trained to provide culturally competent care or do not take reasonable steps to provide language-appropriate services to ensure effective communication;[22] fear of health care providers' collection and reporting of immigration status; and the potential for participation in public programs to affect future immigration status, commonly referred to as "public charge."[23] Collectively, these barriers may impede individuals' decisions to seek care and their ability to take advantage of resources that are available.

Immigration Concerns and Program Participation

Receipt of certain types of government assistance can lead to being denied lawful permanent residence, under the "public charge" designation. Traditionally, this designation was based primarily on the receipt of cash assistance or long-term institutional care, but a 2019 rule expanded its definition to include other forms of non-cash benefits such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), housing assistance and other public benefits. This policy was heavily litigated and created substantial concern and confusion among immigrant communities, resulting in a chilling effect on program participation. An early step of the Biden-Harris Administration was to announce in March 2021 that it would no longer defend the 2019 rule.[24,25] The Centers for Medicare & Medicaid Services (CMS) sent an informational bulletin to states on July 22, 2021, affirming that receipt of Medicaid (except for institutional services) is no longer a factor in public charge determination and urging states to work with local partners in spreading this message to allay concerns of immigrants who may qualify for Medicaid.[26]

Also, in 2019, a Presidential proclamation suspended the entry of immigrants who "will financially burden the U.S. healthcare system," and required immigrants to either have approved health insurance coverage within 30 days of entry, or be able to pay for "reasonably foreseeable" medical costs.[27] The provision was initially barred from implementation by a U.S. District Court in Oregon. However, the U.S. Court of Appeals for the Ninth Circuit in January 2021 reversed the preliminary injunction.[28] In May 2021, President Biden revoked the 2019 proclamation as "not advancing the interest of the United States."[29]

Several studies suggest that immigration enforcement and other policies can substantially affect immigrant enrollment in public programs, even among those who would not be directly affected by the policy.[30] Research suggests that immigration policy related to public charge contributed to fears among immigrant populations about participating in federal health care programs such as Medicaid and the Children's Health Insurance Program (CHIP) or other non-cash assistance programs, and those fears could result in lower rates of health coverage. For example, a 2019 random digit dialing survey conducted in Texas found nearly 1 in 8 low-income Texans had friends or family who avoided public programs or medical care in the past year because of immigration-related concerns.[31]

More broadly, research has found that for families with mixed status (e.g., citizen children born in the U.S. to non-citizen parents), immigrant parents who are not eligible for services often do not realize that their children are eligible or are reluctant to apply for benefits on behalf of their children. Immigrant parents also are reluctant to apply for benefits on behalf of some of their children if other children in the family are not eligible to avoid the appearance of favoring one child over another.[32]

However, under the Biden-Harris Administration, these policy barriers to health care participation among immigrant communities have been eliminated, and eligible individuals are able to enroll in Medicaid, CHIP, and SNAP without any impact on their ability to become permanent residents or citizens in the future.

Social Determinants of Health

Other barriers relate to social determinants of health (SDOH), which are living and social conditions that affect a wide range of health, functioning, and quality-of-life outcomes and health risks. SDOH can be grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[33] Examples of factors that can affect health outcomes include food insecurity, unsafe housing, and limited health literacy, all of which often reflect long-standing systemic inequities in policies. There are reports of high levels of food insecurity among undocumented immigrants: in 2016, 24 percent were reported to be food insecure compared to 14 percent of the general population.*,[34] These percentages have likely increased during the COVID-19 pandemic, given the widely reported increased demand at the nation's food banks.[35]

Addressing SDOH is important for improving health equity and minimizing negative outcomes among underserved populations. For example, new immigrant mothers may be particularly vulnerable to poor mental health after childbirth due to cultural isolation, socioeconomic factors, gender roles, and language difficulties that can influence their postpartum experiences.[36]

Social services can help new immigrants access resources that contribute to better health. Crowded housing is more common in some immigrant communities and has been linked to higher COVID infection rates. For example, in California, with its high cost of living, 18.4 percent of Latinos live in overcrowded conditions, compared to 2.4 percent of Whites.[37] However, valuable social support services are not always available to individuals without qualified status.

Foreign-born workers are also more apt to be employed in occupations that expose individuals to health risks than native-born workers. These include service industry, construction, transportation, and maintenance occupations.[38]

* Estimates are based on a subset of immigrants/refugees.

Low health literacy has been considered by some as a measure of social vulnerability linked to social determinants of health that may be an explanatory factor for some of the health disparities experienced by immigrant populations. However, this has not been well studied.[39] Among those most affected by low health literacy are ethnic minorities, those with limited English proficiency, and persons with limited education. As noted earlier, immigrants in the U.S. are a very diverse population, and not all experience these challenges; nonetheless, there is strong evidence that these factors contribute to adverse outcomes in some immigrant communities.

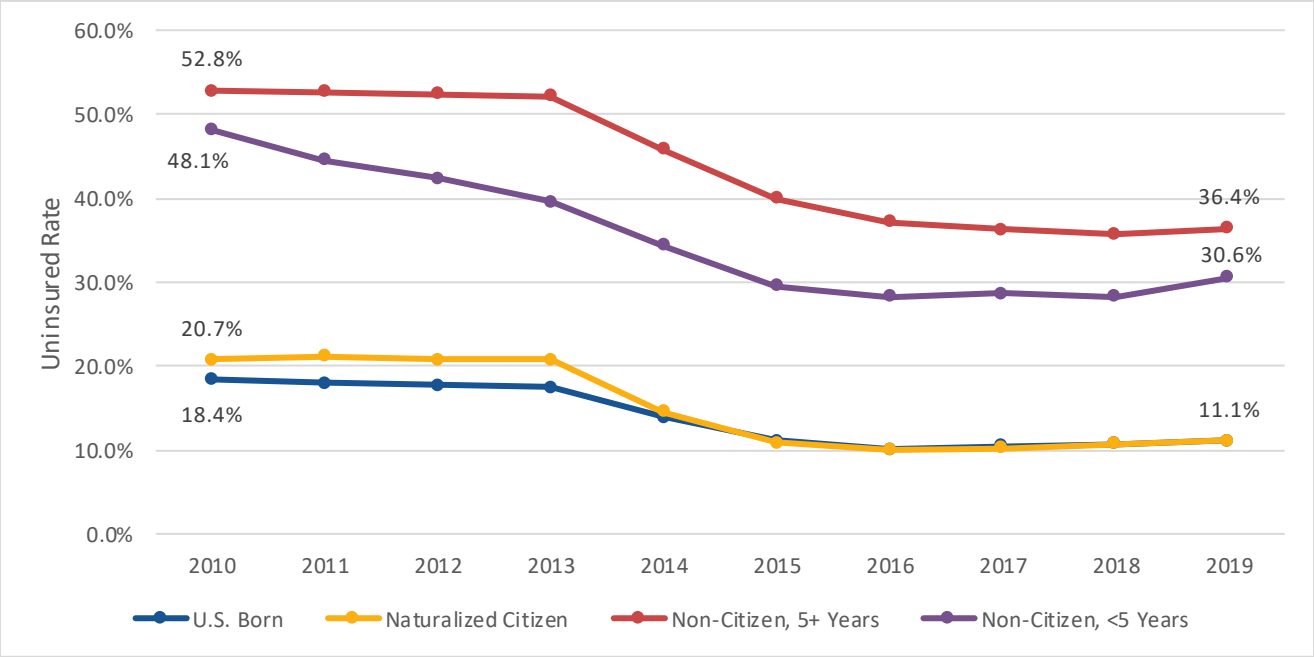
An emerging strategy for addressing the particular social and medical needs some immigrants face is the medico-legal partnership.[40] These partnerships embed a lawyer within a health care facility to address the legal issues that affect the health of the facility's users. They can help patients with housing issues, eligibility for federal programs, and immigration questions. These partnerships now exist in over 450 health care organizations including 168 HRSA-funded health centers.[41]

HEALTH INSURANCE

Noncitizens in the U.S. are much more likely to lack health insurance than citizens. Overall, recent research indicates that 23 percent of documented immigrants and 45 percent of undocumented immigrants were uninsured compared to 9 percent of citizens.[42] Among the reasons for disparities in coverage, discussed throughout this paper are patterns of employment of immigrants (where employer-sponsored insurance is less common), limited eligibility for public programs for some immigrant groups, changing program requirements, and fear and confusion about consequences of program participation.[43]

To provide a more complete picture of recent coverage changes among immigrants, we analyzed data from the American Community Survey from 2010 to 2019. Figure 1 shows changes in the uninsured rate from 2010 to 2019 by U.S. nativity, U.S. citizenship status, and years of U.S. residence – i.e., whether living in the U.S. for at least five years, or less than five years. The uninsured rates for all four groups analyzed sharply declined after implementation of the ACA in 2013. U.S. born citizens and naturalized citizens show similar trends and lower uninsured rates than those of non-citizens. Between 2010 and 2019, the uninsured rate declined from 48.1 percent to 30.6 percent among non-citizens residing in the U.S. for fewer than five years, and 52.8 percent to 36.4 percent for non-citizens residing for at least five years. While uninsured rates have improved substantially for non-citizens, disparities in coverage rates between non-citizens and citizens continue to persist. More concerning, uninsured rates among recent immigrants (those living in the U.S. fewer than 5 years) began to rise again in 2018, from 28.2 percent to 30.6 percent.

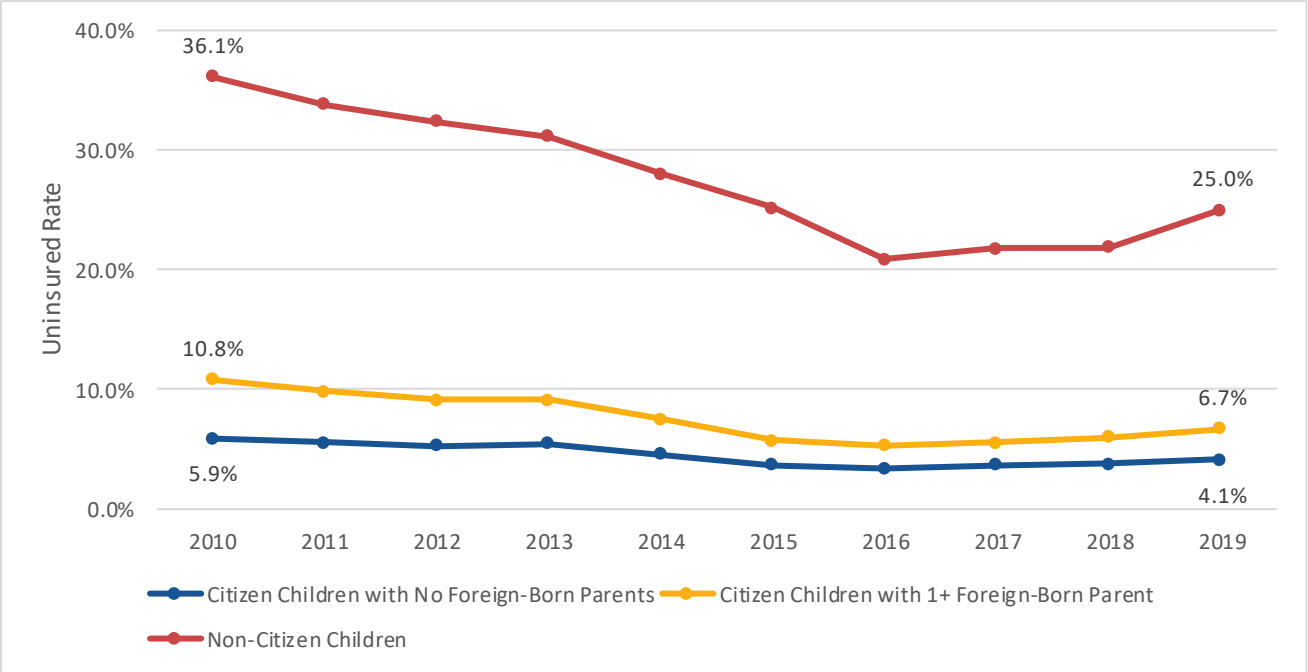
Figure 1. Trends in Uninsured Rates Among Non-Elderly Adults, by Nativity, Citizenship, and Years of Residence, 2010-2019



Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

Figure 2 describes the trend in the uninsured rate among children by citizenship status and nativity of parents. Citizen children's coverage rates may vary depending on whether their parents are citizens by birth or foreign-born. The uninsured rates for citizen children are lower than those for non-citizen children, though citizen children with at least one foreign-born parent have higher uninsured rates than citizen children with no foreign-born parents. From 2010 to 2019, the uninsured rate decreased from 36.1 percent to 25.0 percent for non-citizen children, 10.8 percent to 6.7 percent for citizen children with at least one foreign-born parent, and 5.9 percent to 4.1 percent for citizen children with no foreign-born parents. However, similar to recent immigrant adults in Figure 1, the findings indicate a worsening uninsured rate among non-citizen children between 2016 and 2019 (rising from 20.9 percent to 25.0 percent).

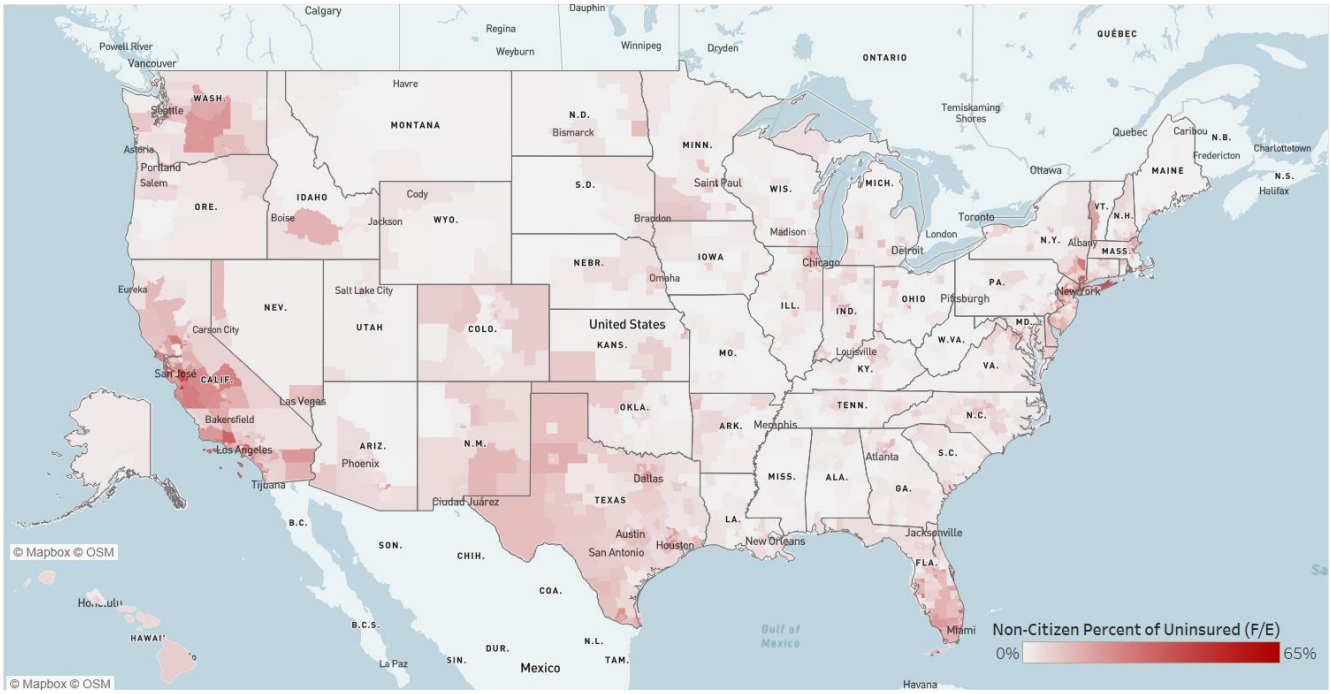
Figure 2. Trends in Uninsured Rates Among Children, by Citizenship and Nativity of Parents, 2010-2019



Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

Figure 3 illustrates where the uninsured foreign-born population (not including undocumented immigrants) resides in largest numbers across the nation. The map indicates that immigrants comprise a major share of the uninsured population in large parts of states along the Southern border including California, Texas, and Florida, but also in states including Washington, Colorado, and New York. Variation within states in this measure is also substantial.

Figure 3. Percent of Uninsured Who Are Non-Citizens, 2019



Source**:** ASPE analysis of 2019 American Community Survey Public Use Microdata Sample data.
Note: Figure reflects the percentage of the uninsured population (not including undocumented immigrants) who are non-citizens.

Medicaid, the Children's Health Insurance Program (CHIP), and Marketplace Coverage

Certain "qualified" non-citizens may be eligible for Medicaid and CHIP, but they are subject to certain eligibility restrictions.[44] For many qualified non-citizens, including most lawful permanent residents, there is a five-year waiting period after being granted qualified status before they can enroll. Other qualified non-citizens, such as refugees and asylees, do not have to wait five years before enrolling.* Many states have taken advantage of the Children's Health Insurance Program Reauthorization Act of 2009 to drop the five-year waiting period for children (35 states) and pregnant women (25 states).[45] Immigrants who have a lawfully present immigration status but do not have a qualified status for purposes of Medicaid and CHIP eligibility, such as those with Temporary Protected Status (TPS),† may be ineligible for Medicaid or CHIP (except for treatment of an emergency medical condition) regardless of their length of time in the country, depending on the state in which they reside.‡ Lawfully present immigrants who are ineligible for Medicaid or CHIP are able to enroll in Marketplace plans, if they meet all other eligibility criteria for coverage.[46] Non-citizens without a verified

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* Afghans with Special Immigrant Visas (SIV) are lawful permanent residents, and they – like refugees and asylees – can also be eligible for Medicaid without a five-year waiting period. If ineligible for Medicaid, arriving Afghan evacuees may be eligible for Marketplace coverage with financial assistance, and if they meet income and eligibility requirements, they can obtain Refugee Medical Assistance for up to eight months post-arrival. Addition details on coverage options for recent Afghan evacuees are available at: Health Coverage Options for Afghan Evacuees, CMS, November 1, 2021 https://www.medicaid.gov/medicaid/eligibility/downloads/hlth-cov-option-afghan-evac-fact-sheet.pdf.

† As of March 11, 2021, approximately 320,000 foreign nationals from these 10 countries were protected by TPS: El Salvador, Haiti, Honduras, Nepal, Nicaragua, Somalia, South Sudan, Sudan, Syria, and Yemen. Three countries had been newly designated for TPS: Venezuela on March 8, 2021; Burma on March 12, 2021; and Haiti on May 22, 2021; 35 each for 18 months. See: Congressional Research Service, Temporary Protected Status and Deferred Enforced Departure, Updated May 28, 2021, Temporary Protected Status and Deferred Enforced Departure

‡ TPS is a form of temporary humanitarian relief granted by the Department of Homeland Security to individuals from countries experiencing armed conflict, natural disaster, or other extraordinary circumstances that prevent their safe return that allows these individuals to work and prevents their deportation.

immigration status are not eligible to enroll in comprehensive Medicaid coverage, Medicare, or a Marketplace plan. Those granted deferred action under DACA can be eligible for Medicare if they meet other eligibility criteria, but they are not currently eligible for comprehensive Medicaid or Marketplace coverage.

However, undocumented persons may qualify for emergency Medicaid benefits. States must provide limited coverage of emergency medical services to non-citizens who would qualify for full Medicaid benefits except for their immigration status, including undocumented immigrants.[47] Emergency Medicaid provides payment for treatment of an emergency medical condition for non-citizens who meet all the eligibility requirements for Medicaid in the state but are not in an immigration status that qualifies them for full benefits. Emergency medical services are defined as services which follow the sudden onset of a medical condition that without immediate attention would cause serious harm to a patient's health.* The services meeting this definition vary by state. For example, through their Medicaid emergency care programs, some states such as Colorado, Washington, Illinois, and Arizona provide patients who have end stage renal disease with regularly scheduled outpatient dialysis services, whereas the majority of states only cover emergency dialysis.[48] New York requires coverage of chemotherapy and radiation treatment associated with a cancer diagnosis, including prescription medications, as long as they are associated with stabilization and treatment of the diagnosis that constituted the medical emergency.[49]

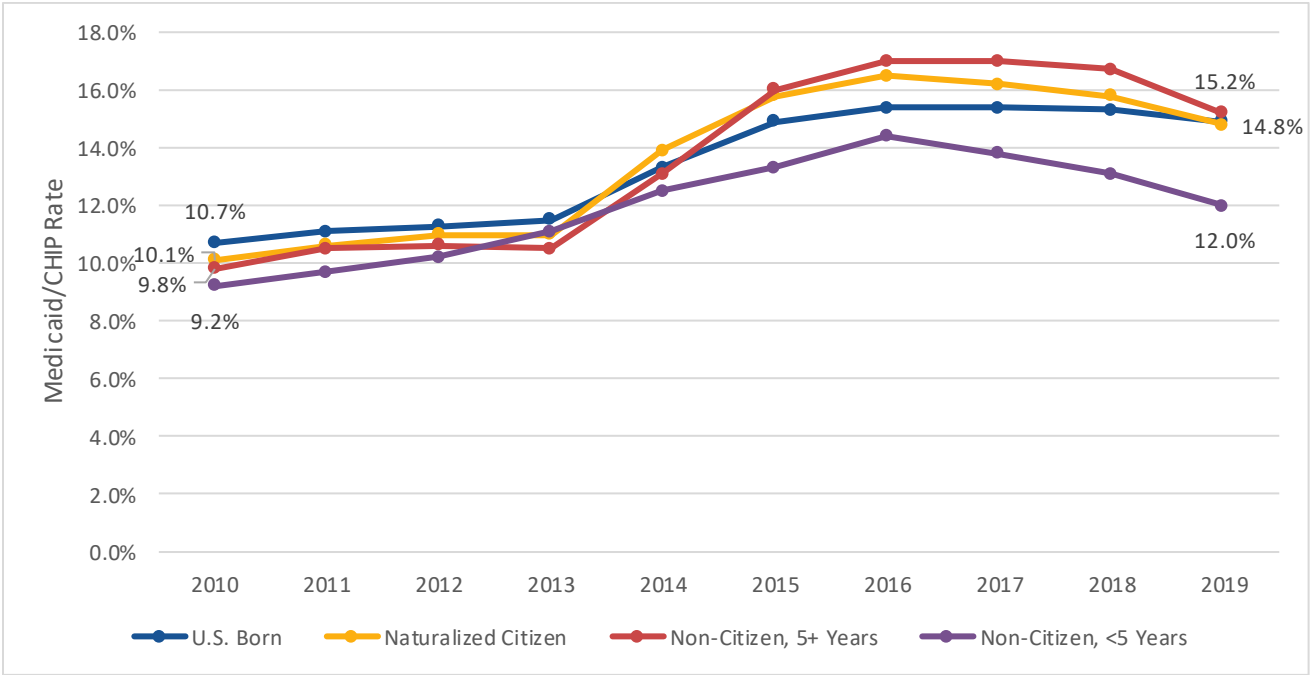
There are also unique Medicaid considerations for the roughly 94,000 citizens of the Freely Associated States who have emigrated to the U.S. from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Under the compacts the U.S. has made with these island nations, the U.S. provides certain economic assistance and has exclusive military access over a fixed period, currently 15 years. Their citizens can enter the U.S. as non-immigrants and are eligible to live and work indefinitely in the U.S.[50] Compact migrants are clustered in a few locations, most notably Guam and Hawaii. Their eligibility for Federal programs varies.[51] While once otherwise eligible individuals qualified for Medicaid, this eligibility was revoked in 1996.[52] However, the Consolidated Appropriations Act, 2021 of December 2020 [53]restored Medicaid eligibility to those who otherwise met Medicaid eligibility requirements.[54] This eligibility was clarified in a letter from CMS to State health Officials on October 18, 2021

We analyzed survey data on Medicaid, CHIP, and Marketplace coverage using ACS as well as Marketplace administrative data, to describe key trends in these coverage types since 2010.

Figure 4 describes trends in Medicaid/CHIP coverage rates among non-elderly adults ages 18-64 from 2010 to 2019. Medicaid/CHIP coverage rates increased across all nativity, citizenship, and years of residence groups after the ACA's Medicaid expansion began to be implemented in 2014. Non-citizens residing in the U.S. for at least five years experienced the greatest increase in Medicaid coverage rate, but with similar increases observed among naturalized citizens and U.S.-born citizens. In 2018-2019, however, Medicaid rates began to fall, particularly among non-citizens who recently immigrated. This timing coincides with the Trump-Pence Administration's efforts to expand the public charge definition and other steps to link immigration status with health care programs, as described earlier.

* See 42 CFR 440.255 Limited services available to certain aliens.

Figure 4. Trends in Medicaid/CHIP Coverage Rates Among Non-Elderly Adults, by Nativity, Citizenship, and Years of Residence, 2010-2019

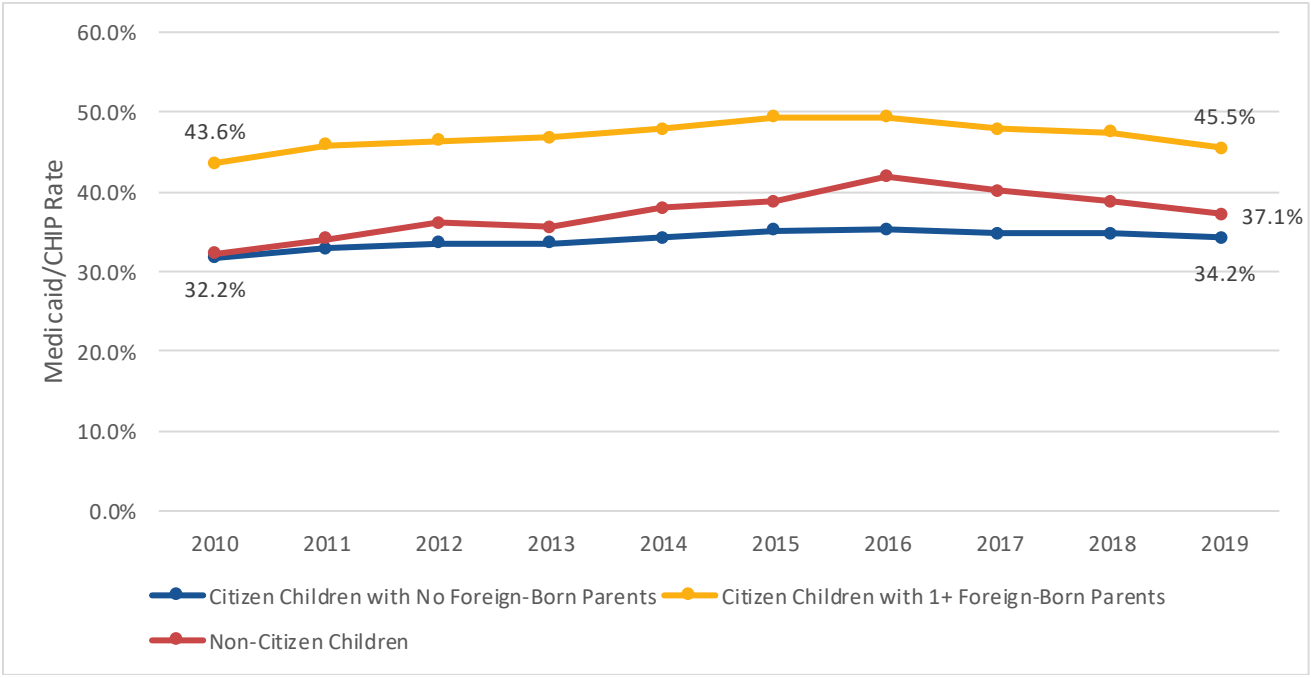


Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

States have the option of extending Medicaid coverage to documented children and documented pregnant women without applying the five-year wait. As of January 1, 2021, 34 states, DC, and 3 territories cover children and 24 states, DC, and 3 territories cover pregnant women under this option..[55] Since 2002, states also have had the option to provide prenatal care to income-eligible women regardless of immigration status by extending CHIP coverage to unborn children. As of 2020, 17 states had adopted this option.[56] Income eligibility levels vary across states from as low as 138 percent of FPL (South Dakota) to as high as 322 percent of FPL (California).[57]

Figure 5 describes changes in Medicaid/CHIP coverage rates among children from 2010 to 2019, by citizenship and nativity of parents. Unlike adults, who experienced a rapid rise in Medicaid coverage after 2014 but declines in more recent years, Medicaid/CHIP coverage rates among children have generally held steady during this time period.

Figure 5. Trends in Medicaid/CHIP Coverage Rates Among Children, by Citizenship and Nativity of Parents, 2010-2019



Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

If they meet other eligibility criteria, lawfully present immigrants can be eligible to purchase health insurance on the Marketplace and can be eligible for advance premium tax credits without the 5-year wait required by Medicaid. Lawfully present immigrants are eligible to purchase health insurance on the Marketplace and are eligible for advance premium tax credits without the 5-year wait required by Medicaid. Table 1 shows the number of individuals enrolled in Marketplace coverage in HealthCare.gov states, by citizenship status. Nearly 16 percent of enrollees in 2021 were non-citizens in HealthCare.gov states, compared to 13 percent in 2018.

Table 1: Trends in U.S. Citizenship Status and Years of Residence Among Non-Elderly Adult Marketplace Enrollees in HealthCare.gov States, 2018-2021

	2018	2019	2020	2021
Marketplace Enrollment, #	8,744,000	8,412,000	8,287,000	8,252,000
Citizen, %	86.9%	85.8%	85.1%	84.2%
Non-Citizen, %	13.1%	14.2%	14.9%	15.8%

Source: ASPE analysis of MIDAS data. HealthCare.gov states examined include both federally-facilitated marketplaces and state-based marketplaces that use the HealthCare.gov platform, including: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada (removed in 2020), New Hampshire, New Jersey (removed in 2021), New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania (removed in 2021), South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Summary of Coverage Trends

Together, these results indicate that the ACA led to a dramatic drop in the uninsured rate for immigrant groups in the U.S., concurrent with the expansion of Medicaid and Marketplace coverage. This is consistent with research indicating that the ACA has expanded coverage among documented immigrants.[58] For example, a study of health insurance coverage of immigrants in California between 2003 and 2016 found a major decrease

in uninsurance for lawfully present immigrant adults aged 19-64 during that time period, with the uninsured decreasing from 32.1 percent to 18 percent.[59]

In 2018-2019, however, in a policy context less supportive of coverage for immigrants, Medicaid coverage fell and uninsured rates began to climb again for some immigrant populations. Results from 2021 Marketplace data provide encouraging evidence that coverage among non-citizens may be rebounding. Additional survey data will be necessary to track the full impact of recent policy changes in 2021, both related to immigrant populations as well as more broadly (such as the passage of the American Rescue Plan, discussed at more length below).

SAFETY NET PROVIDERS FOR IMMIGRANT POPULATIONS

Some public programs help make health care more accessible for immigrant communities, regardless of immigration status, as discussed below. To increase access to care for foreign-born and immigrant communities they serve, safety net providers may make care more accessible to individuals. Providers and health care organizations who disproportionately serve minority and underserved communities may also take steps to ensure the care they provide is culturally and linguistically tailored at a literacy level that patients and their families can understand and build trust among their communities by structuring their care teams and creating partnerships with local community organizations.

Hospital Services

In some circumstances, hospitals are required to provide services without regard to ability to pay to all comers, including those who may not be documented. For example, the Emergency Treatment and Labor Act (EMTALA) was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1986. EMTALA requires that as a condition of participating in Medicare, hospitals that have an emergency room must provide a medical screening examination when a request is made for screening or for treatment of an emergency medical condition, regardless of an individual's ability to pay or immigration status. Hospitals are also required to provide stabilizing treatment for persons found to have emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if a patient requests it, an appropriate transfer is required. However, EMTALA does not replace health insurance, as hospitals can still bill for their services and are not required to treat individuals with non-emergency medical conditions.

In certain circumstances, hospitals provide charity care to patients who are determined to be unable to pay their bills, based on the individual hospital's policies. Hospitals are partially reimbursed for uncompensated care (whether charity care or unpaid medical bills) through disproportionate share hospital (DSH) payments by Medicare and Medicaid, as well as through state uncompensated care pools. Non-profit hospitals may include charity care when accounting for the community benefit they provide in order to meet requirements for tax exemption under the federal tax code.

Primary Care and Health Centers

The Health Resources and Services Administration (HRSA) administers the Health Center program. Health centers, frequently referred to as Federally Qualified Health Centers or Community Health Centers, provide affordable, accessible, quality, and cost-effective primary health care to patients regardless of ability to pay, insurance status, or immigration status. Health centers are essential primary care providers for millions of people across the country. Today, approximately 1,400 health centers operate over 13,500 service delivery sites that provide care in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. In 2020, health centers collectively served 28.6 million patients—approximately 1 in every 11 people living in the U.S.

Health centers serve a predominantly low-income population. Of the approximately 68 percent of patients in 2020 for whom income was known, 91 percent had incomes below 200 percent of the Federal Poverty Level. Some health centers focus on specific populations such as seasonal and agricultural workers that include a high proportion of immigrants.

Health centers are funded through multiple funding streams. Overall, Medicaid represents the largest single funding source. The second largest funding source is HRSA's Health Center program, which in fiscal year 2021 included $5.6 billion in base grant funding, plus an additional one-time $6.1 billion provided through the American Rescue Plan Act. Grants allow health centers to subsidize care for the uninsured and provide services that many immigrant patients benefit from, such as language services, outreach, and community health workers. Other federal grant programs support sites that provide services for the uninsured, including family planning clinics and facilities supported through the Ryan White HIV Program.

State and Local Initiatives

Some states including California, the District of Columbia, Illinois, Massachusetts, New York, Oregon, and Washington cover income-eligible children who are not otherwise eligible due to immigration status using state-only funds.[60,*] The District of Columbia, Massachusetts, New Jersey, New York, Oregon, and Washington provide some services during pregnancy and in the post-partum period not covered through emergency Medicaid (discussed below) for some income-eligible pregnant patients in the post-partum period who are not otherwise eligible due to immigration status using state-only funds.[61]

In several locations across the country with large concentrations of undocumented immigrants, local governments or community organizations have fostered efforts to improve access to care for this population. For instance, Healthy San Francisco, which has been in place since 2006, provides a medical home for primary care and preventive services and a designated site for specialty and emergency services for individuals without other insurance up to 500 percent of the Federal Poverty Level. The program is funded through a mix of city and federal funds, enrollee co-pays, and penalties from employers who do not comply with a local mandate to provide health insurance.[62]

IMMIGRANTS AND THE COVID-19 PANDEMIC

The COVID-19 pandemic has exacerbated existing disparities in access to care for various populations, even as the public health emergency highlights the importance of health access in responding to infectious diseases.[63]

Studies show communities with high numbers of immigrants have been affected by the pandemic, with contributing factors including crowded multi-generational housing, lack of insurance coverage, and disproportionate employment in essential jobs and the service economy, placing them at higher risk of contracting COVID-19.[64] According to a recent report, immigrants are generally at high risk of contracting COVID-19, in part because of their disproportionate frontline employment in essential industries 55 percent of immigrants, and 69 percent of undocumented immigrants hold such jobs compared to 48 percent for the native born.

Under a new "uninsured individuals" eligibility category created by the Families First Coronavirus Response Act,[65] states have the option to provide coverage through Medicaid for COVID-19 testing for immigrants with

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[*] California also covers income-eligible young adults up to age 26 in this way. See: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/youngadultexp.aspx.

qualifying status.* The U.S. Citizenship and Immigration Services (USCIS) stated in 2020 that it would not consider COVID-19 testing, treatment, or preventive care services in a public charge determination, even if those services were paid for by Medicaid.[66] In addition, DHS stated that it supports equal access to the COVID-19 vaccines for undocumented immigrants and encourages all individuals, regardless of immigration status, to receive the COVID-19 vaccine.[67] However, these complex program details are challenging to communicate easily to immigrant communities and may not fully assuage immigrants' underlying "public charge" concerns as to potential adverse consequences if they do seek such services.

The COVID-19 Uninsured Program, operated by HRSA, covers testing, treatment, and immunization services without cost to anyone who is uninsured, regardless of immigration status. Although individuals do not need to provide documentation to receive these services and vaccination is available at no charge, some immigrants have reported facing barriers to COVID-19 vaccination. To counter these and other access barriers, HRSA has conducted extensive outreach to immigrant groups, providers, and other stakeholders to promote awareness of no-cost access to COVID-19 services for patients, ensure providers know claims without patient insurance or identification information can still be reimbursed, and reaffirm that use of these services will not affect anyone's immigration status or be shared with immigration agencies. HRSA also established a program of direct distribution of vaccines to health centers to address access challenges and promote equity. The program initially targeted health centers that served large numbers of individuals experiencing homelessness, public housing residents, migrant/seasonal agricultural workers, and patients with limited English proficiency, but was eventually expanded to all health centers. As of November 5, 2021, HRSA's Health Center program has provided first or second dose COVID vaccines to 15.9 million people, 67 percent of whom are people of color. This total likely includes many immigrant patients.[68]

POTENTIAL POLICY APPROACHES TO IMPROVE HEALTH CARE EQUITY FOR IMMIGRANTS

Expanding Insurance Coverage

As noted earlier, the ACA created new options for affordable health insurance for millions of documented immigrants, and the American Rescue Plan Act of 2021 (ARP) substantially enhances the generosity of premium subsidies for Marketplace coverage, which likely will extend coverage to many more lawfully present immigrants. Changes included in the ARP are estimated to increase the availability of zero-premium and low-premium Marketplace plans after premium tax credits in HealthCare.gov states by 19 and 16 percentage points, respectively, among all uninsured eligible for these plans. The ARP also substantially increased the availability of low-premium silver and gold plans.[69]

Other **potential** policy steps to further expand coverage among immigrant communities could include:

- Conducting outreach and engaging local trusted partners to help inform documented immigrants and their families about the ARP's temporary expanded eligibility and subsidies.
- Encouraging expansion of Medicaid in states that have not already done so, including several with large immigrant populations.
- Communicating recent changes in federal policy, including those around public charge and DACA, through public education efforts and via trusted community messengers.
- Consider establishing Medicaid or Marketplace plan eligibility for DACA recipients and/or eliminating the 5-year waiting period for Medicaid among lawful permanent residents.

* As of May 2020, twenty states offered this optional Medicaid eligibility category to cover COVID-19 testing for uninsured individuals. Dolan R and S Artiga. State Actions to Facilitate Access to Medicaid and CHIP Coverage in Response to COVID-19. https://www.kff.org/coronavirus-covid-19/issue-brief/state-actions-to-facilitate-access-to-medicaid-and-chip-coverage-in-response-to-covid-19/

- Expansion of Medicaid/CHIP prenatal coverage to undocumented immigrants under the current state "unborn child" option.
- Encouraging state-only coverage of family planning services.
- State-funded initiatives to expand insurance coverage like those already implemented in some states (e.g., California's state funded expansion of undocumented young adults up to age 26, other states' coverage of children).

Health and Social Services

Many federal programs address the health and social service requirements of high-need populations. A broad focus addressing equity across such programs could produce important gains in access to services for immigrant populations. Potential areas of focus include:

- Targeting new or expanded safety net efforts (and reinforcing existing efforts) to areas that have disproportionately large populations of immigrants with unmet health care and social service needs.
- In grant-funded programs, encouraging program links to immigrant communities through hiring members of the community, use of community health workers, language services, and multilingual hotlines to triage calls and connect people to care.
- Funding services that address social determinants of health such as subsidizing transportation services; customizing interventions based on immigrants' diverse cultural traditions (e.g., diet and traditional foods), medico-legal partnerships, and addressing housing challenges.
- Ensuring that culturally and linguistically competent health and social services are available, with appropriate training in these areas for providers and consumer-facing organizations and ensuring compliance with federal civil rights laws[70] that require recipients of HHS funding to take reasonable steps to ensure meaningful access to their programs or activities by limited English proficient individuals, which may require provision of language assistance services.

COVID-19 Outreach to Immigrant Communities

While much progress has been made in raising COVID-19 immunization levels and access to testing, there are still geographic areas and populations where rates lag. Targeted efforts to improve access to services and protect immigrant populations could include:

- Providing language-appropriate and medically accurate information regarding COVID-19 testing and immunization to improve access to COVID-related services.
- Raising awareness through a culturally and linguistically tailored multi-level and multi-lingual public education campaign
- Improving referrals to community-based services to address social needs identified through improved data collection noted below
- Improving workplace safety for essential workers, who are disproportionately represented among immigrant populations

Improving Data on Race/Ethnicity, Language, and SDOH

- Improving routine collection and analysis of data related to race/ethnicity, spoken and written languages, and social determinants of health in public program administrative data is critical to promoting policies that better meet the needs of immigrant communities.
- Developing, testing, and applying improved techniques for imputing missing data elements related to immigrant populations can improve the usefulness of existing data to address health disparities
- Addressing knowledge gaps through research with a special focus on policy changes and impacts on coverage, utilization, and health is needed to inform both national and state-specific efforts to improve health equity for immigrant populations.

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National Health Care Spending In 2020: Growth Driven By Federal Spending In Response To The COVID-19 Pandemic

ABSTRACT US health care spending increased 9.7 percent to reach $4.1 trillion in 2020, a much faster rate than the 4.3 percent increase seen in 2019. The acceleration in 2020 was due to a 36.0 percent increase in federal expenditures for health care that occurred largely in response to the COVID-19 pandemic. At the same time, gross domestic product declined 2.2 percent, and the share of the economy devoted to health care spending spiked, reaching 19.7 percent. In 2020 the number of uninsured people fell, while at the same time there were significant shifts in types of coverage.

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The year 2020 was unlike any other in recent memory, as the COVID-19 pandemic swept across the world and disrupted nearly every aspect of normal life. The US health sector was affected by a number of factors, such as the direct treatment of the millions of Americans contracting COVID-19; the influence of social distancing restrictions and requirements regarding access to and use of health services; the short but dramatic two-month recession and its impact on health insurance coverage; and federal government spending on COVID-19 testing, vaccine development, insurance safety nets, and supplemental revenue support to providers. The many unique and, at times, opposing forces at play combined to result in national health expenditures increasing by 9.7 percent (the fastest rate since 2002) to $4.1 trillion in 2020, while gross domestic product (GDP) declined by 2.2 percent (the largest drop since 1938), which led to the health spending share of GDP reaching 19.7 percent, up from 17.6 percent in 2019 (exhibit 1).

Health care spending by the federal government increased 36.0 percent in 2020 (compared with 5.9 percent growth in 2019) (exhibit 2), with much of the growth not directly linked to patient care events. Rather, spending growth was driven by the following: assisting health care providers—in particular, hospitals, physicians, and nursing homes—with revenue lost because of lower utilization and increased costs (through the Provider Relief Fund, which provided direct financial support to providers, and through loans made under the Paycheck Protection Program to provide assistance to firms with qualifying expenses), assisting states with Medicaid funding, and providing increased public health activity related to COVID-19. Increased federal government spending related to COVID-19 led to an increase in the federal government's share of all national health expenditures (36 percent in 2020 compared with 29 percent in 2019), as the other sponsors of health care (state and local governments, households, and businesses) all paid for a smaller share in 2020 than in 2019.

Total national health expenditures that exclude spending associated with federal public health and other federal programs (the latter category includes Paycheck Protection Program loans and the Provider Relief Fund) increased just 1.9 percent in 2020 after an increase of 4.3 percent in 2019 (exhibit 3). This was a function of less use of medical services and goods in 2020 both by those covered through health insurance as well as by those paying directly out of

EXHIBIT 1

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and annual growth, calendar years 2014–20

	2014[a]	2015	2016	2017	2018	2019	2020
EXPENDITURE AMOUNT							
NHE, billions	$3,001.4	$3,163.6	$3,305.6	$3,446.5	$3,604.5	$3,759.1	$4,124.0
GDP, billions	$17,550.7	$18,206.0	$18,695.1	$19,479.6	$20,527.2	$21,372.6	$20,893.7
NHE as percent of GDP	17.1	17.4	17.7	17.7	17.6	17.6	19.7
Population (millions)[b]	318.1	320.4	322.8	324.8	326.5	328.0	329.1
NHE per capita	$9,436	$9,873	$10,242	$10,611	$11,040	$11,462	$12,530
GDP per capita	$55,179	$56,818	$57,923	$59,975	$62,871	$65,166	$63,482
Prices (2012 = 100.0)							
Chain-weighted NHE deflator	103.0	103.8	105.2	106.3	108.7	109.9	113.3
GDP price index	103.7	104.7	105.7	107.7	110.3	112.3	113.7
Real spending							
NHE, billions of chained dollars	$2,914	$3,047	$3,143	$3,241	$3,316	$3,422	$3,640
GDP, billions of chained dollars	$16,932	$17,390	$17,680	$18,079	$18,607	$19,033	$18,385
ANNUAL GROWTH							
NHE	5.1%	5.4%	4.5%	4.3%	4.6%	4.3%	9.7%
GDP	4.2	3.7	2.7	4.2	5.4	4.1	–2.2
Population[b]	0.7	0.7	0.7	0.6	0.5	0.5	0.4
NHE per capita	4.3	4.6	3.7	3.6	4.0	3.8	9.3
GDP per capita	3.4	3.0	1.9	3.5	4.8	3.6	–2.6
Prices (2012 = 100.0)							
Chain-weighted NHE deflator	1.7	0.8	1.3	1.1	2.2	1.1	3.1
GDP price index	1.9	1.0	1.0	1.9	2.4	1.8	1.3
Real spending							
NHE, billions of chained dollars	3.3	4.6	3.2	3.1	2.3	3.2	6.4
GDP, billions of chained dollars	2.3	2.7	1.7	2.3	2.9	2.3	–3.4

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper, 2020 definitions, sources, and methods [Internet]. Baltimore (MD): CMS; 2021 Dec 15 [cited 2021 Dec 15]. Available from: https://www.cms.gov/files/document/definitions-sources-and-methods.pdf. Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2013–14. [b]Estimates reflect the Census Bureau's definition of resident-based population, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, members of the US Armed Forces overseas, and US citizens whose usual place of residence is outside of the US. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts.

pocket. Similarly, spending for those with health insurance (through private health insurance, Medicare, Medicaid, the Children's Health Insurance Program, the Department of Defense, and the Department of Veterans Affairs) grew at a low rate of 3.0 percent in 2020, slowing from 4.3 percent in 2019 (exhibit 3). Out-of-pocket spending on health care (defined as direct consumer payments such as copayments, deductibles, coinsurance, and spending for noncovered services) declined by 3.7 percent in 2020, as the reduction in the use of services and in the number of uninsured people, along with the changing mix of services, led to reduced spending for nearly all health care services and goods.

Hospital care, physician and clinical services, and retail prescription drugs accounted for 59 percent of total health care expenditures (data not shown) and experienced mixed trends in 2020 (exhibit 4). Hospital spending grew at about the same rate in 2020 (6.4 percent) as in 2019 (6.3 percent), whereas physician and clinical services spending increased at a faster rate (5.4 percent compared with 4.2 percent in 2019). For these services, as was the case with almost all health care services, strong growth in federal program spending—primarily for the Provider Relief Fund and Paycheck Protection Program loans—far outweighed the negative or slow growth in private health insurance and out-of-pocket spending that was associated with less use of care in 2020 (exhibit 5). Spending growth on retail prescription drugs slowed (3.0 percent in 2020 compared with 4.3 percent in 2019), mainly because of slower growth in utilization and a decline in retail prescription drug prices.

Classification Of Federal COVID-19 Funding

The global pandemic caused major disruptions to the overall economy and to the delivery of health care goods and services. Economic shutdowns, increased pandemic-related hospitaliza-

EXHIBIT 2

National health expenditures (NHE) amounts, annual growth, and percent distribution, by type of sponsor, calendar years 2014–20

Type of sponsor	2014[a]	2015	2016	2017	2018	2019	2020
EXPENDITURE AMOUNT							
NHE, billions	$3,001.4	$3,163.6	$3,305.6	$3,446.5	$3,604.5	$3,759.1	$4,124.0
Businesses, household, and other private revenues	1,639.5	1,709.7	1,789.1	1,881.5	1,966.9	2,050.2	2,037.3
Private businesses	577.5	595.1	624.1	654.2	686.6	712.5	690.5
Household	856.3	900.8	937.7	977.5	1,021.7	1,067.0	1,078.3
Other private revenues	205.7	213.8	227.2	249.7	258.7	270.7	268.6
Governments	1,361.9	1,454.0	1,516.5	1,565.0	1,637.6	1,708.9	2,086.7
Federal government	843.5	916.2	959.3	988.8	1,041.2	1,102.3	1,498.7
Federal government contribution to employer-sponsored private health insurance premiums	33.2	33.9	36.2	37.5	38.3	38.6	39.8
Federal general revenue and Medicare net trust fund expenditures[b]	279.6	293.7	303.5	307.6	326.8	359.3	370.0
Federal portion of Medicaid payments	305.9	342.8	357.8	361.4	372.2	387.3	460.0
Other federal health insurance and programs[c]	193.2	203.6	213.2	225.7	236.5	250.2	559.3
All other federal health expenditures[d]	31.5	42.2	48.6	56.6	67.3	66.8	69.6
State and local governments	518.4	537.8	557.1	576.3	596.4	606.6	588.0
ANNUAL GROWTH							
NHE	5.1%	5.4%	4.5%	4.3%	4.6%	4.3%	9.7%
Businesses, household, and other private revenues	3.0	4.3	4.6	5.2	4.5	4.2	–0.6
Private businesses	3.4	3.0	4.9	4.8	4.9	3.8	–3.1
Household	3.5	5.2	4.1	4.2	4.5	4.4	1.1
Other private revenues	0.0	3.9	6.3	9.9	3.6	4.7	–0.8
Governments	7.7	6.8	4.3	3.2	4.6	4.4	22.1
Federal government	11.0	8.6	4.7	3.1	5.3	5.9	36.0
Federal government contribution to employer-sponsored private health insurance premiums	2.6	2.1	6.6	3.6	2.3	0.6	3.2
Federal general revenue and Medicare net trust fund expenditures[b]	3.5	5.0	3.3	1.4	6.2	10.0	3.0
Federal portion of Medicaid payments	19.2	12.0	4.4	1.0	3.0	4.1	18.8
Other federal health insurance and programs[c]	3.6	5.4	4.7	5.8	4.8	5.8	123.5
All other federal health expenditures[d]	123.6	34.0	15.1	16.4	19.0	–0.7	4.1
State and local governments	2.7	3.7	3.6	3.4	3.5	1.7	–3.1
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	55	54	54	55	55	55	49
Private businesses	19	19	19	19	19	19	17
Household	29	28	28	28	28	28	26
Other private revenues	7	7	7	7	7	7	7
Governments	45	46	46	45	45	45	51
Federal government	28	29	29	29	29	29	36
Federal government contribution to employer-sponsored private health insurance premiums	1	1	1	1	1	1	1
Federal general revenue and Medicare net trust fund expenditures[b]	9	9	9	9	9	10	9
Federal portion of Medicaid payments	10	11	11	10	10	10	11
Other federal health insurance and programs[c]	6	6	6	7	7	7	14
All other federal health expenditures[d]	1	1	1	2	2	2	2
State and local governments	17	17	17	17	17	16	14

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in CMS. National Health Expenditure Accounts: methodology paper (see the exhibit 1 notes). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2013–14. [b]Excludes Medicare Hospital Trust (HI) Fund payroll taxes and premiums, Medicare Supplementary Medical Insurance premiums, Part D state phase-down payments to Medicare beginning in 2006, Medicare premium buy-in programs by Medicaid for people eligible for both Medicaid and Medicare, and Trust Fund revenues from the income taxation of Social Security benefits. [c]Includes maternal and child health, vocational rehabilitation, SAMHSA, IHS, federal workers' compensation, other federal programs, public health activities, Department of Defense, Department of Veterans Affairs, CHIP Titles XIX and XXI, and investment (research, structures, and equipment). Also includes government subsidy payments for COBRA coverage for 2009–11, small business tax credits beginning in 2010, Early Retirement Reinsurance Program payments for 2010–11, and payments for the Basic Health Program beginning in 2015. Excludes premiums paid for the Pre-Existing Condition Insurance Plan for 2010–14. [d]Includes employer Medicare HI Trust Fund payroll taxes, federal portion of Medicare buy-in premiums, retiree drug subsidy payments to employee plans, and Marketplace tax credits and cost-sharing subsidies (beginning in 2014).

EXHIBIT 3

National health expenditures (NHE) and annual growth, by source of funds, calendar years 2014–20

Source of funds	2014[a]	2015	2016	2017	2018	2019	2020
EXPENDITURE AMOUNT (BILLIONS)							
NHE	$3,001.4	$3,163.6	$3,305.6	$3,446.5	$3,604.5	$3,759.1	$4,124.0
Health consumption expenditures	2,841.9	3,000.6	3,139.5	3,266.3	3,415.9	3,564.2	3,931.3
Out of pocket	340.3	352.9	365.6	372.6	386.5	403.7	388.6
Health insurance	2,150.2	2,287.6	2,395.8	2,494.5	2,613.3	2,726.4	2,809.3
Private health insurance	921.9	975.6	1,029.8	1,079.1	1,131.0	1,165.6	1,151.4
Medicare	617.6	647.9	675.7	704.8	749.4	801.4	829.5
Medicaid	498.2	543.0	564.9	578.6	596.4	614.4	671.2
Federal	305.9	342.8	357.8	361.4	372.2	387.3	460.0
State and local	192.2	200.2	207.0	217.1	224.2	227.1	211.2
Other health insurance programs[b]	112.6	121.1	125.4	132.1	136.5	145.0	157.2
Other third-party payers and programs	267.0	274.6	288.1	303.1	316.3	329.2	509.7
Other federal programs[c]	12.2	12.6	12.4	12.2	12.8	14.0	193.9
Other third-party payers and programs less other federal programs	254.9	262.0	275.8	290.9	303.5	315.2	315.8
Public health activity	84.4	85.5	90.0	96.2	99.7	105.0	223.7
Federal[d]	10.8	11.3	11.8	12.6	12.1	13.3	128.2
State and local	73.5	74.2	78.2	83.6	87.7	91.7	95.5
Investment	159.6	163.1	166.1	180.2	188.6	194.9	192.7
ANNUAL GROWTH							
NHE	5.1%	5.4%	4.5%	4.3%	4.6%	4.3%	9.7%
Health consumption expenditures	5.5	5.6	4.6	4.0	4.6	4.3	10.3
Out of pocket	2.9	3.7	3.6	1.9	3.7	4.4	–3.7
Health insurance	6.5	6.4	4.7	4.1	4.8	4.3	3.0
Private health insurance	4.9	5.8	5.5	4.8	4.8	3.1	–1.2
Medicare	4.9	4.9	4.3	4.3	6.3	6.9	3.5
Medicaid	12.0	9.0	4.0	2.4	3.1	3.0	9.2
Federal	19.2	12.0	4.4	1.0	3.0	4.1	18.8
State and local	2.1	4.2	3.4	4.9	3.3	1.3	–7.0
Other health insurance programs[b]	6.3	7.5	3.6	5.3	3.4	6.2	8.4
Other third-party payers and programs	1.9	2.8	4.9	5.2	4.4	4.1	54.8
Other federal programs[c]	–6.0	3.0	–1.6	–1.1	5.2	9.3	1,282.0
Other third-party payers and programs less other federal programs	2.4	2.8	5.3	5.5	4.3	3.9	0.2
Public health activity	3.5	1.3	5.2	6.9	3.7	5.3	113.1
Federal[d]	4.8	4.6	4.0	7.0	–4.3	10.3	864.5
State and local	3.3	0.9	5.4	6.9	4.9	4.6	4.2
Investment	–2.2	2.2	1.8	8.5	4.7	3.4	–1.2
NHE IMPACTS BY DIRECT FEDERAL COVID-19 SUPPLEMENTAL FUNDING[e]							
NHE excluding federal public health activity expenditures	$2,990.6	$3,152.3	$3,293.8	$3,433.9	$3,592.5	$3,745.8	$3,995.8
NHE excluding federal public health activity expenditures and other federal programs	$2,978.4	$3,139.8	$3,281.4	$3,421.7	$3,579.6	$3,731.8	$3,801.9
NHE IMPACTS, ANNUAL GROWTH							
NHE excluding federal public health activity expenditures	5.1%	5.4%	4.5%	4.3%	4.6%	4.3%	6.7%
NHE excluding federal public health activity expenditures and other federal programs	5.2	5.4	4.5	4.3	4.6	4.3	1.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in CMS. National Health Expenditure Accounts: methodology paper (see the exhibit 1 notes). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2013–14. [b]Includes health-related spending for CHIP Titles XIX and XXI, Defense, and VA. [c]Federal COVID-19 supplemental funding here includes Paycheck Protection Program (PPP) loans and Provider Relief Fund. [d]Includes COVID-19-related federal public health spending. [e]Billions of dollars. Includes PPP loans, Provider Relief Fund, and COVID-19-related federal public health spending.

tions, shortages of available medical professionals and personal protective equipment, and increased disease surveillance and testing, among other impacts, all contributed to major changes in the way in which health care was delivered, the sources of funds that paid for care, and the amount of services used. To alleviate many of the devastating impacts of the public health

EXHIBIT 4

National health expenditures (NHE) amounts and annual growth, by spending category, calendar years 2014–20

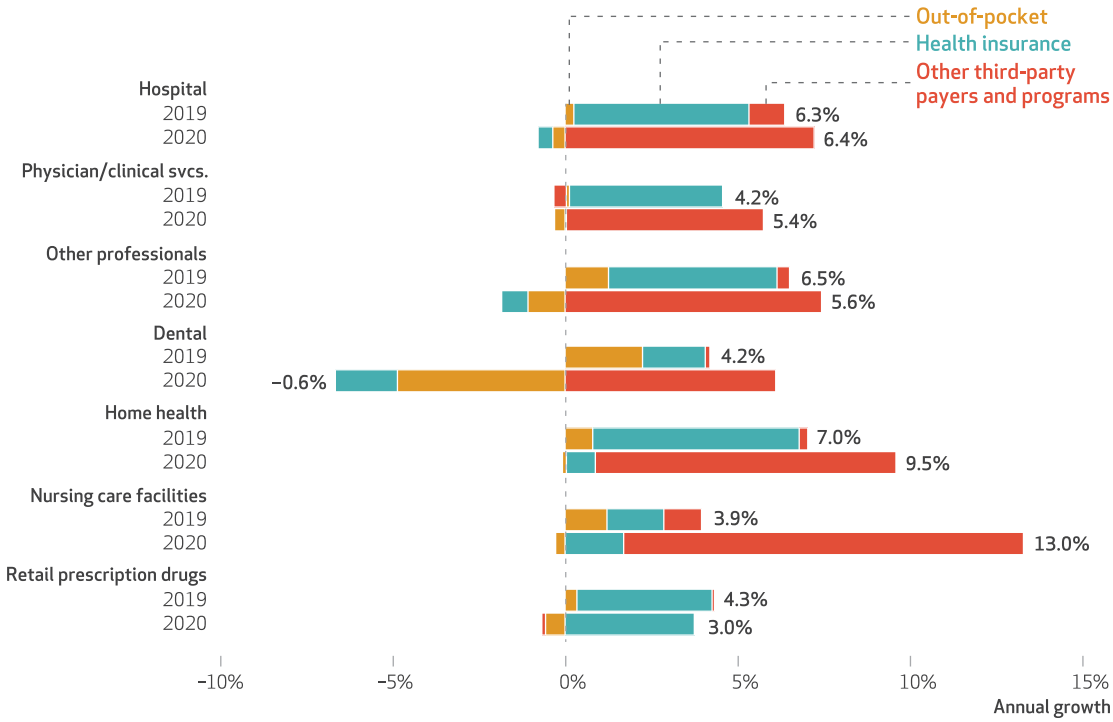
Spending category	2014[a]	2015	2016	2017	2018	2019	2020
EXPENDITURE AMOUNT (BILLIONS)							
NHE	$3,001.4	$3,163.6	$3,305.6	$3,446.5	$3,604.5	$3,759.1	$4,124.0
Health consumption expenditures	2,841.9	3,000.6	3,139.5	3,266.3	3,415.9	3,564.2	3,931.3
Personal health care	2,527.3	2,674.1	2,795.3	2,905.2	3,021.8	3,175.2	3,357.8
Hospital care	940.5	989.0	1,035.4	1,077.6	1,122.6	1,193.7	1,270.1
Professional services	794.8	843.8	893.8	937.5	978.9	1,022.4	1,069.3
Physician and clinical services	597.7	636.4	675.3	709.4	736.9	767.9	809.5
Other professional services	82.4	87.4	92.2	96.9	104.5	111.3	117.4
Dental services	114.7	120.0	126.2	131.1	137.5	143.2	142.4
Other health, residential, and personal care	152.3	165.2	175.0	185.1	191.0	195.7	208.8
Home health care	84.6	89.6	93.7	99.4	105.6	113.0	123.7
Nursing care facilities and continuing care retirement communities	152.3	156.4	161.6	163.4	167.6	174.2	196.8
Retail outlet sales of medical products	402.7	430.2	435.8	442.2	456.0	476.3	489.1
Prescription drugs	290.6	312.2	313.3	315.9	324.2	338.1	348.4
Durable medical equipment	46.6	48.7	50.6	51.9	54.4	57.0	54.9
Other nondurable medical products	65.5	69.3	71.9	74.5	77.5	81.1	85.7
Government administration	41.7	41.7	44.0	43.9	46.3	47.4	48.4
Net cost of health insurance	188.5	199.3	210.2	221.1	248.1	236.6	301.4
Government public health activities	84.4	85.5	90.0	96.2	99.7	105.0	223.7
Investment	159.6	163.1	166.1	180.2	188.6	194.9	192.7
Noncommercial research	46.0	46.4	47.5	50.7	53.6	56.2	60.2
Structures and equipment	113.5	116.7	118.6	129.4	135.0	138.7	132.5
ANNUAL GROWTH							
NHE	5.1%	5.4%	4.5%	4.3%	4.6%	4.3%	9.7%
Health consumption expenditures	5.5	5.6	4.6	4.0	4.6	4.3	10.3
Personal health care	5.1	5.8	4.5	3.9	4.0	5.1	5.8
Hospital care	3.7	5.2	4.7	4.1	4.2	6.3	6.4
Professional services	4.9	6.2	5.9	4.9	4.4	4.4	4.6
Physician and clinical services	5.2	6.5	6.1	5.0	3.9	4.2	5.4
Other professional services	5.6	6.1	5.4	5.1	7.8	6.5	5.6
Dental services	3.0	4.6	5.2	3.9	4.9	4.2	–0.6
Other health, residential, and personal care	5.5	8.4	6.0	5.7	3.2	2.4	6.7
Home health care	4.6	5.8	4.6	6.1	6.2	7.0	9.5
Nursing care facilities and continuing care retirement communities	2.5	2.7	3.4	1.1	2.6	3.9	13.0
Retail outlet sales of medical products	9.6	6.8	1.3	1.5	3.1	4.4	2.7
Prescription drugs	12.1	7.4	0.4	0.8	2.6	4.3	3.0
Durable medical equipment	3.6	4.5	3.9	2.6	4.8	4.9	–3.7
Other nondurable medical products	3.7	5.7	3.8	3.7	4.0	4.7	5.7
Government administration	11.5	–0.0	5.6	–0.3	5.5	2.3	2.1
Net cost of health insurance	12.1	5.7	5.5	5.2	12.2	–4.6	27.4
Government public health activities	3.5	1.3	5.2	6.9	3.7	5.3	113.1
Investment	–2.2	2.2	1.8	8.5	4.7	3.4	–1.2
Noncommercial research	–1.4	0.7	2.4	6.8	5.6	4.9	7.0
Structures and equipment	–2.5	2.8	1.6	9.1	4.3	2.7	–4.5

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in CMS. National Health Expenditure Accounts: methodology paper (see the exhibit 1 notes). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2013–14.

emergency, the federal government implemented five pieces of legislation that included major new funding sources for health care providers and for state and local governments: the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020; the Families First Coronavirus Response Act of 2020; the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020; the Paycheck Protection Program and Health Care Enhancement Act of 2020; and the Coronavirus Response and Relief Supplemental Appropriations Act of 2021. These new flows of federal funds were classified in the National Health Expenditure Accounts in part on the basis of international recommendations that considered the nature of the transactions,

EXHIBIT 5

Contributions to growth in expenditures, by type of medical good or service, 2019 and 2020



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTE** The colored segments within each bar represent the contribution of the designated payer (out-of-pocket, health insurance, and other third-party payers and programs) to overall growth for each medical good or service.

their policy intent, and their real effects on the health sector and the economy.[1–3]

The Provider Relief Fund ($122 billion in 2020) supplied direct federal subsidies to health care providers and is classified under "other federal programs" in the National Health Expenditure Accounts.[4] Similarly, loans under the Paycheck Protection Program ($53 billion in 2020) provided funding for payroll and other eligible expenses to many health care providers.[5] These loans are also recognized as federal subsidies because they are eligible to be forgiven if used for qualifying expenses; to date, they have a very high forgiveness rate (99 percent).[6] In addition, increased federal public health funding included payments for Operation Warp Speed for developing vaccines and therapeutics,[7] strategic stockpiles of drugs and vaccines, and health facility preparedness. Some federal health care providers (such as the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service) were also given direct federal supplemental funding to support operations during the pandemic; these expenditure amounts are included with their respective source-of-funds categories.[8]

Sponsors Of Health Care

In 2020 the federal government and households accounted for the largest shares of national health spending (36 percent and 26 percent, respectively), followed by private businesses (17 percent), state and local governments (14 percent), and other private revenues (7 percent). Most of the growth in overall national health expenditures in 2020 was a result of increased spending by the federal government, as there were declines in spending by private businesses, state and local governments, and other private revenues and slow growth in spending by households (exhibit 2).

Health care expenditures that were financed by the federal government increased rapidly, at 36.0 percent in 2020 (exhibit 2). Growth was driven mainly by spending for the Provider Relief Fund and Paycheck Protection Program loans, increased spending for federal public health activity, and growth in the federal portion of Medicaid payments (a 31 percent share of federal government expenditures) (data not shown). Growth in federal Medicaid payments resulted from the Families First Coronavirus Response Act of 2020 and led to a 6.2-percentage-point increase in the federal medical assistance per-

The pandemic contributed to major changes in the way in which health care was delivered.

centage.[9]

Households experienced slower health care expenditure growth in 2020, increasing 1.1 percent after growth of 4.4 percent in 2019 (exhibit 2). Out-of-pocket spending (a 36 percent share of household expenditures) and households' contributions to employer-sponsored private health insurance premiums (a 27 percent share) were the largest contributors to the deceleration (data not shown). Out-of-pocket spending declined 3.7 percent in 2020 after growing 4.4 percent in 2019, largely attributable to reductions in the use of dental services, hospital care, physician and clinical services, and retail prescription drugs (exhibit 3). In addition, households' contributions to employer-sponsored insurance premiums increased 3.8 percent after growth of 5.5 percent in 2019 (data not shown). The slowdown was driven largely by a decline in enrollment in employer-sponsored insurance.

Health care expenditures by private businesses declined 3.1 percent in 2020 after increasing 3.8 percent in 2019 (exhibit 2). The largest share of private businesses' health spending was contributions to employer-sponsored private health insurance premiums (a 76 percent share of private business spending), which declined 3.6 percent in 2020 after a 4.1 percent increase in 2019 (data not shown). This reflects a decline in enrollment as well as a reduction in spending by self-insured employers resulting from declines in the use of health care goods and services by their employees.

Health care expenditures financed by state and local governments decreased 3.1 percent in 2020 after growth of 1.7 percent in 2019 (exhibit 2). The decrease was driven by a 7.0 percent decline (exhibit 3) in state and local Medicaid expenditures (representing a 36 percent share of state and local spending; data not shown). This expenditure decline occurred as the federal government's share of expenditures for Medicaid increased to help ease the financial burden experienced by state and local governments as a result of the pandemic.

Enrollment

Despite the significant economic and employment disruptions caused by the pandemic in 2020, the number of uninsured people fell slightly. However, there were significant shifts in types of coverage as fewer people were covered through employer-sponsored insurance and more people had insurance through the individual market and public programs, in particular through Medicaid (exhibit 6).

Total private health insurance enrollment declined by 1.7 million (0.8 percent) in 2020, as a 2.3 million decrease in enrollment for employer-sponsored private health insurance was somewhat offset by a 0.6 million increase in enrollment for Marketplace plans (data not shown). The decline in employer-sponsored insurance was largely due to job losses; for Marketplace plans, the pandemic may have caused more people to qualify for subsidies and may have caused existing enrollees to maintain their coverage longer during the year, leading to less attrition and higher enrollment.

Medicare enrollment growth slowed in 2020, with the number of enrollees increasing 2.1 percent compared with growth of 2.6 percent in 2019 (exhibit 6). The deceleration was driven in part by increased mortality in the population age sixty-five and older on account of the pandemic. COVID-19 had a disproportionate impact on Medicare beneficiaries, as people ages sixty-five and older constituted 14 percent of all COVID-19 cases but 80 percent of all COVID-19-related deaths (through the first half of 2021).[10,11]

Medicaid enrollment increased by an estimated 3.7 million (or 5.1 percent) in 2020 after declining slightly in both 2018 and 2019 (exhibit 6). The 2020 increase was the largest since 2015 and can be attributed to pandemic-related job losses as well as enactment of Section 6008 of the Families First Coronavirus Response Act, which provided states that adhered to the "maintenance of eligibility" provisions with a 6.2-percentage-point increase in the federal medical assistance percentage as an incentive for states to not disenroll Medicaid beneficiaries.[9]

The number of uninsured people decreased by 0.6 million (1.9 percent) in 2020 to 31.2 million, and accordingly, the uninsured share of the US population was 9.5 percent in 2020 compared with 9.7 percent in 2019 (exhibit 6).

Other Federal Programs And Government Public Health Activity

In the National Health Expenditure Accounts, the category titled "other federal programs" includes federal subsidies and all other federal medical expenditures not elsewhere classified.

EXHIBIT 6

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and annual growth, by source of funds, calendar years 2014–20

	2014[a]	2015	2016	2017	2018	2019	2020
PRIVATE HEALTH INSURANCE							
Expenditure (billions)	$921.9	$975.6	$1,029.8	$1,079.1	$1,131.0	$1,165.6	$1,151.4
Expenditure growth	4.9%	5.8%	5.5%	4.8%	4.8%	3.1%	–1.2%
Per enrollee expenditure	$4,735	$4,871	$5,105	$5,340	$5,639	$5,770	$5,749
Per enrollee expenditure growth	2.9%	2.9%	4.8%	4.6%	5.6%	2.3%	–0.4%
Enrollment (millions)	194.7	200.3	201.7	202.1	200.6	202.0	200.3
Enrollment growth	2.0%	2.9%	0.7%	0.2%	–0.8%	0.7%	–0.8%
MEDICARE							
Expenditure (billions)	$617.6	$647.9	$675.7	$704.8	$749.4	$801.4	$829.5
Expenditure growth	4.9%	4.9%	4.3%	4.3%	6.3%	6.9%	3.5%
Per enrollee expenditure	$11,685	$11,934	$12,118	$12,328	$12,771	$13,309	$13,490
Per enrollee expenditure growth	1.8%	2.1%	1.5%	1.7%	3.6%	4.2%	1.4%
Enrollment (millions)	52.8	54.3	55.8	57.2	58.7	60.2	61.5
Enrollment growth	3.1%	2.7%	2.7%	2.5%	2.6%	2.6%	2.1%
MEDICAID							
Expenditure (billions)	$498.2	$543.0	$564.9	$578.6	$596.4	$614.4	$671.2
Expenditure growth	12.0%	9.0%	4.0%	2.4%	3.1%	3.0%	9.2%
Per enrollee expenditure	$7,462	$7,596	$7,690	$7,822	$8,126	$8,499	$8,836
Per enrollee expenditure growth	–0.9%	1.8%	1.2%	1.7%	3.9%	4.6%	4.0%
Enrollment (millions)	66.8	71.5	73.5	74.0	73.4	72.3	76.0
Enrollment growth	13.0%	7.1%	2.7%	0.7%	–0.8%	–1.5%	5.1%
UNINSURED AND POPULATION							
Uninsured (millions)	35.5	29.5	28.7	29.7	30.6	31.8	31.2
Uninsured growth	–19.5%	–17.0%	–2.8%	3.7%	2.9%	3.8%	–1.9%
Population (millions)[b]	318.1	320.4	322.8	324.8	326.5	328.0	329.1
Population growth	0.7%	0.7%	0.7%	0.6%	0.5%	0.5%	0.4%
Insured share of total population	88.8%	90.8%	91.1%	90.8%	90.6%	90.3%	90.5%

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in CMS. National Health Expenditure Accounts: methodology paper (see the exhibit 1 notes). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2013–14. [b]Estimates reflect the Census Bureau's definition of resident-based population, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, members of the US Armed Forces overseas, and US citizens whose usual place of residence is outside of the US. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts.

In 2020 this category includes federal supplemental COVID-19 funding from the Provider Relief Fund and Paycheck Protection Program loans. Expenditures in this category increased dramatically because of this supplemental funding to health care providers—from $14.0 billion in 2019 to $193.9 billion in 2020 (exhibit 3).

Moreover, spending for public health activity increased 113.1 percent to reach $223.7 billion in 2020 as the federal portion of such spending grew rapidly because of pandemic-related public health activities (exhibit 3). Public health expenditures include federal, state, and local governments' provision of population-based health care services, including epidemiological surveillance, immunization and vaccination services, and disease prevention programs. In 2020 federal public health expenditures accounted for 57 percent of all public health spending, whereas typically the federal portion accounts for less than 15 percent of such spending overall (data not shown). Public health expenditures through the Department of Health and Human Services, including the Centers for Disease Control and Prevention, experienced rapid growth in 2020 as COVID-19 supplemental funding increased. In addition to Biomedical Advanced Research and Development Authority funding for Operation Warp Speed; strategic stockpiles of drugs, vaccines, and equipment; and health facility preparedness, the federal health response to the pandemic also included an increase in grants to states for pandemic-related public health activities. However, state and local public health spending increased at about the same rate in 2019 and 2020, at 4.6 percent and 4.2 percent, respectively (exhibit 3).

Private Health Insurance

Private health insurance spending accounted for 28 percent of total health care expenditures, or

Health care expenditures that were financed by the federal government increased rapidly, at 36.0 percent in 2020.

$1.15 trillion, in 2020, decreasing by 1.2 percent because of a decline in enrollment and lower utilization as a result of the COVID-19 pandemic (exhibits 3 and 6).

Total private health insurance spending for medical goods and services declined 3.5 percent in 2020 to $1.0 trillion (data not shown). Pandemic-related reductions in health care use, particularly for some elective procedures,[12,13] along with economic shutdowns and moratoria on certain procedures, led to declines in private health insurance spending for hospital care (−5.9 percent), physician and clinical services (−2.6 percent), and dental services (−3.8 percent) (data not shown).

The combination of the health insurance tax (which was reinstated in 2020 after a moratorium in 2019) and a decline in private health insurance spending for most medical goods and services resulted in an increase in the net cost of insurance (the difference between revenues received by private health insurers and the amounts paid by private health insurers for medical care incurred).[14] Spending attributable to the net cost of insurance, which includes administrative costs, taxes, fees, changes in reserves, and profits, increased by $21.6 billion in 2020 to reach $151.1 billion, or a 13.1 percent share of total private health insurance expenditures compared with a share of 11.1 percent in 2019 (data not shown).

Private health insurance enrollment fell by 1.7 million in 2020 as pandemic-related job losses led to some people losing employer-sponsored health insurance coverage. This decrease in the number of enrollees was partially offset by an increase in enrollment in Marketplace plans. Per enrollee private health insurance spending decreased 0.4 percent in 2020 to $5,749, after increasing 2.3 percent to $5,770 in 2019 (exhibit 6).

Medicare

Medicare spending accounted for 20 percent of total national health care expenditures and reached $829.5 billion in 2020. The growth rate for total Medicare spending (for the fee-for-service program and Medicare private plans combined) was 3.5 percent in 2020, decelerating from 6.9 percent in 2019 (exhibit 3).[8] Medicare per enrollee spending increased at a slower rate in 2020 (1.4 percent) than in 2019 (4.2 percent) (exhibit 6), driven by slower growth in expenditures for such services as hospital care and physician and clinical services.

Medicare private plan spending (which accounted for 45 percent of total Medicare expenditures in 2020) increased 17.1 percent in 2020, an acceleration from growth of 15.3 percent in 2019 (data not shown). Consisting mainly of Medicare Advantage plans, Medicare private plans experienced an enrollment increase of 9.5 percent in 2020—accelerating from a growth rate of 7.7 percent in 2019—and represented 40 percent of total Medicare enrollment. Per enrollee Medicare private plan spending increased 6.9 percent in 2020—a relatively steady growth rate compared with that of 7.0 percent in 2019. In 2020, primarily on account of lower utilization resulting from the COVID-19 pandemic, medical benefits paid for by Medicare private plans were lower than had been estimated when plans submitted their premium bids in mid-2019. Although some plans adjusted their benefit packages—modifications that may have included lower cost-sharing requirements[15]—the amount of premiums used to pay for incurred medical care was less than had been anticipated. As a result, the plan's net cost of insurance, which includes administrative costs, taxes, fees, changes in reserves, and profits, increased in 2020 (data not shown).[16]

As a share of total Medicare spending, fee-for-service expenditures accounted for 55 percent in 2020, down from a share of 61 percent in 2019. The decrease was fueled by a 5.5 percent decline in expenditures for health care goods and services—the first decline in such spending since 1999 (data not shown). Although spending for most goods and services (with the notable exception of nursing home care and other nondurable medical products) decreased in 2020, the main drivers in the traditional fee-for-service Medicare program were pronounced decreases in expenditures for hospital care and physician and clinical services, as the COVID-19 pandemic led to reductions in utilization that can be attributed to beneficiaries delaying or forgoing non-COVID-19-related care. In addition, the number of fee-for-service beneficiaries declined 2.2 percent in 2020 (after a smaller decrease of 0.2 per-

cent in 2019); per beneficiary fee-for-service spending declined 3.2 percent in 2020 (data not shown).

Medicaid

In 2020 Medicaid spending accounted for 16 percent of national health care expenditures and reached $671.2 billion. Medicaid spending increased 9.2 percent in 2020—its fastest rate of growth since 2014 (the first year of expanded coverage under the Affordable Care Act) and a rate approximately three times faster than the growth of 3.0 percent in 2019 (exhibit 3). The faster growth in 2020 was influenced primarily by increased enrollment (exhibit 6).

Medicaid hospital spending, which accounted for a third of total Medicaid expenditures, increased 6.7 percent in 2020 compared with 4.6 percent in 2019, driven in part by faster growth in enrollment and increased Medicaid supplemental payments to hospitals, inpatient payments, and payments to mental health facilities. Spending for the second largest category—"other health, residential, and personal care services"—also grew rapidly, accelerating from 1.5 percent growth in 2019 to 9.0 percent in 2020 as a result of faster growth in expenditures for home and community-based waiver services (data not shown).

Medicaid enrollment is estimated to have increased 5.1 percent in 2020. Total Medicaid per enrollee spending growth decelerated slightly to 4.0 percent in 2020, down from 4.6 percent in 2019 (exhibit 6), whereas Medicaid per enrollee growth for personal health care expenditures slowed from 5.6 percent to 1.0 percent (data not shown).

Federal Medicaid spending increased 18.8 percent in 2020 after growth of 4.1 percent in 2019 (exhibit 2). The faster growth was largely attributable to a 6.2-percentage-point increase in the federal medical assistance percentage that resulted from the Families First Coronavirus Response Act.[9] Because of the increase in the federal medical assistance percentage, along with, to a lesser degree, the recent increases from Medicaid expansion (as Idaho, Nebraska, and Utah expanded coverage), the federal share of Medicaid spending was about 69 percent in 2020, the highest percentage in the history of the Medicaid program (data not shown). After a growth rate of 1.3 percent in 2019, Medicaid state and local expenditures fell by 7.0 percent in 2020 (exhibit 3)—a decline that was also attributable in part to the increase in the federal medical assistance percentage.

Out-Of-Pocket Spending

Total out-of-pocket spending declined by 3.7 percent in 2020 after an increase of 4.4 percent in 2019 (exhibit 3). This decline was only the fourth in the history of the National Health Expenditure Accounts, and it was the first since the Great Recession in 2009.

The decrease in out-of-pocket spending was driven primarily by people's responses to the pandemic, as utilization for most goods and services declined and there were little or no cost-sharing requirements for COVID-19 testing and treatment in 2020. In 2020 the largest decreases in out-of-pocket spending were for hospital care and dental services, with spending in each category falling about 12 percent. In addition, retail prescription drugs and physician and clinical services also experienced declines (of 4.2 percent and 3.8 percent, respectively). Partially offsetting these decreases was a 5.8 percent increase in expenditures for other nondurable medical products such as over-the-counter medicines, which represent the largest share of out-of-pocket spending, at 21 percent (data not shown).

Hospital Care

Hospital spending reached $1.3 trillion (a 31 percent share of national health spending) and increased 6.4 percent in 2020, a similar growth rate to that of 6.3 percent in 2019 (exhibit 4). Growth in 2020 reflected a substantial amount of funding from other federal programs (COVID-19 relief is included in this category) and faster increases in Medicaid spending for hospital care (with growth rates of 4.6 percent in 2019 and 6.7 percent in 2020) (data not shown). This faster Medicaid spending growth was offset by a decline in private health insurance expenditures for hospital care (from an increase of 6.6 percent in 2019 to a decrease of 5.9 percent in 2020), a decline in out-of-pocket spending for hospital care (from an increase of 8.3 percent in 2019 to a decrease of 12.6 percent in 2020), and slower growth in Medicare expenditures (from 5.8 percent in 2019 to 0.4 percent in 2020) (data not shown).

Payments from other federal programs to hospitals increased by $84.8 billion in 2020 (data not shown); this category reflects COVID-19 relief spending, with the largest contributor being the Provider Relief Fund.

During 2020 many states decided to place a moratorium on elective procedures to prevent the spread of COVID-19, and many people may have lowered their use of health care and interacted less with the health care system.[17] At the same time, there was a limited supply of critical care hospital equipment and capacity in different

The story that unfolded in 2020 and continues today is unlike anything that has happened in the past 100 years.

areas around the US on account of the pandemic, and this shortage may have contributed to lowered admissions for nonemergency care.[18,19] The number of hospital inpatient days and discharges decreased by 4.7 percent and 9.8 percent, respectively,[20,21] and this lower utilization contributed to the decline in private health insurance and out-of-pocket spending for hospital care in 2020.[22]

Hospital prices, as measured by the Producer Price Index, increased by 3.2 percent in 2020 compared with 2.0 percent in 2019.[23]

Physician And Clinical Services

Spending for physician and clinical services increased 5.4 percent in 2020; it reached $809.5 billion, representing 20 percent of total health care expenditures. This increase followed growth of 4.2 percent in 2019 (exhibit 4). The substantial growth in funding from federal programs that provided COVID-19 relief (Paycheck Protection Program loans and the Provider Relief Fund) was the main reason for faster growth in 2020. In addition, spending was bolstered by strong growth in expenditures for independently billing laboratories resulting from COVID-19-related testing; in the National Health Expenditure Accounts, these expenditures are classified within the physician services category.[24]

Although total physician and clinical services spending growth accelerated, both Medicare and Medicaid expenditure growth for physician and clinical services slowed in 2020. Medicare spending increased 0.5 percent, down from 8.9 percent in 2019, with the deceleration driven by a decline in fee-for-service expenditures. Medicaid spending grew 4.0 percent in 2020 after increasing 6.5 percent in 2019. The slower expenditure growth for Medicaid physician and clinical services was also driven by decreased fee-for-service spending, including expenditures for federally qualified health centers that declined in 2020 after rapid growth in 2019. For private health insurance, spending for physician and clinical services declined for the first time since 2013, decreasing 2.6 percent in 2020 after an increase of 2.6 percent in 2019 (data not shown).

Retail Prescription Drugs

Retail prescription drug spending reached $348.4 billion in 2020 (constituting 8 percent of total health care expenditures) and increased 3.0 percent, which was slower growth than the rate of 4.3 percent seen in 2019 (exhibit 4). COVID-19 had less of an impact on prescription drug spending and use than on medical services, with spending for new prescriptions partially affected by fewer doctor visits during the pandemic and with spending for refills less so.[25] The slowdown in spending growth for retail prescription drugs in 2020 was primarily a result of a 4.2 percent decline in out-of-pocket spending on these drugs (data not shown), which resulted from slower growth in overall utilization and an increased use of coupons, which lower point-of-sale expenditures for consumers.[25] Furthermore, even as new drugs were launched in 2020, expenditure growth on new brand-name drugs decelerated in part because of the pandemic's impact on visits to physicians' offices and a decreased opportunity to prescribe new products.[25]

Growth in utilization, as measured by the number of prescriptions dispensed (based on a thirty-day supply), slowed in 2020 to 1.7 percent from a rate of 2.3 percent in 2019.[25] Also contributing to the slowdown in overall prescription drug spending growth was a decline in prices for the third consecutive year; in 2020 prices for prescription drugs declined 0.1 percent after decreases of 0.4 percent in 2019 and 1.0 percent in 2018.[26] This occurred as retail prescription drug prices declined for generic drugs and as price growth slowed for brand-name drugs.[27] The generic dispensing rate continued to increase in 2020, reaching 86.6 percent compared with 86.4 percent in 2019.[28]

The largest payers of retail prescription drug spending—private health insurance, Medicare, and out-of-pocket spending—experienced slower growth or declining expenditures in 2020. Private health insurance spending, which represented the largest share of prescription drug expenditures (40 percent), increased 2.3 percent in 2020—a slightly lower rate than the growth of 2.9 percent in 2019. Medicare, the second-largest payer at 32 percent, also experienced slower spending growth, with expenditures for retail prescription drugs increasing by 5.1 percent in 2020 after growth of 7.5 percent in 2019. Out-of-

pocket spending accounted for a 13 percent share of total retail prescription drug expenditures in 2020, declined 4.2 percent, and had a significant influence on the overall trend (data not shown).

Conclusion

The year 2020 will always be remembered for the dramatic impact that COVID-19 had on nearly every aspect of life, including the heath care sector and the overall economy. The substantial increase in national health expenditures, with a growth rate of 9.7 percent in 2020, was the result of an unprecedented government response to the global pandemic through increased funding for programs such as the Paycheck Protection Program and the Provider Relief Fund, increased public health spending, and strong growth in federal Medicaid payments. The pandemic's impact on the overall economy was dramatic, causing the GDP to decline by 2.2 percent and contributing to the largest jump in the health spending share of GDP in the sixty-one-year history of the National Health Expenditure Accounts.

Although the specific impact of the pandemic on health expenditures in 2021 is still unknown because of incomplete data, there will likely be notable effects from the widespread vaccination efforts that began in the spring of 2021 and from the emergence of the Delta variant in the summer of 2021, including the variant's influence on cases and hospitalizations. Uncertainty remains regarding how the pandemic may evolve during the winter months (given the emergence of the Omicron variant in late fall 2021), whether the pandemic plays a significant role in 2022 and beyond, and whether there are other factors that might affect future health care consumption decisions. We do know, however, that the story that unfolded in 2020 and continues today is unlike anything that has happened in the past 100 years. ■

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NOTES

1 New pandemic-related federal funds required a detailed consideration of how these expenditures should be classified in a national accounting framework.

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3 In response to the pandemic, the United Nations Statistical Commission (working group on National Accounts), along with an expert advisory group, developed guidance on how to classify new government funding for COVID-19 response. Several important principles underlie these recommendations, including the recognition that national accounts should reflect the nature of the transactions and their policy intent and that accounts should reflect the real economic effects of the new programs. We used these broad guidelines to help inform the classification of federal COVID-19 supplemental funding in the National Health Expenditure Accounts (see note 2).

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House Advances Build Back Better Act

Congress considers building on the Affordable Care Act as Marketplace enrollment for the 2022 plan year begins robustly.

BY KATIE KEITH

The US House of Representatives passed the Build Back Better (BBB) Act, which will now be considered by the Senate. The new legislation includes a range of policies that would augment the Affordable Care Act (ACA) and Medicaid. Meanwhile, the open enrollment period for the ACA Marketplaces is well under way; data suggest strong enrollment. The Supreme Court considered a lawsuit related to Section 1557 of the ACA even as much ACA litigation remains on hold. States continue to seek amended or extended waivers under Section 1332, and federal officials want public comment on Georgia's approved waiver to restructure its individual market. Other actions include a new risk-adjustment technical paper and a temporary premium credit policy for small employers.

House Advances New Coverage Policies

After months of negotiation, House Democrats passed the highly anticipated BBB Act November 19. The bill will now be considered by the Senate, where its passage requires a simple majority.

The BBB Act would extend through the end of 2025 the two most significant enhanced Marketplace subsidies authorized under the American Rescue Plan Act (ARPA) of 2021. It would continue to eliminate the income limit for subsidies for people with incomes more than 400 percent of the federal poverty level and extend increased subsidies for those with lower incomes who are already eligible under the ACA. The BBB Act would extend an additional enhanced Marketplace subsidy, for people who receive unemployment compensation, through the end of 2022. The legislation would also make other Marketplace changes—such as revising the employer "firewall" to make it easier for employees offered workplace coverage to qualify for Marketplace subsidies—and would authorize $10 billion in annual funding from 2023 through 2025 for states to establish a reinsurance or other affordability program for Marketplace coverage. There would be $50 million in new funding for states to pursue Section 1332 waivers and $100 million for consumer assistance programs.

The law would also close the Medicaid coverage gap in nonexpansion states by allowing people with incomes below the federal poverty level to newly qualify for subsidized Marketplace coverage through 2025. The bill would amend existing ACA rules to better mimic Medicaid coverage for qualified enrollees (such as authorizing continuous enrollment, lower out-of-pocket expenses, and coverage of certain benefits without cost sharing).

Among other changes, the law would add hearing benefits to Medicare; cap cost sharing for insulin products; permanently authorize the Children's Health Insurance Program (CHIP); require Medicaid and CHIP to provide twelve months of continuous eligibility for children; and authorize Medicare to negotiate some drug prices.

The Congressional Budget Office estimates that the BBB Act would reduce the number of uninsured people by 3.4 million from 2022 through 2025. The legislation would also help narrow health disparities and improve the affordability of coverage for millions of people. That said, the legislation does not adopt broader reforms, such as fixing the "family glitch," tying the ACA benchmark plan to a gold plan (as opposed to the current silver plan), or adopting a public option.

2022 Open Enrollment

November 1 marked the beginning of the ninth Marketplace open enrollment period. This year's period extends through January 15, 2022 in the thirty-three states that use HealthCare.gov and several of the eighteen states with state-based Marketplaces. Three additional states—Kentucky, Maine, and New Mexico—will operate their own Marketplaces for 2022.

Consistent with recent years, overall premiums for 2022 are down slightly for Marketplace plans sold through HealthCare.gov, and insurer participation continues to rise. In one change from prior years, the Department of Health and Human Services (HHS) reports making the largest marketing investment for open enrollment since 2013; this is coupled with its investment of $80 million in funding for the navigator program. Aside from these changes, HealthCare.gov operations for the 2022 open enrollment period are relatively similar to those of recent years.

As of November 27 more than three million people had selected a 2022 plan in the thirty-three states that use HealthCare.gov. This is outpacing enrollment in the 2021 open enrollment period; 2.9 million people had selected a plan during the same time period in 2020. Enrollment is up even though three states have since transitioned from HealthCare.gov to their own Marketplaces, meaning that their data are no longer reflected in the enrollment data for HealthCare.gov.

Coverage gains from the 2022 open enrollment period will build on already record-high Marketplace enrollment in fall 2021. Enrollment peaked thanks to enhanced ARPA subsidies and the COVID-19 special enrollment period, during which 2.8 million people newly enrolled in coverage.

Some ACA Litigation Proceeds

Much ACA litigation remains on hold pending review by the Biden administration. This includes lawsuits over unpaid cost-sharing reductions and Trump-era rules on association health plans, provider conscience protections, and the contraceptive mandate. Other legal challenges are resolved or nearly resolved: These lawsuits focused on a presidential proclamation leaving the ACA and Medicaid off the list of "approved" forms of health insurance that immigrants must obtain within thirty days; a "double billing" rule for abortion services; unpaid risk-corridors payments; and the "sunset" rule (which would add global expiration dates to federal rules).

There has been movement in some ACA cases. The Supreme Court heard oral argument in a case that involves the rights of those protected under existing federal civil rights statutes, including Section 1557 of the ACA. The justices will rule on whether Title VI of the Civil Rights Act of 1964 (and, by extension, Section 504 of the Rehabilitation Act and Section 1557) allows victims of intentional discrimination to seek compensation for emotional distress, such as stigma and humiliation, associated with the mistreatment they face. And we are waiting to learn if the Supreme Court will agree to hear a lawsuit over whether states can recoup the ACA's health insurance tax as it applies to Medicaid managed care entities. Not related to the ACA, the justices heard oral argument in challenges to two Medicare rules and considered state limits on access to abortion services.

Finally, ACA lawsuits over the preventive services mandate and other aspects of Section 1557 are proceeding or have been newly filed. There have also been two legal challenges—one brought by the Texas Medical Association and the other brought by the Association of Air Medical Services—to the Biden administration's interim final rules to implement parts of the No Surprises Act. These new lawsuits should not affect the No Surprises Act's underlying patient protections but could lead the act's independent dispute resolution system to become more costly and result in higher premiums for consumers, employers, and the government.

Section 1332 Waivers

State and federal officials continue to pursue or consider state innovation waivers under Section 1332 of the ACA. Alaska, Hawaii, Maine, Oregon, and Wisconsin have requested (or signaled their intent to apply for) extensions or amendments to current waivers. The federal comment period for Hawaii's request ended in mid-October.

Following approval for a five-year extension of its reinsurance waiver, Colorado officials submitted a separate waiver amendment request to incorporate new standardized public option plans. Insurers in the individual and small-group markets must, beginning with the 2023 plan year, offer a Colorado Option plan at premiums that are up to 15 percent lower than current premiums. Colorado wants to amend its current waiver to receive additional federal pass-through funding that reflects these new premium savings; the state intends to use the additional funding to help make coverage more affordable for individuals who do not currently qualify for Marketplace subsidies.

In early November HHS and the Department of the Treasury opened a new sixty-day comment period to solicit input on Georgia's approved waiver. The announcement came after Georgia repeatedly rebuffed requests from HHS and Treasury to provide updated actuarial and economic analyses. These data, federal officials believe, are necessary to reassess Georgia's waiver in light of recent federal legal and policy changes such as enhanced ARPA subsidies and the COVID-19 special enrollment period. Federal officials identified the types of information that would be helpful for their analysis and provided a list of background documents. Comments are due in early January.

HHS issued evaluation reports of Section 1332 waivers in Alaska, Minnesota, and Oregon. These were the first states with approved Section 1332 waivers for reinsurance programs that began in 2018. The waivers in Alaska and Minnesota were found to help stabilize each state's individual health insurance market, while the analysis of Oregon's program was less conclusive.

HHS also announced additional funding for two states that have a Basic Health Program under the ACA. Minnesota and New York will receive about $100 million and about $750 million, respectively, more than expected. The increase stems from an update to HHS's methodology for determining federal funding for the Basic Health Program to account for enhanced ARPA subsidies.

Other Regulatory Action

As we await major proposed rules for the 2023 plan year, HHS has continued to issue guidance on ACA-related issues. This includes a new technical paper outlining possible model changes to the ACA's risk-adjustment program. The proposals are generally consistent with those considered but not adopted during the rulemaking process for the 2022 plan year. The technical paper includes analysis of the updates to help stakeholders better understand the potential impact of the proposed changes.

HHS authorized temporary premium credits in the small-group market for the remainder of the 2021 benefit year. This allows insurers to reduce employer premiums if they meet certain requirements and could help support small employers that are struggling to maintain coverage for employees.

Federal officials also solicited public comment on two updated draft recommendations for women's preventive services under the ACA. The two recommendations address the coverage of contraceptives and HIV screening for women. HHS also approved additional entities to use enhanced direct enrollment, posted data on individual health coverage health reimbursement arrangements for the 2022 plan year, and proposed repealing the Trump-era so-called good guidance rule (which adopted heightened procedural requirements for HHS guidance). ■

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How ACA Marketplace Premiums Are Changing by County in 2022

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ISSUE BRIEF

Premiums for ACA Marketplace benchmark silver plans are decreasing on average across the U.S. in 2022 for the fourth consecutive year. However, premium changes vary widely by location and by metal level, with premiums increasing in several cases. As most enrollees receive significant premium subsidies on the ACA Marketplaces, the net premium amount an exchange enrollee pays out-of-pocket depends on their income and the difference in the cost between the benchmark plan (second-lowest silver plan) and the premium for the plan they choose.

The American Rescue Plan Act (ARPA) increased (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/) and expanded (https://www.kff.org/health-reform/issue-brief/ten-changes-to-watch-in-open-enrollment-2022/) subsidies (https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/) temporarily for 2021 and 2022 for low- and middle-income individuals and families to purchase health coverage on the ACA Marketplaces. For 2021, some states automatically applied the increased subsidies whereas other states and HealthCare.gov for a period required enrollees to re-select a plan to get additional ARPA subsidies. Many enrollees will get the additional ARPA subsidies when filing taxes for 2021. The additional ARPA subsidies will expire at the end of 2022, but Congress is considering extending them through 2025 as part of the Build Back Better (https://www.kff.org/health-costs/issue-brief/potential-costs-and-impact-of-health-provisions-in-the-build-back-better-act/#one) Act.

> *ACA premiums are falling in many areas of the U.S in 2022. This analysis has an interactive map with county-level data illustrating changes for the lowest-cost bronze, silver & gold plans across the country.*

In this analysis, we analyze data from rate filings insurers submit to state regulators, state exchange websites, and HealthCare.gov (https://www.healthcare.gov/) to see how premiums are changing at the county level both before and after subsidies in 2022. In an earlier analysis (https://www.healthsystemtracker.org/brief/insurer-filings-suggest-covid-19-pandemic-will-not-drive-health-spending-in-2022/) of insurer rate filings, we found that health services spending remained below projected levels through the middle of 2021 and most insurers do not expect COVID-19 to affect their 2022 costs. We published state-level data on average 2022 Marketplace premiums at each metal level here (https://www.kff.org/state-category/affordable-care-act/health-insurance-marketplaces/).

As we show in this analysis, unsubsidized premiums are holding flat or falling on average nationally across metal levels, but actual payments net of subsidies vary greatly depending on location and income. After taking into account subsidies next year, many subsidized enrollees may find their premium payments for low-cost bronze plans are actually higher than this year, while payments net of subsidies for silver plans are similar and for gold plans are lower than this year.

Due to the American Rescue Plan Act (ARPA) (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/), Marketplace enrollees with incomes between 100-150% of poverty are eligible for free ($0 premium) or nearly free (requiring a nominal payment of less than $1 to $4 per month to cover non-essential benefits) silver plans. We find that free or nearly free silver plans are also available in 66% of counties to 40-year-old Marketplace enrollees with incomes of $20,000 (155% of poverty). These low-income enrollees also qualify for additional cost-sharing subsidies in silver metal level plans. Though most of them could also get a free ($0 premium) bronze plan, paying a small premium (e.g., $1 per month) for silver over bronze plans would substantially lower their deductible and other out-of-pocket cost-sharing payments.

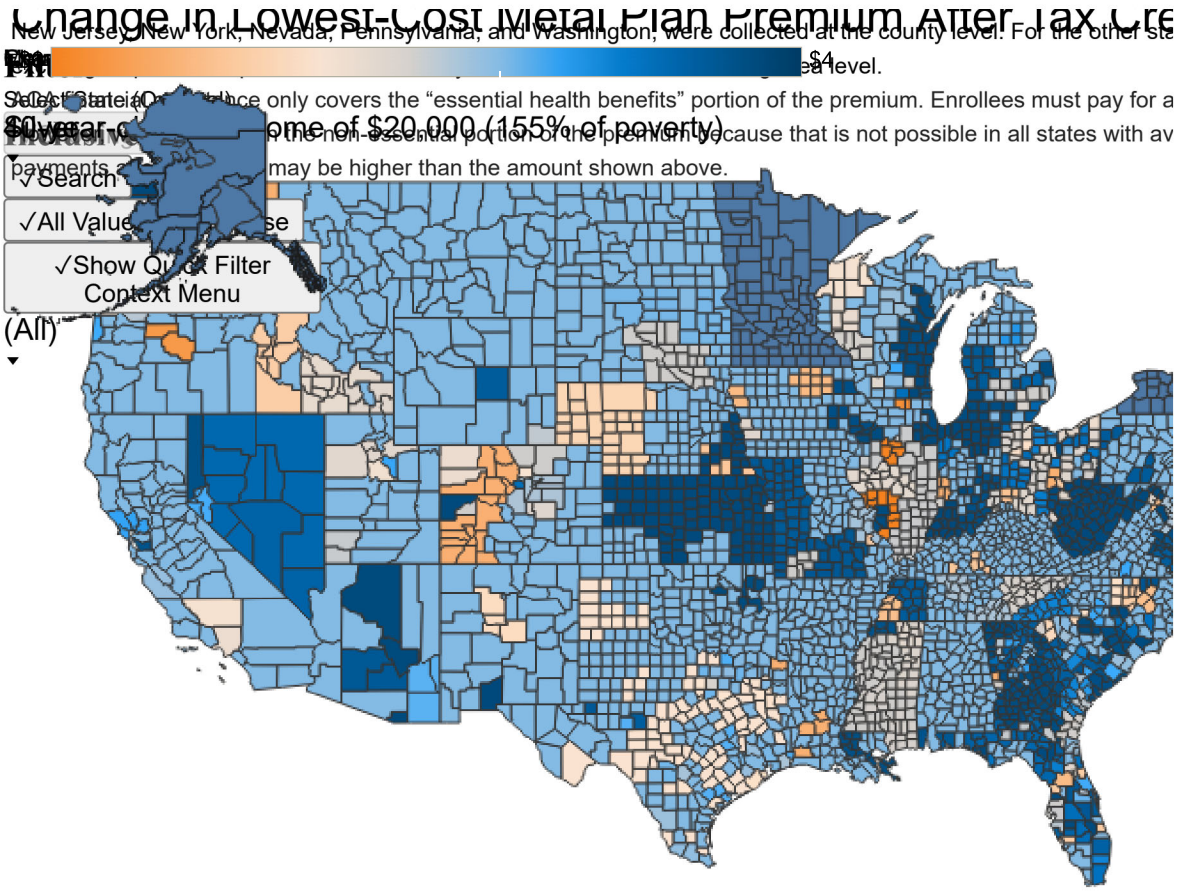
2022 ACA Premium and Subsidy Changes

With the ARPA's enhanced financial assistance for ACA Marketplace coverage, subsidized enrollees with incomes below 150% of poverty ($19,320 for an individual and $39,750 for a family of 4) can get a free ($0 premium) or nearly free silver plan with a very low deductible. Because financial assistance only covers (https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/) the "essential health benefits" portion of the premium, enrollees with incomes below 150% of poverty may have to pay a nominal amount (e.g., $0.50 or $1 per month) for health coverage in counties where the lowest-cost silver plan and the second-lowest cost silver plan include non-EHB benefits (for example, dental or vision coverage for adults or non-Hyde abortion coverage).

In this analysis, we do not add in the non-EHB portion of premiums because that is not possible in all states with available data Therefore net premiums after subsidies may be higher in some counties. In 2022, 311 of 2,143 (12.7%) counties in HealthCare.gov states have non-EHB benefits in the lowest-cost silver and benchmark silver plans. The non-EHB portion of lowest-cost silver plan premiums (which tax credits would not cover) in these counties range from $0.04 to $4.34 per month with half counties falling between $0.04 to $2.36 per month for a 40-year-old.

The map below illustrates changes in premiums for the lowest-cost bronze, silver, and gold plans by county. (For data at the state-level, see our state tables here (https://www.kff.org/state-category/affordable-care-act/health-insurance-marketplaces/)). Results are shown for a 40-year-old paying the full premium and for a 40-year old with an income ranging between $20,000 (roughly 160% of poverty) and $40,000 (roughly 310% of poverty), who would be eligible for a premium tax credit. The ARPA's enhanced subsidies are included for 2021 and 2022 estimates of premiums after a tax credit.

Figure 1



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Nationally, the average benchmark silver premium – on which subsidies are calculated – is decreasing by about 2.4% (Table 1). Meanwhile, average unsubsidized premiums for lowest-cost bronze plans are holding flat (0.3% change), and lowest-cost silver and lowest-cost gold plan premiums are decreasing by an average of 1.8% and 4.1%, respectively.

Table 1: Change in the Average Premium by Metal Level Before Tax Credit, 2021-2022 for a 40-year-old

Metal Level	2021	2022	% Change
Lowest Cost Bronze Premium	$328	$329	0.3%
Lowest Cost Silver Premium	$436	$428	−1.8%
Benchmark (2nd Lowest) Silver Premium	$452	$438	−3.1%
Lowest Cost Gold Premium	$482	$462	−4.1%

SOURCE: KFF analysis of premium data from HealthCare.gov, state exchange websites, and rate filings.

Because benchmark premiums are dropping on average while lowest-cost bronze premiums are holding flat, 2022 subsidies will cover a somewhat smaller share of bronze premiums than they did in 2021. However, lowest-cost gold premiums are dropping at a faster rate than benchmark premiums, meaning that the tax credit may cover a larger share of the premium, on average, for people buying gold plans. In either case, premium changes vary by geography as shown in the map above, so whether enrollees will see their premiums increase or decrease for 2022 will depend on how benchmark premiums are changing and how premiums for plans at their preferred metal level are changing in their county.

Table 2 provides examples of average net premiums for Marketplace enrollees with certain income and age combinations, after accounting for tax credits.

Table 2: Average Lowest-Cost Premium by Metal Level After Tax Credit, 2021-2022

Metal Level	2021	2022	% Change
40-year-old with $20,000 income (155% of poverty)			
Lowest Cost Bronze Premium	$0	$0	N/A
Lowest Cost Silver Premium	$1	$1	0%
Lowest Cost Gold Premium	$41	$33	−19.5%
40-year-old with $25,000 income (194% of poverty)			
Lowest Cost Bronze Premium	$0	$0	N/A
Lowest Cost Silver Premium	$27	$27	0%
Lowest Cost Gold Premium	$70	$60	−14.3%
40-year-old with $30,000 income (233% of poverty)			
Lowest Cost Bronze Premium	$3	$4	33.3%
Lowest Cost Silver Premium	$71	$72	1.4%
Lowest Cost Gold Premium	$1…	$107	−8.5%
40-year-old with $35,000 income (272% of poverty)			
Lowest Cost Bronze Premium	$33	$39	18.2%
Lowest Cost Silver Premium	$…	$…	0%
Lowest Cost Gold Premium	$176	$165	−6.2%
40-year-old with $40,000 income (311% of poverty)			
Lowest Cost Bronze Premium	$91	$100	9.9%
Lowest Cost Silver Premium	$197	$198	0.5%
Lowest Cost Gold Premium	$242	$232	−4.1%

NOTE: ACA financial assistance only covers the “essential health benefits” portion of the premium. Enrollees must pay for any non-essential benefits. However, we do not add in the non-essential portion of the premium because that is not possible in all states with available data. Therefore, premium payments after subsidies may be higher than the amount shown above.

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As has been the case since 2018, insurers generally load the cost (https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/) from the termination of federal cost-sharing reduction payments entirely onto the silver tier (a practice sometimes called “silver loading”). The relatively higher price for silver plans due to silver loading means subsidy-eligible Marketplace enrollees will continue to receive relatively large premium tax credits, although the dollar amount may be somewhat smaller than in past years based on decreases in the underlying benchmark silver premiums. Subsidies

calculated based on silver-loaded premiums continue to make gold and bronze plans less expensive (or even $0 in some cases) compared to before cost-sharing reduction payments were terminated.

For low-income individuals, the tax credit may cover the full premium of the lowest-cost silver plan, which also has significantly lower deductibles (Table 3). For example, the tax credit for a 40-year-old individual making $20,000 covers the full cost of the premium for the lowest-cost silver plan in 66% of counties (2,087 of 3,143 counties) in 2022. This is slightly lower than in 2021, when the tax credit for a 40-year-old individual making $20,000 covered the full cost of the lowest-cost silver plan premium in 72% of counties (2,261).

Table 3: Number of Counties Where an Individual's Tax Credit Covers the Full Premium by Metal Level, for a 40-year-old, 2021-2022

Metal Level	2021	2022
40-year-old with $20,000 income (155% of poverty)		
Lowest Cost Bronze Premium	3,142 (100% of counties)	3,142 (100% of counties)
Lowest Cost Silver Premium*	2,261 (72%)	2,087 (66%)
Lowest Cost Gold Premium	1,090 (35%)	1,072 (34%)
40-year-old with $25,000 income (194% of poverty)		
Lowest Cost Bronze Premium	3,129 (100%)	3,134 (100%)
Lowest Cost Silver Premium*	650 (21%)	528 (17%)
Lowest Cost Gold Premium	602 (19%)	699 (22%)
40-year-old with $30,000 income (233% of poverty)		
Lowest Cost Bronze Premium	2,571 (82%)	2,473 (79%)
Lowest Cost Silver Premium	204 (6%)	36 (1%)
Lowest Cost Gold Premium	201 (6%)	188 (6%)
40-year-old with $35,000 income (272% of poverty)		
Lowest Cost Bronze Premium	1,266 (40%)	1,053 (34%)
Lowest Cost Silver Premium	33 (1%)	3 (0%)
Lowest Cost Gold Premium	126 (4%)	30 (1%)
40-year-old with $40,000 income (311% of poverty)		
Lowest Cost Bronze Premium	445 (14%)	277 (9%)
Lowest Cost Silver Premium	10 (0%)	N/A
Lowest Cost Gold Premium	10 (0%)	N/A

NOTE: ACA financial assistance only covers the "essential health benefits" portion of the premium.

Subsidized bronze plans may be particularly attractive to people eligible for premium tax credits but not eligible for cost-sharing subsidies. For example, the tax credit for a 40-year-old individual making $35,000 (272% of poverty) covers the full cost of the premium for the lowest-cost bronze plan in 34% of counties.

In order to qualify for a plan with a cost-sharing reduction (CSR), low-income enrollees must sign up for a silver plan. CSR in silver plans lowers the amount an enrollee spends out-of-pocket by setting a lower out-of-pocket cost-sharing maximum, which also translates to lower deductibles, copayments, and coinsurance. For example, a single individual making between 100-200% of the poverty level can qualify for a silver plan with an out-of-pocket maximum of no more than $2,900, and the deductible would be significantly lower than that. If the same individual instead signs up for a bronze plan, the out-of-pocket maximum and deductible could be up to $8,700. People with incomes under 200% of poverty who are eligible for significant assistance with cost-sharing are often eligible for silver plans with no monthly payment. Even if they do have a small payment each month, they are often better off paying a small monthly premium for a silver plan even if a bronze plan is available for a $0 premium.

We also find that a 40-year-old Marketplace enrollee making $30,000 per year (233% of poverty) would be eligible for a free bronze plan in 79% of counties, and those with incomes of $35,000 (272% of poverty) would be eligible for a free bronze plan in 34% of counties. Enrollees at these incomes are eligible for little or no financial aid to lower deductibles and therefore may find a free bronze plan to be an attractive option.

Discussion

Although the sticker prices for many ACA Marketplace plans are dropping, what a given person actually pays depends on their income, location, and differences in pricing between their selected plan and the benchmark silver plan. For people to know how much they will pay net of subsidies (https://www.kff.org/interactive/subsidy-calculator/), they must return to Healthcare.gov or their state's exchange each year and carefully consider their options.

Because of ARPA subsidies, enrollees with incomes between 100% and 150% of poverty qualify for free or nearly-free benchmark and lowest-cost silver plans with substantially reduced out-of-pocket costs. Enrollees with incomes over 150% of poverty in many parts of the country can similarly qualify for free (zero-premium) or nearly free (requiring a nominal payment to cover non-essential benefits) silver and bronze plans. The benchmark (second-lowest cost) silver plan is the basis for determining the amount of financial assistance people receive. The large tax credit may cover all or most of the cost of the lowest-cost silver or several bronze plans.

While free bronze plans will be available to subsidized enrollees in many counties in 2022, it is still important for low-income enrollees to consider the significant cost-sharing assistance that is only available if they enroll in a silver plan. Marketplace enrollees eligible for cost-sharing subsidies are often best off in a silver plan, which will reduce their out-of-pocket costs when they need medical care.

Methods

We analyzed data from the 2021 and 2022 Individual Market Medical files to determine premiums and the benchmark amounts to calculate premium tax credits for the scenarios presented. These files are available at data.healthcare.gov (https://data.healthcare.gov/). Premiums for the state-based marketplaces are from a review of insurer rate filings and state plan finders. Premiums for California and Massachusetts were collected at the zip code level, and premiums for the District of Columbia, Idaho, Maine, Minnesota, New Mexico, New Jersey, New York, Nevada, Pennsylvania, and Washington, were collected at the county level. For the other states running their own exchange, premiums presented in this analysis are at the rating area level. ACA financial assistance only covers the "essential health benefits" portion of the premium. Enrollees must pay for any non-essential benefits. However, we do not add in the non-essential portion of the premium because that is not possible in all states with available data. Therefore, premium payments after subsidies may be higher than the amount in this analysis.

The average changes in plan costs were weighted by county using 2021 plan selections obtained from the 2021 Marketplace Open Enrollment Period County-Level Public Use file provided by CMS, available here (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files). 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, available here (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files).

APPENDIX (HTTPS://WWW.KFF.ORG/REPORT-SECTION/HOW-ACA-MARKETPLACE-PREMIUMS-ARE-CHANGING-BY-COUNTY-IN-2022-APPENDIX/) ›

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CHCF Issue Brief

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by Katherine L. Gudiksen, Amy Y. Gu, and Jaime S. King

Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California

Over the past three decades, markets for health insurers and providers have gone through waves of consolidation.[1] As of 2018, 95% of metropolitan areas in the United States had highly concentrated hospital markets.[2] Markets for health insurers are also highly concentrated — between 2006 and 2014, the combined market share of the top four insurers climbed from 74% to 83%.[3] The coronavirus pandemic appears to be fueling another round of consolidation — especially acquisition of providers by private equity firms.[4] While past consolidation typically resulted from mergers and acquisitions, consolidation now also occurs through other types of transactions including joint ventures, strategic alliances, affiliations, and other agreements between companies.[5] Because it is clearly increasing throughout market segments and across the state, it is important to understand different forms of health care consolidation, common measurements of market concentration, the evidence on the effects of past consolidation, the current sources and types of regulatory oversight in California, and potential considerations for future policymaking.

Types of Consolidation: Definitions and Measures

Horizontal Concentration

Horizontal concentration refers to how many direct competitors are in a market and how much market share each competitor has. A market can become horizontally concentrated through mergers and acquisitions (e.g., if two hospitals in a market merge) or if companies gain substantial market share through expansion or by outcompeting their rivals. One commonly used measure of market concentration is the Herfindahl–Hirschman Index (HHI). When calculating an HHI, the market share of each firm in the relevant market is squared and the squares are summed. For example, if there are three hospitals in a market, each with 20%, 30%, and 50% market shares, the HHI for that hospital market is 3,800 (or $20^2 + 30^2 + 50^2$). HHI measurements range from 0 (an infinite number of firms) to 10,000 (a monopoly). Antitrust enforcers consider a market with an HHI of less than 1,500 as a competitive marketplace, one with an HHI between 1,500 to 2,500 as moderately concentrated, and one with an HHI of greater than 2,500 as highly concentrated. Researchers from the Petris Center at the University of California, Berkeley calculated that the average HHI level for counties in California in 2018 exceeded the "highly concentrated" threshold for hospitals (average HHI = 5,695), specialists (4,191), and insurers (3,121), and was "moderately concentrated" for primary care physicians (1,540).[6] Furthermore, if they removed counties with populations over 500,000 from the analysis, the average hospital HHI in California was over 7,000,[7] demonstrating that hospital markets in most California counties are approaching monopoly levels of concentration, especially in rural areas. Other studies show that these trends are not limited to California.[8]

Hospital markets in most California counties are approaching monopoly levels of concentration, especially in rural areas.

Vertical Concentration

Vertical consolidation occurs when firms at different levels of the supply chain merge. In health care, vertical consolidation often refers to hospitals acquiring physician practices or clinics, but vertical consolidation also applies to insurers purchasing physician practices

or pharmacy benefit managers. To measure vertical consolidation, researchers typically report the percentage of companies in the market owned by a firm higher up in the supply chain (e.g., the percentage of physicians or clinics owned by a hospital or health system). Unlike HHI levels in horizontal merger guidelines, antitrust enforcers have not issued thresholds for percentage ownership that warrant increased scrutiny of vertical mergers. Nonetheless, the percentage of ownership measures demonstrate that physicians in California are increasingly vertically consolidated — as of 2018, 52% of specialists and 42% of primary care physicians in California were in practices owned by a health system.[9] Another study reported similar findings nationwide.[10] Of note, this vertical consolidation has increased dramatically over the past decade. For example, researchers found that the percentage of specialists in California that were in practices affiliated with a health system increased from 25% in 2010 to 52% in 2018 — an increase of 108%.[11]

Physicians in California are increasingly vertically consolidated — as of 2018, 52% of specialists and 42% of primary care physicians in California were in practices owned by a health system.

Cross-Market Concentration

Cross-market consolidation occurs when two companies that operate in different geographic markets merge. For example, a cross-market merger occurs when a hospital in one city merges with a hospital in another city. While there is no widely accepted methodology for measuring the extent of cross-market consolidation — like HHI for horizontal consolidation — researchers have used "willingness-to-pay" calculations and "common customers" to try to estimate the impact of a particular cross-market merger.[12]

Impacts of Consolidation on Consumers

When assessing the potential impacts of a health care merger,[13] it is important to ask whether the patient or the public will benefit. For instance, will the merger result in decreased administrative costs that result in lower prices for consumers? Will the merger allow investment in technologies that increase quality or efficiency of care that patients receive? Or will the merger reduce competition and allow companies to raise prices or decrease quality without losing market share?

Unfortunately, a large and growing body of evidence demonstrates that mergers of health care companies have consistently resulted in increased prices for health care services with little to no improvement in quality.

Effects of Horizontal Mergers

A diverse set of research studies clearly demonstrate that hospital prices increase following a horizontal merger with another hospital in the same market and that those price increases happen for both nonprofit and for-profit hospitals.[14] The demonstrated price increases can be quite large, ranging from 20% to 40% post-merger. In 2020, the Medicare Payment Advisory Commission (MedPAC) reviewed the published research on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices."[15] While there are fewer studies about horizontal concentration of physician practices, studies found that physicians in consolidated markets are paid higher prices for their services[16] and that prices increased 10% to 20% following a merger of two specialty practices in the same market.[17] Importantly, the effects of these higher prices are not limited to the patients at these hospitals because insurers pass on these increased prices to all enrollees and their employers through increased premiums.[18] Furthermore, workers bear the burden of these increased premiums as employers depress wages to pay more for health insurance coverage.[19]

When analyzing mergers of insurers, the effect is a bit more complex because insurers with market power may be able to negotiate lower prices from providers, but that market power may also enable them to retain higher profits without passing those savings to employers or individuals through lower premiums.[20] For example, one study looking at the impact of health plan concentration on hospital prices found that hospital prices in the most concentrated health insurer markets were approximately 12% lower than in more competitive health plan markets.[21] Other studies, however, documented that lower provider prices only translate into lower premiums if the insurance market is sufficiently competitive,[22] as insurers who do not face competitive pressure may not have the incentive to pass any savings on to consumers.[23] Nonetheless, the medical loss ratio requirements in the Affordable Care Act (ACA) essentially cap profits of all commercial insurance plans.[24] Furthermore, because insurers with market power may be able to demand rates that are below competitive prices, providers may respond by reducing services or quality or exiting the market entirely. Accordingly, the effect of insurance mergers on costs for consumers depends on whether the newly merged insurer can negotiate lower rates, whether regulations or market forces require the insurer to pass on any savings generated from decreased provider prices, and whether those rates negatively affect providers in the area.

Horizontal consolidation affects more than prices. Antitrust theory and empirical research both reveal the mixed to negative impact that horizontal consolidation can have on health care quality and the negative impact it can have on the labor market for health care workers. A report sponsored by the American Hospital Association found that mergers increased the standardization of clinical protocols, increased investments and access to medical staff at acquired hospitals, and improved outcomes from complex services because of an increase in volume at the acquiring hospital.[25] The bulk of the research evidence, however, finds that these efficiencies are not consistently borne out and that quality suffers in highly concentrated markets, and multiple studies find higher patient mortality for some conditions.[26] Beyond impacts on prices and quality, evidence suggests that consolidation can also decrease wage growth for hospital employees. Prager and Schmitt found that among the mergers resulting in the highest increases in concentration, wage growth for nurses and pharmacists was about two-thirds of what it would have been without the merger.[27]

Effects of Vertical Mergers

A number of studies find increased prices and little improvement in quality following vertical mergers.[28] For example, Capps, Dranove, and Ody found that physician prices increased, on average, by 14% for medical groups acquired by hospital systems.[29] Further, researchers found that in California, an increase in the share of physicians in practices owned by a hospital was associated with an increase in premiums for private plans sold on Covered California, the state's marketplace.[30]

A number of studies find increased prices and little improvement in quality following vertical mergers.

Proponents of vertical mergers have frequently claimed that the merger will help improve continuity of care, reduce duplicative care, or increase quality.[31] A few studies have found improvements in specific areas, like increased number of patients getting cancer screening and increased care utilization, while other studies found no statistically significant effects on mortality or patient satisfaction.[32] More recent studies have found that physicians change their referral and prescribing patterns after they are acquired by a hospital in ways that lead to wasteful spending.[33] For example, Young and colleagues found that the odds of a patient receiving an inappropriate MRI referral increased by more than 20% after a physician transitioned from independent practice to hospital employment.[34] Overall, studies on quality improvements following a vertical merger remain ambiguous.[35]

Effects of Cross-Market Mergers

While the effects of cross-market mergers are less studied than those of horizontal and vertical mergers, economic researchers have found that cross-market mergers can have a significant impact on prices charged by health systems.[36] For example, a growing body of research demonstrates a 7% to 17% increase in prices for hospitals purchased by out-of-market systems,[37] a 7% to 9% increase in prices at the acquiring hospital after merging with a hospital in a different market in the same state,[38] and an 8% increase in prices at nonmerging nearby hospitals that shadow the price increases at the newly merged facility.[39]

Current Regulatory Oversight of Consolidation in California

Currently, three agencies in California — the Department of Insurance (CDI), the Department of Managed Health Care (DMHC), and the Office of the Attorney General — have the authority to review some mergers involving health care entities. CDI must approve any mergers involving domestic insurers, DMHC must approve mergers involving health care service plans, and the attorney general (AG) must approve most mergers of *nonprofit* hospitals. In addition, the AG can challenge *any* merger under antitrust laws that would "substantially lessen competition" or "tend to create a monopoly."[40]

Review of Transactions Involving Insurers or Health Care Service Plans by CDI and DMHC

CDI and DMHC both have the authority to review and block some mergers involving carriers or insurers through an administrative process.[41] For mergers involving a California domestic insurer[42] or a commercially domiciled insurer,[43] which are subject to examination by CDI, parties must obtain written consent or approval of the insurance commissioner before entering into any transaction that transfers substantially all of the business to a new entity[44] or that changes control of the insurer.[45] CDI may approve, approve with conditions, or reject the merger. In reviewing a merger, CDI analyzes whether the transaction may "substantially lessen competition" or "create a monopoly."[46] Additionally, CDI may consider other factors including financial solvency, fair and reasonable terms, and adverse effects on policyholders' interests.[47]

Similarly, mergers involving health care service plans regulated by DMHC must be approved by the director of DMHC.[48] If the transaction is a "major transaction or agreement" — one that affects a significant number of enrollees, transfers "a material amount of assets," or adversely affects the "stability of the health care delivery system"[49] — DMHC must hold a public meeting,[50] and if a material amount of the assets will be transferred, DMHC must also prepare a statement describing the transaction and make it publicly available before the public meeting.[51] The director then reviews the merger and may approve, conditionally approve, or reject the merger. The standards for rejecting a merger mirror federal antitrust law, and DMHC is authorized to block any transaction that would "substantially lessen competition in health care service plan products or create a monopoly in this state, including, but not limited to, health coverage products for a specific line of business."[52]

The Department of Managed Health Care regulates only the plans operating in California (not any parent corporations), and the Department of Insurance does not have the authority to oversee a proposed merger that may affect California residents but does not involve an insurer residing in the state.

CDI and DMHC currently have the authority to oversee mergers involving domestic insurers and health plans regulated by the state. Importantly though, DMHC and CDI cannot block mergers of insurers outside of the state. DMHC regulates only the plans operating in California (not any parent corporations), and CDI does not have the authority to oversee a

proposed merger that may affect California residents but does not involve an insurer residing in the state (e.g., when an insurer sells plans in California but does not meet the definition of a commercially domiciled insurance company).[53] Nonetheless, the administrative processes at DMHC and CDI allow the agencies to oppose or condition mergers not easily challenged through litigation under antitrust laws.

The Attorney General Can Sue to Block Any Anticompetitive Transactions

The California AG, on the other hand, can file a lawsuit under state or federal antitrust laws to block any merger or acquisition when the "effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[54] The AG's office can file the lawsuit under its law enforcement capacity either on its own behalf as a purchaser of health services or as *parens patriae* on behalf of the interests of the citizens of California.[55] The AG has authority to sue to block mergers that involve insurers, health care service plans, and health care providers, even if another agency has approved the merger.[56] Blocking a merger through litigation, however, requires significant resources, may be time-consuming, and has uncertainty associated with judicial decisionmaking. Furthermore, because bringing a case is extremely resource-intensive and time-consuming, the AG is likely to oppose only the largest mergers under antitrust laws.

Limitations of using the courts to mitigate the harmful impacts of consolidation are apparent in the cases against Sutter Health in Northern California. In 1999, the AG filed a lawsuit alleging that the merger of Sutter Health's Alta Bates Medical Center with Summit Medical Center would have anticompetitive effects and, therefore, violated the federal Clayton Act.[57] The judge, however, denied the AG's request for an injunction, saying health plans could "discipline" hospitals by steering patients to lower-cost health providers, and if anticompetitive price increases did occur because of the merger, patients could choose to join Kaiser.[58] Over a decade later, a retrospective study by the Federal Trade Commission, which helped to revise the economic tools, found that Summit's price increases after the merger were among the largest of any comparable hospital in California.[59] In 2014, a health benefit trust filed a class action lawsuit against Sutter Health alleging that the market power Sutter Health gained through this merger coupled with anticompetitive contract terms led to excessive price increases in Northern California.[60] In 2018, the California AG joined the lawsuit.[61] The case was finally resolved in 2021, when the court approved a settlement that contained $575 million in damages and injunctive relief to stop Sutter Health from using specific contracting practices. This case illustrates the harm that can result when antitrust law fails to prevent potentially harmful mergers. Subsequent antitrust lawsuits to curb abuses of market power created by a merger can take years to resolve and, even after resolution, the parties not involved in the lawsuit will not typically receive restitution.

The AG Can Block Transactions of Nonprofit Health Facilities Using an Administrative Review

California's AG currently has the authority to block transactions that transfer a "material amount of the assets" of a *nonprofit health facility* without going to court. California law defines a health facility as any place or building that "is operated for the diagnosis, care, prevention, and treatment of human illness . . . to which . . . persons are admitted for a 24-hour stay or longer," and includes acute care hospitals, skilled nursing facilities, psychiatric hospitals, and specialized maternity hospitals. It does not include physician practices or outpatient clinics. Before 2000, this authority only applied to a *conversion* of a nonprofit health facility (i.e., the purchase of a nonprofit health facility by a for-profit entity). Following the AG's loss in the Sutter-Summit merger challenge (where both Sutter and Summit were nonprofit health systems), the California legislature amended the law to include mergers and acquisitions of nonprofit health facilities, irrespective of the tax status of the purchaser.[62] Currently, any nonprofit corporation that operates or controls a health care facility must provide written notice to, and obtain approval from, the AG before completing any transaction that sells or transfers a "material amount of the assets" or control of the operations of the nonprofit

corporation.[63] In reviewing the transaction, the AG may consider any factors the AG deems relevant, including whether the transaction is in the public interest.[64]

This administrative process has significant benefits relative to antitrust lawsuits, including that it is less resource-intensive than a trial and allows more timely review of proposed mergers. In one of the first challenges to a cross-market merger, the AG issued a conditional approval of the affiliation between Cedars-Sinai Health System and Huntington Memorial Hospital, two nonprofit hospital systems in Southern California,[65] that included a price cap on the newly affiliated entities and a requirement to maintain separate teams when negotiating prices with payers.[66] The hospitals filed a lawsuit challenging that conditional approval, alleging that the AG acted in an arbitrary and capricious manner and overstepped the AG's administrative authority.[67] Before the scheduled trial date, the merging parties and the AG came to a settlement that imposes modified price caps, prohibits the bundling or tying of hospital contracts, and grants insurers the option to request a negotiation firewall.[68]

This case demonstrates that the AG can use nonprofit merger review authority to block or to apply conditions to potentially anticompetitive mergers. The major limitation of this authority is that it applies only to mergers involving nonprofit health care facilities, as defined in the statute. To oppose a merger involving a physician practice, an outpatient clinic, for-profit health systems, or an insurer, the AG must face the uncertainty of a lawsuit and expend the time, effort, and resources required for a trial.

Opportunities for Additional Oversight of Health Care Transactions in California

While nonprofit health care facilities must notify and get approval from the AG before a sale or transfer of their assets, the AG must rely on news reports and other sources to track consolidation of other health care entities, including for-profit hospitals and physician practices. The AG may be unaware of transactions that do not involve a nonprofit health care facility, and therefore may be unable to challenge them until after their completion. Furthermore, even if the AG becomes aware of these transactions before they happen, the AG has no authority to impose a waiting period before consummation of the proposed merger to allow the office to review the transaction. While the AG can use antitrust law to challenge any merger, even after it is completed, these legal proceedings may take years, and unwinding the merger ("unscrambling the egg") is very likely to be ineffective and difficult, so antitrust enforcers almost never attempt it in health care.[69]

To increase scrutiny of provider mergers in California, policymakers could require all health care providers (not just nonprofit ones) to provide written notice to, and obtain the written consent of, the AG before entering into any transaction that transfers a material amount of their assets or changes control or governance of the provider. This notification and approval authority could mirror that currently required for nonprofit health care facilities. Additionally, to expedite review of smaller transactions unlikely to impact competitive factors, policymakers could create a tiered review process.[70] In Oregon, health entities with revenues over a given threshold must obtain approval from the Oregon Health Authority before merging, including transactions involving a private equity firm.[71] California could adopt a similar approach by establishing a new agency to review health care mergers or to expand the authority of the AG to approve, conditionally approve, or block *all* mergers involving health care providers.[72]

To increase scrutiny of provider mergers in California, policymakers could require all health care providers (not just nonprofit ones) to provide written notice to, and obtain the written consent of, the attorney general before entering into any transaction that transfers a material amount of their assets or changes control or governance of the provider.

Importantly, granting the AG or another state agency an increased authority to review and block all health care mergers through an administrative process does not address the market power gained through decades of consolidation in California. Consequently, policymakers may choose to consider how to regulate conduct and the harms that may result from previously consummated mergers. For example, while CDI and DMHC have the authority to block or condition mergers of domestic insurers and health care service plans, respectively, policymakers could also consider expanding the authority of these regulatory agencies to include "affordability standards" when they review health plans for sale in California. Currently, DMHC and CDI can *review* rate changes in the individual and group markets, but neither department has the authority to *deny* rate increases.[73] Policymakers could consider granting DMHC and CDI additional authority to reject rates or rate increases they deem "unaffordable."[74] In addition, policymakers could consider prohibiting specific contractual terms likely to be anticompetitive (e.g. all-or-nothing or anti-tiering clauses).[75] And finally, policymakers could consider directly regulating prices or price increases for high-cost providers. Several states are implementing this policy approach, and the California legislature has explored it in recent years.[76] While increased oversight of future mergers is critical, increased administrative review alone is unlikely to restore competition to health care markets at a level sufficient to restrain prices and increase quality.

While the Department of Insurance and the Department of Managed Health Care have the authority to block or condition mergers of domestic insurers and health care service plans, respectively, policymakers could also consider expanding the authority of these regulatory agencies to include "affordability standards" when they review health plans for sale in California.

Conclusion

California's health care provider and insurer markets are highly concentrated, and empirical research has consistently shown that health care consolidation drives increases in health care prices and insurance premiums without commensurate improvements in health care quality. Because health care provider and insurer markets in most regions of California are already highly concentrated, policymakers and state officials could consider additional scrutiny and interventions to promote competition and mitigate consolidation's most harmful consumer impacts.

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The Source on Healthcare Price and Competition provides up-to-date and easily accessible research and analysis on health care price and competition in the US.

About the Foundation

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

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

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Potential Costs and Impact of Health Provisions in the Build Back Better Act

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The Build Back Better Act (https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-117HR5376RH-RCP117-18.pdf), H.R. 5376, (BBBA), adopted by the House of Representatives on November 19, 2021 with the support of President Biden, includes a broad package of health, social, climate change and revenue provisions. The total package includes $1.7 trillion in spending, according to the Congressional Budget Office (https://www.cbo.gov/publication/57626) (CBO), which also projects that three of the health provisions would reduce the number of uninsured by 3.4 million people. This brief summarizes the version that passed the House, which may be modified as it moves through the Senate.

Here, we walk through 11 of the major health coverage and financing provisions of the Build Back Better Act, with discussion of the potential implications for people and the federal budget. We summarize provisions relating to the following areas and provide data on the people most directly affected by each provision and the potential costs or savings to the federal government.

1. ACA Marketplace Subsidies
2. New Medicare Hearing Benefit

3. Lowering Prescription Drug Prices and Spending
4. Medicare Part D Benefit Redesign
5. Medicaid Coverage Gap
6. Maternal Care and Postpartum Coverage
7. Other Medicaid / Children's Health Insurance Changes CHIP Changes
8. Other Medicaid Financing and Benefit Changes
9. Medicaid Home and Community Based Services and the Direct Care Workforce
10. Paid Family and Medical Leave
11. Consumer Assistance, Enrollment Assistance, and Outreach

A recent KFF poll (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-october-2021/) found broad support for many of these provisions, though it did not probe on the costs or trade-offs associated with them. The poll (https://www.kff.org/health-costs/poll-finding/public-weighs-in-on-medicare-drug-negotiations/) also found that the vast majority of the public supports allowing the federal government to negotiate drug prices, after hearing arguments made by proponents and opponents.

Major Provisions of the Build Back Better Act and their Potential Costs and Impact

1. ACA Marketplace Subsidies

BACKGROUND

Under the Affordable Care Act, people purchasing Marketplace coverage could only qualify for subsidies if they met other eligibility requirements and had incomes between one and four times the federal poverty level. People eligible for subsidies would have to contribute a sliding-scale percentage of their income toward a benchmark premium, ranging from 2.07% to 9.83%. Once income passed 400% FPL, subsidies stopped and many individuals and families were unable to afford coverage.

In 2021, the American Rescue Plan Act (ARPA) temporarily expanded eligibility for subsidies by removing (https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/) the upper income threshold. It also temporarily increased the dollar value of premium subsidies across the board, meaning nearly everyone on the Marketplace paid lower premiums, and the lowest income people pay ***zero*** (https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-

relief-on-marketplace-premiums/) premium for coverage with very low deductibles. The ARPA also made people who received unemployment insurance (UI) benefits during 2021 eligible for zero-premium, low-deductible plans.

However, the ARPA provisions removing the upper income threshold and increasing tax credit amounts are only in effect for 2021 and 2022. The unemployment provision is only in effect for 2021.

PROVISION DESCRIPTION

Section 137301 of The Build Back Better Act would extend the ARPA subsidy changes that eliminate the income eligibility cap and increase the amount of APTC for individuals across the board through the end of 2025.

Additionally, Section 30605 of The Build Back Better Act would extend the special Marketplace subsidy rule for individuals receiving UI benefits for an additional 4 years, through the end of 2025.

Section 137303 of the Act would, for purposes of determining eligibility for premium tax credits, disregard any lump sum Social Security benefit payments in a year. This provision would be permanent and effective starting in the 2022 tax year. Starting in 2026, people would have the option to have the lump sum benefit included in their income for purposes of determining tax credit eligibility.

Finally, Section 137302 modifies the affordability test for employer-sponsored health coverage. The ACA makes people ineligible for marketplace subsidies if they have an offer of affordable coverage from an employer, currently defined as requiring an employee contribution of no more than 9.61% of household income in 2022. The Build Back Better Act would reduce this affordability threshold to 8.5% of income, bringing it in line with the maximum contribution required to enroll in the benchmark marketplace plan. This provision would take effect for tax years starting in 2022 through 2025. Thereafter the affordability threshold would be set at 9.5% of household income with no indexing.

PEOPLE AFFECTED

CBO projects that the enhanced tax credits in Section 137301 would reduce the number of uninsured by 1.2 million people. As of August 2021, 12.2 million (https://www.cms.gov/files/document/2019-2021-aug-effectuated-enrollment.xlsx) people were actively enrolled in Marketplace plans – an 8% increase from 11.2 million (https://www.cms.gov/document/Early-2021-2020-Effectuated-Enrollment-Report.pdf) people enrollees as of the close of Open Enrollment for the 2021 plan year. HealthCare.gov and all state Marketplaces reopened for a special enrollment period of at least 6 months in 2021, enrolling 2.8 million (https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf) people (not all of whom were necessarily previously uninsured). Of these, 44% selected plans with monthly premiums of $10 or less.

The US Department of Health and Human Services (HHS) reports that ARPA reduced Marketplace premiums for the 8 million existing Healthcare.gov enrollees by $67 per month, on average. If the ARPA subsidies are allowed to expire, these enrollees will likely see their premium payments double (https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/).

HHS also reports that between July 1 and August 15, more than 280,000 (https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf) individuals received enhanced subsidies due to the ARPA UI provisions. Individuals eligible for these UI benefits can continue to enroll in 2021 coverage through the end of this year.

The ARPA changes made people with income at or below 150% FPL eligible for zero-premium silver plans with comprehensive cost sharing subsidies. 40% of new consumers who signed up during the SEP are in a plan that covers 94% of expected costs (with average deductibles below $200). As a result of the ARPA, HHS reports the median deductible for new consumers selecting plan during the COVID-SEP decreased by more than 90% (from $750 in 2020 to $50 in 2021).

With the ARPA and ACA subsidies, as well as Medicaid in states that expanded the program, we estimate (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/) that at least 46% of non-elderly uninsured people in the U.S. are eligible for free or nearly-free health plans, often with low or no deductibles.

BUDGETARY IMPACT

CBO estimates that extension of the ARPA marketplace subsidy improvements through 2025 (Section 13701) will cost $73.9 billion over the ten-year budget window, with “cost” reflecting both direct spending and on-budget revenue losses. This total also includes the cost of modifying the affordability threshold for employer-sponsored coverage (Section 13602)

CBO further estimates the cost of extending the enhanced marketplace subsidies for people receiving unemployment benefits (Section 13705) will be $1.8 billion over the ten-year budget window.

The cost of disregarding lump sum Social Security benefits payments for purposes of determining premium tax credit eligibility (Section 13703) is $416 million over the ten-year budget window.

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2. New Medicare Hearing Benefit

BACKGROUND

Medicare currently does not cover hearing services, except under limited circumstances, such as cochlear implantation when beneficiaries meet certain eligibility criteria. Hearing services are typically offered as an extra benefit by Medicare Advantage plans, and in 2021, 97% of Medicare Advantage enrollees in individual plans, or 17.1 million people, are offered some hearing benefits, but according to our analysis, the extent of that coverage and the value of these benefits varies (https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/). Some beneficiaries in traditional Medicare may have private coverage or coverage through Medicaid for these services, but many do not.

PROVISION DESCRIPTION

Section 30901 of the Build Back Better Act would add coverage of hearing services to Medicare Part B, beginning in 2023. Coverage for hearing care would include hearing rehabilitation and treatment services by qualified audiologists, and hearing aids. Hearing aids would be available once per ear, every 5 years, to individuals diagnosed with moderately severe, severe, or profound hearing loss. Hearing services would be subject to the Medicare Part B deductible and 20% coinsurance. Hearing aids would be covered similar to other Medicare prosthetic devices and would also be subject to the Part B deductible and 20% coinsurance. For people in traditional Medicare who have other sources of coverage such as Medigap or Medicaid, their cost sharing for these services might be covered. Payment for hearing aids would only be on an assignment-related basis. As with other Medicare-covered benefits, Medicare Advantage plans would be required to cover these hearing benefits.

Effective Date: The Medicare hearing benefit provision would take effect in 2023.

PEOPLE AFFECTED

Adding coverage of hearing services, including hearing aids, to Medicare would help beneficiaries with hearing loss who might otherwise go without treatment by an audiologist or hearing aids, particularly those who cannot afford the cost of hearing aids. It would also lower out-of-pocket costs for some beneficiaries who would otherwise pay the full cost of their hearing aids without the benefit. Among beneficiaries who used hearing services in 2018, average out-of-pocket spending according to our analysis was $914 (https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/), although many hearing aids are considerably more expensive than the average.

While the majority of enrollees in Medicare Advantage plans have access to a hearing benefit, a new defined Medicare Part B benefit could also lead to enhanced and more affordable hearing benefits for Medicare Advantage enrollees. Because costs are often a barrier to care, adding this benefit to Medicare could increase use of these services, and contribute to better health outcomes.

BUDGETARY IMPACT

CBO estimates that the new Medicare Part B hearing benefit would increase federal spending by $36.7 billion over 10 years (2022-2031).

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3. Lowering Prescription Drug Prices and Spending

BACKGROUND

Currently, under the Medicare Part D program, which covers retail prescription drugs, Medicare contracts with private plan sponsors to provide a prescription drug benefit. The law that established the Part D benefit includes a provision known as the "noninterference (https://www.ssa.gov/OP_Home/ssact/title18/1860D-11.htm)" clause, which stipulates that the HHS Secretary "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP [prescription drug plan] sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs." For drugs administered by physicians that are covered under Medicare Part B, Medicare reimburses providers 106% of the Average Sales Price (ASP) (https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/64xx/doc6481/06-16-prescriptdrug.pdf), which is the average price to all non-federal purchasers in the U.S, inclusive of rebates, A recent KFF Tracking Poll (https://www.kff.org/health-costs/poll-finding/public-weighs-in-on-medicare-drug-negotiations/) finds large majorities support allowing the federal government to negotiate and this support holds steady even after the public is provided the arguments being presented by parties on both sides of the legislative debate (83% total, 95% of Democrats, 82% of independents, and 71% of Republicans).

In addition to the inability to negotiate drug prices under Part D, Medicare lacks the ability to limit annual price increases for drugs covered under Part B (which includes those administered by physicians) and Part D. In contrast, Medicaid has an inflationary rebate in place. Year-to-year drug price increases exceeding inflation are not uncommon and affect people with both Medicare and private insurance. Our analysis (https://www.kff.org/medicare/issue-brief/price-increases-continue-to-outpace-inflation-for-many-medicare-part-d-drugs/) shows that half of all covered Part D drugs had list price increases that exceeded the rate of inflation between 2018 and 2019.

PROVISION DESCRIPTION

Drug Price Negotiations. Sections 139001, 139002, and 139003 of the Build Back Better Act would amend the non-interference clause by adding an exception that would allow the federal government to negotiate prices with drug companies for a small number of high-cost drugs lacking generic or biosimilar competitors covered under Medicare Part B and Part D. The negotiation process would apply to no more than 10 (in 2025), 15 (in 2026 and 2027), and 20 (in 2028 and later years)

single-source brand-name drugs lacking generic or biosimilar competitors, selected from among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending (for 2027 and later years). The negotiation process would also apply to all insulin products.

The legislation exempts from negotiation drugs that are less than 9 years (for small-molecule drugs) or 13 years (for biological products, based on the Manager's Amendment (https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-117HR5376-RCP117-19.pdf)) from their FDA-approval or licensure date. The legislation also exempts "small biotech drugs" from negotiation until 2028, defined as those which account for 1% or less of Part D or Part B spending and account for 80% or more of spending under each part on that manufacturer's drugs.

The proposal establishes an upper limit for the negotiated price (the "maximum fair price") equal to a percentage of the non-federal average manufacturer price: 75% for small-molecule drugs more than 9 years but less than 12 years beyond approval; 65% for drugs between 12 and 16 years beyond approval or licensure; and 40% for drugs more than 16 years beyond approval or licensure. Part D drugs with prices negotiated under this proposal would be required to be covered by all Part D plans. Medicare's payment to providers for Part B drugs with prices negotiated under this proposal would be 106% of the maximum fair price (rather than 106% of the average sales price under current law).

An excise tax would be levied on drug companies that do not comply with the negotiation process, and civil monetary penalties on companies that do not offer the agreed-upon negotiated price to eligible purchasers.

Effective Date: The negotiated prices for the first set of selected drugs (covered under Part D) would take effect in 2025. For drugs covered under Part B, negotiated prices would first take effect in 2027.

Inflation Rebates. Sections 139101 and 139102 of the Build Back Better Act would require drug manufacturers to pay a rebate to the federal government if their prices for single-source drugs and biologicals covered under Medicare Part B and nearly all covered drugs under Part D increase faster than the rate of inflation (CPI-U). Under these provisions, price changes would be measured based on the average sales price (for Part B drugs) or the average manufacturer price (for Part D drugs). For price increase higher than inflation, manufacturers would be required to pay the difference in the form of a rebate to Medicare. The rebate amount is equal to the total number of units multiplied by the amount if any by which the manufacturer price exceeds the inflation-adjusted payment amount, including all units sold outside of Medicaid and therefore applying not only to use by Medicare beneficiaries but by privately insured individuals as well. Rebate dollars would be deposited in the Medicare Supplementary Medical Insurance (SMI) trust fund.

Manufacturers that do not pay the requisite rebate amount would be required to pay a penalty equal to at least 125% of the original rebate amount. The base year for measuring price changes is 2021.

Effective Date: These provisions would take effect in 2023.

Limits on Cost Sharing for Insulin Products. Sections 27001, 30604, 137308, and 139401 would require insurers, including Medicare Part D plans and private group or individual health plans, to charge no more than $35 for insulin products. Part D plans would be required to charge no more than $35 for whichever insulin products they cover for 2023 and 2024 and all insulin products beginning in 2025. Coverage of all insulin products would be required beginning in 2025 because the drug negotiation provision (described earlier) would require all Part D plans to cover all drugs that are selected for price negotiation, and all insulin products are subject to negotiation under that provision. Private group or individual plans do not have to cover all insulin products, just one of each dosage form (vial, pen) and insulin type (rapid-acting, short-acting, intermediate-acting, and long-acting) for no more than $35.

Effective Date: These provisions would take effect in 2023.

Vaccines. Section 139402 would require that adult vaccines covered under Medicare Part D that are recommended by the Advisory Committee on Immunization Practices (ACIP), such as for shingles, be covered at no cost. This would be consistent with coverage of vaccines under Medicare Part B, such as the flu and COVID-19 vaccines.

Effective Date: This provision would take effect in 2024.

Repealing the Trump Administration's Drug Rebate Rule. Section 139301 would prohibit implementation of the November 2020 final rule issued by the Trump Administration that would have eliminated rebates negotiated between drug manufacturers and pharmacy benefit managers (PBMs) or health plan sponsors in Medicare Part D by removing the safe harbor protection currently extended to these rebate arrangements under the federal anti-kickback statute. This rule was slated to take effect on January 1, 2022, but the Biden Administration delayed implementation to 2023 (https://public-inspection.federalregister.gov/2021-05903.pdf) and the infrastructure legislation (https://www.congress.gov/bill/117th-congress/house-bill/3684/text) passed by the House and Senate includes a further delay to 2026.

Effective Date: This provision would take effect in 2026.

PEOPLE AFFECTED

The number of Medicare beneficiaries and privately insured individuals who would see lower out-of-pocket drug costs in any given year under these provisions would depend on how many and which drugs were subject to the negotiation process,

and how many and which drugs had lower price increases, and the magnitude of price reductions relative to current prices under each provision.

Neither CBO nor the Biden Administration have published estimates of beneficiary premium and out-of-pocket budget effects associated with the provision to allow the HHS Secretary to negotiate drug prices. An earlier version of the negotiations proposal in H.R.3 that passed the House of Representatives in 2019 would have lowered cost sharing (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/HR3) for Part D enrollees by $102.6 billion in the aggregate (2020-2029) and Part D premiums for Medicare beneficiaries by $14.3 billion. Based on our analysis of the H.R. 3 version of this provision, the negotiations provision in H.R. 3 would have reduced Medicare Part D premiums for Medicare beneficiaries by an estimated (https://www.kff.org/medicare/issue-brief/how-would-drug-price-negotiation-affect-medicare-part-d-premiums/) 9% of the Part D base beneficiary premium in 2023 and by as much as 15% in 2029. However, the effects on beneficiary premiums and cost sharing under the drug negotiation provision in the BBBA are expected to be more modest than the effects of H.R. 3 due to the smaller number of drugs eligible for negotiation and a different method of calculating the maximum fair price.

While it is expected that some people would face lower cost sharing under these provisions, it is also possible that drug manufacturers could respond to the inflation rebate by increasing launch prices for new drugs. In this case, some individuals could face higher out-of-pocket costs for new drugs that come to market, with potential spillover effects on total costs incurred by payers as well.

In terms of insulin costs, a $35 cap on monthly cost sharing for insulin products could lower out-of-pocket costs for many insulin users with private insurance and those in Medicare Part D without low-income subsidies. While formulary coverage and tier placement of insulin products vary across Medicare Part D plans, our analysis (https://www.kff.org/medicare/issue-brief/insulin-costs-and-coverage-in-medicare-part-d/) shows that in 2019, a large number of Part D plans placed insulin products on Tier 3, the preferred drug tier, which typically had a $47 copayment per prescription during the initial coverage phase. However, once enrollees reach the coverage gap phase, they face a 25% coinsurance rate, which equates to $100 or more per prescription in out-of-pocket costs for many insulin therapies, unless they qualify for low-income subsidies. Paying a flat $35 copayment rather than 25% coinsurance could reduce out-of-pocket costs for many people with diabetes who use insulin products.

In terms of vaccines, providing for coverage of adult vaccines under Medicare Part D at no cost could help with vaccine uptake among older adults and would lower out-of-pocket costs for those who need Part D-covered vaccines. Our analysis (https://www.kff.org/medicare/issue-brief/who-didnt-get-a-second-shingrix-shot-implications-for-multidose-covid-19-vaccines/) shows that in 2018, Part D enrollees without low-income

subsidies paid an average of $57 out-of-pocket for each dose of the shingles shot, which is generally free (https://www.cdc.gov/vaccines/adults/pay-for-vaccines.html) to most other people with private coverage.

BUDGETARY IMPACT

Drug Price Negotiations. CBO estimates $78.8 billion in Medicare savings over 10 years (2022-2031) from the drug negotiation provisions.

Inflation Rebates. CBO estimates a net federal deficit reduction of $83.6 billion over 10 years (2022-2031) from the drug inflation rebate provisions in the BBBA. This includes net savings of $49.4 billion ($61.8 billion in savings to Medicare and $7.7 billion in savings for other federal programs, such as DoD, FEHB, and subsides for ACA Marketplace coverage, offset by $20.1 billion in additional Medicaid spending) and higher federal revenues of $34.2 billion.

***Limits on Cost Sharing for Insulin Products*.** CBO estimates additional federal spending of $1.4 billion ($0.9 billion for Medicare and $0.5 billion in other federal spending) and a reduction in federal revenues of $4.6 billion over 10 years associated with the insulin cost-sharing limits in the BBBA.

Vaccines. CBO estimates that this provision would increase federal spending by $3.3 billion over 10 years (2022-2031).

Repealing the Trump Administration's Drug Rebate Rule. Because the rebate rule was finalized (although not implemented), its cost has been incorporated in CBO's baseline for federal spending. Therefore, repealing the rebate rule is expected to generate savings. CBO estimates savings of $142.6 billion from the repeal of the Trump Administration's rebate rule between 2026 (when the BBBA provision takes effect) and 2031. In addition, CBO estimated savings of $50.8 billion between 2023 and 2026 for the three-year delay of this rule included in the Infrastructure Investment and Jobs Act.

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4. Medicare Part D Benefit Redesign

BACKGROUND

Medicare Part D currently provides catastrophic coverage for high out-of-pocket drug costs, but there is no limit on the total amount that beneficiaries pay out-of-pocket each year. Medicare Part D enrollees with drug costs high enough to exceed the catastrophic coverage threshold are required to pay 5% of their total drug costs unless they qualify for Part D Low-Income Subsidies (LIS). Medicare pays 80% of total costs above the catastrophic threshold and plans pay 15%. Medicare's reinsurance payments to Part D plans now account for close to half (https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/) of total Part D spending (45%), up from 14% in 2006.

Under the current structure of Part D, there are multiple phases, including a deductible, an initial coverage phase, a coverage gap phase, and the catastrophic phase. When enrollees reach the coverage gap benefit phase, they pay 25% of drug costs for both brand-name and generic drugs; plan sponsors pay 5% for brands and 75% for generics; and drug manufacturers provide a 70% price discount on brands (there is no discount on generics). Under the current benefit design, beneficiaries can face different cost sharing amounts for the same medication depending on which phase of the benefit they are in, and can face significant out-of-pocket costs for high-priced drugs because of coinsurance requirements and no hard out-of-pocket cap.

PROVISION DESCRIPTION

Sections 139201 and 139202 of the Build Back Better Act amend the design of the Part D benefit by adding a hard cap on out-of-pocket spending set at $2,000 in 2024, increasing each year based on the rate of increase in per capita Part D costs. It also lowers beneficiaries' share of total drug costs below the spending cap from 25% to 23%. It also lowers Medicare's share of total costs above the spending cap ("reinsurance") from 80% to 20% for brand-name drugs and to 40% for generic drugs; increases plans' share of costs from 15% to 60% for both brands and generics; and adds a 20% manufacturer price discount on brand-name drugs. Manufacturers would also be required to provide a 10% discount on brand-name drugs in the initial coverage phase (below the annual out-of-pocket spending threshold), instead of a 70% price discount.

The legislation also increases Medicare's premium subsidy for the cost of standard drug coverage to 76.5% (from 74.5% under current law) and reduces the beneficiary's share of the cost to 23.5% (from 25.5%). The legislation also allows beneficiaries the option of smoothing out their out-of-pocket costs over the year rather than face high out-of-pocket costs in any given month.

Effective Date: The Part D redesign and premium subsidy changes would take effect in 2024. The provision to smooth out-of-pocket costs would take effect in 2025.

PEOPLE AFFECTED

Medicare beneficiaries in Part D plans with relatively high out-of-pocket drug costs are likely to see substantial out-of-pocket cost savings from this provision. While most Part D enrollees have not had out-of-pocket costs high enough to exceed the catastrophic coverage threshold in a single year, the likelihood of a Medicare beneficiary incurring drug costs above the catastrophic threshold increases over a longer time span.

Our analysis (https://www.kff.org/medicare/issue-brief/millions-of-medicare-part-d-enrollees-have-had-out-of-pocket-drug-spending-above-the-catastrophic-threshold-over-time/) shows that in 2019, nearly 1.5 million Medicare Part D enrollees had out-of-pocket spending

above the catastrophic coverage threshold. Looking over a five-year period (2015-2019), the number of Part D enrollees with out-of-pocket spending above the catastrophic threshold in at least one year increases to 2.7 million, and over a 10-year period (2010-2019), the number of enrollees increases to 3.6 million.

Based on our analysis (https://www.kff.org/medicare/issue-brief/potential-savings-for-medicare-part-d-enrollees-under-proposals-to-add-a-hard-cap-on-out-of-pocket-spending/), 1.2 million Part D enrollees in 2019 incurred annual out-of-pocket costs for their medications above $2,000 in 2019, averaging $3,216 per person. Based on their average out-of-pocket spending, these enrollees would have saved $1,216, or 38% of their annual costs, on average, if a $2,000 cap had been in place in 2019. Part D enrollees with higher-than-average out-of-pocket costs could save substantial amounts with a $2,000 out-of-pocket spending cap. For example, the top 10% of beneficiaries (122,000 enrollees) with average out-of-pocket costs for their medications above $2,000 in 2019 – who spent at least $5,348 – would have saved $3,348 (63%) in out-of-pocket costs with a $2,000 cap.

BUDGETARY IMPACT

CBO estimates the benefit redesign and smoothing provisions of the BBBA would reduce federal spending by $1.5 billion over 10 years (2022-2031), which consists of $1.6 billion in lower spending associated with Part D benefit redesign and $0.1 billion in higher spending associated with the provision to smooth out-of-pocket costs.

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5. Medicaid Coverage Gap

BACKGROUND

There are currently 12 states (https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) that have not adopted the ACA provision to expand Medicaid to adults with incomes through 138% of poverty. The result is a coverage gap for individuals whose below-poverty-level income is too high to qualify for Medicaid in their state, but too low to be eligible for premium subsidies in the ACA Marketplace.

PROVISION DESCRIPTION

Section 137304 of the Build Back Better Act would allow people living in states that have not expanded Medicaid to purchase subsidized coverage on the ACA Marketplace for 2022 through 2025. The federal government would fully subsidize the premium for a benchmark plan. People would also be eligible for cost sharing subsidies that would reduce their out-of-pocket costs to 1% of overall covered health expenses on average.

Section 30608 includes adjustments to uncompensated care (UCC) pools and disproportionate share hospital (DSH) payments for non-expansion states. These states would not be able draw down federal matching funds for UCC amounts for individuals who could otherwise qualify for Medicaid expansion, and their DSH allotments would be reduced by 12.5% starting in 2023.

Section 30609 would increase the federal match rate for states that have adopted the ACA Medicaid expansion from 90% to 93% from 2023 through 2025, designed to discourage states from dropping current expansion coverage.

PEOPLE AFFECTED

We estimate that 2.2 million (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/) uninsured people with incomes under poverty fall in the "coverage gap". Most in the coverage gap are concentrated in four states (TX, FL, GA and NC) where eligibility levels for parents in Medicaid are low, and there is no coverage pathway for adults without dependent children. Half of those in the coverage gap are working and six in 10 (https://www.kff.org/policy-watch/taking-a-closer-look-at-characteristics-of-people-in-the-coverage-gap/) are people of color.

CBO estimates (https://www.cbo.gov/publication/57626) that provisions to address the coverage gap would result in 1.7 million fewer uninsured people.

BUDGETARY IMPACT

CBO estimates (https://www.cbo.gov/publication/57626) that the net federal cost of extending Marketplace coverage to certain low-income people would increase federal spending by $57 billion over the next decade (this reflects $43.8 billion in federal costs and a loss of federal revenues of $13.2 billion).

CBO estimates (https://www.cbo.gov/publication/57623) provisions to limit DSH and uncompensated care pool funding (https://www.kff.org/policy-watch/build-back-better-would-reduce-dsh-payments-and-limit-ucc-pools-in-non-expansion-states/) for non-expansion states would reduce federal costs by $18.3 billion over 5 years and $34.5 billion over the next 10 years and federal costs would increase by $10.4 billion due to the increase in the match rate for current expansion states from 90% to 93% for expansion states for 2023 through 2025.

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6. Maternity Care and Postpartum Coverage

BACKGROUND

Medicaid (https://www.kff.org/medicaid/fact-sheet/medicaids-role-for-women/) currently covers almost half of births in the U.S. Federal law requires that pregnancy-related Medicaid coverage last through 60 days postpartum. After that period, some may

qualify for Medicaid through another pathway, but others may not qualify, particularly in non-expansion states. In an effort to improve maternal health and coverage stability and to help address racial disparities (https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-maternal-infant-health-overview/) in maternal health, a provision in the American Rescue Plan Act (ARPA) of 2021 gives states a new option (https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/) to extend Medicaid postpartum coverage to 12 months. This new option takes effect on April 1, 2022 and is available to states for five years.

PROVISION DESCRIPTION

Section 30721 of the Build Back Better Act would require states to extend Medicaid postpartum coverage from 60 days to 12 months, ensuring continuity of Medicaid coverage for postpartum individuals in all states. This requirement would take effect in the first fiscal quarter beginning one year after enactment and also applies to state CHIP programs that cover pregnant individuals.

Section 30722 would create a new option for states to coordinate care for Medicaid-enrolled pregnant and post-partum individuals through a maternal health home model. States that take up this option would receive a 15% increase in FMAP for care delivered through maternal health homes for the first two years. States that are interested in pursuing this new option can receive planning grants prior to implementation.

Sections 31031 through 31048 of the Build Back Better Act provide federal grants to bolster other aspects of maternal health care. The funds would be used to address a wide range of issues, such as addressing social determinants of maternal health; diversifying the perinatal nursing workforce, expanding care for maternal mental health and substance use, and supporting research and programs that promote maternal health equity.

PEOPLE AFFECTED

Largely in response to the new federal option, at least 26 states (https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/) have taken steps to extend (https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/) Medicaid postpartum coverage. Pregnant people in non-expansion states could see the biggest change as they are more likely than those in expansion states to become uninsured after the 60-day postpartum coverage period. For example, in Alabama, the Medicaid eligibility level for pregnant individuals is 146% FPL, but only 18% FPL (approximately $4,000/year for a family of three) for parents.

Some states have piloted maternal health homes and seen positive impacts (https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity) on health outcomes. The federal grant provisions

related to maternal health could affect care for all persons giving birth, but the focus of these proposals is on reducing racial and ethnic inequities. There were approximately 3.7 million births in 2019, and nearly half were to women of color. There are approximately 700-800 pregnancy-related deaths annually, with the rate 2-3 times higher among Black and American Indian and Alaska Native women compared to White women. Additionally, there are stark racial and ethnic disparities in other maternal and health outcomes, including preterm birth and infant mortality.

BUDGETARY IMPACT

CBO estimates that requiring 12 month postpartum coverage in Medicaid and CHIP would have a net federal cost of $1.2 billion over 10 years (new costs of $2.2 billion offset by new revenues of $1.0 billion. CBO estimates that the option to create a maternal health home would increase federal spending by $1.0 billion over 10 years.

CBO estimates that federal outlays for the grant sections in the Build Back Better Act related to maternal health care outside of the postpartum extension and maternal health homes are $1.1 billion.

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7. Other Medicaid and Children's Health Insurance (CHIP) Changes

BACKGROUND

Under current law, states have the option to provide 12-months of continuous coverage for children. Under this option, states allow a child to remain enrolled for a full year unless the child ages out of coverage, moves out of state, voluntarily withdraws, or does not make premium payments. As such, 12-month continuous eligibility eliminates coverage gaps due to fluctuations in income over the course of the year.

To help support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) provides a 6.2 percentage point increase (https://www.kff.org/medicaid/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/) in the federal share of certain Medicaid spending, provided that states meet maintenance of eligibility (https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/) (MOE) requirements that include ensuring continuous coverage for current enrollees.

Under current law, Medicaid is the base of coverage for low-income children. CHIP complements Medicaid by covering uninsured children in families with incomes above Medicaid eligibility levels. Unlike Medicaid, federal funding for CHIP is

capped and provided as annual allotments to states. CHIP funding is authorized through September 30, 2027. While CHIP generally has bipartisan support, during the last reauthorization funding lapsed before Congress reauthorized funding.

PROVISION DESCRIPTION

Section 30741 of the Build Back Better Act would require states to extend 12-month continuous coverage for children on Medicaid and CHIP.

Section 30741 of the Build Back Better Act would phase out the FFCRA enhanced federal funding to states. States would continue to receive the 6.2 percentage point increase through March 31, 2022, followed by a 3.0 percentage point increase from April 1, 2022 through June 30, 2022, and a 1.5 percentage point increase from July 1, 2022 through September 30, 2022.

Section 30741 also would modify the FFCRA MOE requirement for continuous coverage. From April 1 through September 30, 2022, states could continue receiving the enhanced federal matching funds if they only terminate coverage for individuals who are determined no longer eligible for Medicaid and have been enrolled at least 12 consecutive months. The legislation includes other rules for states about conducting eligibility redeterminations and when states can terminate coverage.

Section 30801 of the Build Back Better Act would permanently extend the CHIP program.

PEOPLE AFFECTED

As of May 2021, there were 39 million children (https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) enrolled in Medicaid and CHIP (nearly half of all enrollees). As of January 2020, 34 states (https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html) provide 12-month continuous eligibility to at least some children in either Medicaid or CHIP. A recent MACPAC report (https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf) found that the overall mean length of coverage for children in 2018 was 11.7 months, and also that rates of churn (in which children dis-enroll and reenroll within a short period of time) were lower in states that had adopted the 12-month continuous coverage option and in states that did not conduct periodic data checks. Another recent report (https://ccf.georgetown.edu/2021/10/08/why-is-medicaid-chip-continuous-eligibility-so-important-for-kids/) shows that children with gaps in coverage during a year are more likely to be children of color with lower incomes.

As of May 2021, there were 6.9 million people (https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (mostly children) enrolled in CHIP.

BUDGETARY IMPACT

CBO estimates that Section 30741 would reduce federal costs by a net $3.5 billion over 10 years. This 10 year number reflects $17.1 billion in federal savings in FY 2022 that is likely related to the provisions to end the enhanced fiscal relief and the continuous coverage requirements and then federal costs starting in FY 2024. CBO estimates that permanently extending the CHIP program would reduce federal costs by $1.2 billion over 10 years.

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8. Other Medicaid Financing and Benefit Changes

BACKGROUND

Unlike in the 50 states and D.C., annual federal funding for Medicaid in the U.S. Territories (https://www.kff.org/medicaid/issue-brief/implications-of-the-medicaid-fiscal-cliff-for-the-u-s-territories/) is subject to a statutory cap and fixed matching rate. The funding caps and match rates have been increased by Congress in response to emergencies over time.

Vaccines are an optional benefit (https://www.kff.org/coronavirus-covid-19/issue-brief/vaccine-coverage-pricing-and-reimbursement-in-the-u-s/) for certain adult populations, including low-income parent/caretakers, pregnant women, and persons who are eligible based on old age or a disability. For adults enrolled under the ACA's Medicaid expansion and other populations for whom the state elects to provide an "alternative benefit plan," their benefits are subject to certain requirements in the ACA, including coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) (https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/) with no cost sharing.

Under the Families First Coronavirus Response Act (https://www.kff.org/coronavirus-covid-19/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/), coverage of testing and treatment for COVID-19, including vaccines, is required with no cost sharing in order for states to access temporary enhanced federal funding for Medicaid which is tied to the public health emergency. The American Rescue Plan Act (ARPA) (https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/) clarified that coverage of COVID-19 vaccines and their administration, without cost sharing, is required for nearly all Medicaid enrollees, through the last day of the 1st calendar quarter beginning at least 1 year after the public health emergency ends. The ARPA also provides 100% federal financing for this coverage.

PROVISION DESCRIPTION

Section 30731 of the Build Back Better Act would increase the Medicaid cap amount and match rate for the territories. The FMAP would be permanently adjusted to 83% for the territories beginning in FY 2022, except that Puerto Rico's match rate would be 76% in FY 2022 before increasing to 83% in FY 2023 and subsequent years. The legislation would also require a payment floor for certain physician services in Puerto Rico with a penalty for failure to establish the floor.

Section 30751 of the Build Back Better Act would establish a 3.1 percentage point FMAP reduction from October 1, 2022 through December 31, 2025 for states that adopt eligibility standards, methodologies, or procedures that are more restrictive than those in place as of October 1, 2021 (except the penalty would not apply to coverage of non-pregnant, non-disabled adults with income above 133% FPL after December 31, 2022, if the state certifies that it has a budget deficit).

Section 139405 of the Build Back Better Act would require state Medicaid programs to cover all approved vaccines recommended by ACIP and vaccine administration, without cost sharing, for categorically and medically needy adults. States that provide adult vaccine coverage without cost sharing as of the date of enactment would receive a 1 percentage point FMAP increase for 8 quarters.

PEOPLE AFFECTED

In June 2019 there were approximately 1.3 million Medicaid enrollees (https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf) in the territories (with 1.2 million in Puerto Rico).

From February 2020 through May 2021 Medicaid and CHIP enrollment has increased by 11.5 million or 16.2% (https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/) due to the economic effects of the pandemic and MOE requirements.

All states provide some vaccine coverage (https://www.kff.org/coronavirus-covid-19/issue-brief/vaccine-coverage-pricing-and-reimbursement-in-the-u-s/) for adults enrolled in Medicaid who are not covered as part of the ACA's Medicaid expansion, but as of 2019, only about half of states covered all ACIP-recommended vaccines.

BUDGETARY IMPACT

CBO estimates that the changes in Medicaid financing for the Territories would increase federal spending by $9.5 billion over 10 years.

CBO estimates that the provision to impose a penalty in the match rate if states implement eligibility or enrollment restrictions through 2025 would increase federal costs by $7.0 billion.

CBO estimates that extending vaccines to adults on Medicaid would increase federal spending by $2.8 billion over 10 years.

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9. Medicaid Home and Community Based Services and the Direct Care Workforce

BACKGROUND

Medicaid is currently the primary payer (https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/) for long-term services and supports (LTSS), including home and community-based services (HCBS), that help seniors and people with disabilities with daily self-care and independent living needs. There is currently a great deal of state variation (https://www.kff.org/medicaid/issue-brief/state-variation-in-medicaid-ltss-policy-choices-and-implications-for-upcoming-policy-debates/) as most HCBS eligibility pathways and benefits are optional for states.

PROVISION DESCRIPTION

Sections 30711-30713 of the Build Back Better Act would create the HCBS Improvement Program, which would provide a permanent 6 percentage point increase in federal Medicaid matching funds for HCBS. To qualify for the enhanced funds, states would have to maintain existing HCBS eligibility, benefits, and payment rates and have an approved plan to expand HCBS access, strengthen the direct care workforce, and monitor HCBS quality. The bill includes some provisions to support family caregivers. In addition, the Act would include funding ($130 million) for state planning grants and enhanced funding for administrative costs for certain activities (80% instead of 50%).

Section 30714 of the Build Back Better Act would require states to report HCBS quality measures to HHS, beginning 2 years after the Secretary publishes HCBS quality measures as part of the Medicaid/CHIP core measures for children and adults. The bill provides states with an enhanced 80% federal matching rate for adopting and reporting these measures.

Sections 30715 and 30716 of the Build Back Better Act would make the ACA HCBS spousal impoverishment protections (https://www.kff.org/medicaid/issue-brief/implications-of-the-expiration-of-medicaid-long-term-care-spousal-impoverishment-rules-for-community-integration/) and the Money Follows the Person (MFP) program (https://www.kff.org/report-section/medicaids-money-follows-the-person-program-state-progress-and-uncertainty-pending-federal-funding-reauthorization-issue-brief/#endnote_link_440665-6) permanent.

Sections 22301 and 22302 of the Build Back Better Act would provide $1 billion in grants to states, community-based organizations, educational institutions, and other entities by the Department of Labor Secretary to develop and implement

strategies for direct service workforce recruitment, retention, and/or education and training.

Section 25005 of the Build Back Better Act would provide $20 million for HHS and the Administration on Community Living to establish a national technical assistance center for supporting the direct care workforce and family caregivers.

Section 25006 of the Build Back Better Act would provide $40 million for the HHS Secretary to award to states, nonprofits, educational institutions, and other entities to address the behavioral health needs of unpaid caregivers of older individuals and older relative caregivers.

PEOPLE AFFECTED

The majority of HCBS are provided by waivers (https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/), which served over 2.5 million enrollees in 2018. There is substantial unmet need (https://www.kff.org/medicaid/issue-brief/state-variation-in-medicaid-ltss-policy-choices-and-implications-for-upcoming-policy-debates/) for HCBS, which is expected (https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/) to increase with the growth in the aging population in the coming years. Nearly 820,000 people in 41 states were on a Medicaid HCBS waiver waiting list (https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/) in 2018. Though waiting lists alone are an incomplete (https://www.kff.org/report-section/state-variation-in-medicaid-ltss-policy-choices-and-implications-for-upcoming-policy-debates-issue-brief/) measure, they are one proxy for unmet need for HCBS. Additionally, a shortage (https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-long-term-services-and-supports-reforms/) of direct care workers predated and has been intensified by the COVID-19 pandemic, characterized by low wages (https://www.kff.org/medicaid/issue-brief/voices-of-paid-and-family-caregivers-for-medicaid-enrollees-receiving-hcbs/) and limited opportunities for career advancement. The direct care workforce is disproportionately female and Black (https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/).

A KFF survey (https://www.kff.org/medicaid/issue-brief/implications-of-the-expiration-of-medicaid-long-term-care-spousal-impoverishment-rules-for-community-integration/) found that, as of 2018, 14 states expected (https://www.kff.org/medicaid/issue-brief/implications-of-the-expiration-of-medicaid-long-term-care-spousal-impoverishment-rules-for-community-integration/) that allowing the ACA spousal impoverishment provision to expire would affect Medicaid HCBS enrollees, for example by making fewer individuals eligible for waiver services.

Over 101,000 seniors and people with disabilities across 44 states and DC moved (https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf) from nursing homes to the community using MFP funds from

2008-2019. A federal evaluation (https://mathematica.org/publications/money-follows-the-person-demonstration-overview-of-state-grantee-progress-january-to-december-2016) of MFP showed about 5,000 new participants in each six month period from December 2013 through December 2016, indicating a continuing need for the program.

BUDGETARY IMPACT

CBO estimates (https://www.cbo.gov/publication/57623) that all of the Medicaid-related HCBS provisions together will increase federal spending by about $150 billion in the 10-year budget window. The new HCBS Improvement Program (Section 30712) accounts for most of this spending ($146.5 billion).

CBO scores (https://www.cbo.gov/publication/57622) the Department of Labor direct care workforce provisions according to the amount of spending authorized for each in the bill: $1 billion for grants to support the direct care workforce (Section 22302), $20 million for a technical assistance center for supporting direct care and caregiving (Section 25005), and $40 million for funding to support unpaid caregivers (Section 25006).

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10. Paid Family and Medical Leave

BACKGROUND

The U.S. (https://worldpolicycenter.org/policies/is-paid-annual-leave-available-to-workers) is the only industrialized nation without a minimum standard of paid family or medical leave. Although six states and DC (https://www.kff.org/coronavirus-covid-19/issue-brief/coronavirus-puts-a-spotlight-on-paid-leave-policies/) have paid family and medical leave laws in effect, and some employers voluntarily offer these benefits, this has resulted in a patchwork of policies with varying degrees of generosity and leaves many workers without a financial safety net when they need to take time off work to care for themselves or their families.

PROVISION DESCRIPTION

Section 130001 of the Build Back Better Act would guarantee four weeks per year of paid family and medical leave to all workers in the U.S. who need time off work to welcome a new child, recover from a serious illness, or care for a seriously ill family member. Annual earnings up to $15,080 would be replaced at approximately 90% of average weekly earnings, plus about 73% of average weekly earnings for annual wages between $15,080 and $32,248, capping out at 53% of average weekly earnings for annual wages between $32,248 and $62,000. While all workers taking qualified leave would be eligible for at least some wage replacement, the progressive benefits formula means that the share of pay replaced while on qualified leave is highest for workers with lower wages. The original Act called for 12 weeks of paid leave for similar qualified reasons, plus

three days of bereavement leave, and benefits began at 85% of average weekly earnings for annual wages up to $15,080 and were capped at 5% of average weekly earnings for annual wages up to $250,000.

PEOPLE AFFECTED

According to the Bureau of Labor Statistics (BLS), approximately one in four (23% (https://www.bls.gov/ncs/ebs/benefits/2021/employee-benefits-in-the-united-states-march-2021.pdf)) workers has access to paid family leave through their employer. Data on the share of workers with access to paid medical leave for their own longer, serious illness are limited, although BLS also reports that 40% of workers have access to short-term disability insurance.

It is estimated that 53 million (https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf) adults are caregivers for a dependent child or adult and 61% of them are women. Sixty percent (60%) of caregivers reported having to take a leave of absence leave from work or cut their hours in order to care for a family member. Workers who take leave do so for different reasons (https://www.dol.gov/sites/dolgov/files/OASP/evaluation/pdf/WHD_FMLA2018SurveyResults_FinalReport_Aug2020.pdf): Half (51%) reported taking leave due to their own serious illness, one-quarter (25%) for reasons related to pregnancy, childbirth, or bonding with a new child, and one-fifth (19%) to care for a seriously ill family member. In total, four in ten (42%) reported receiving their full pay while on leave, one-quarter (24%) received partial pay, and one-third (34%) received no pay.

BUDGETARY IMPACT

CBO estimates that the federal cost of these provisions would be about $205.5 billion over the 2022-2031 period. The estimate accounts for funding the paid leave benefits and administration, grants for the state administration option for states that already have a comprehensive paid leave law, and partial reimbursements for employers that provide equally comprehensive paid leave as a benefit to all their workers. The CBO estimate is modestly offset by application fees paid by employers participating in the reimbursement option for employer-sponsored paid leave benefits.

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11. Consumer Assistance, Enrollment Assistance, and Outreach

BACKGROUND

Consumer Assistance in Health Insurance – The Affordable Care Act (ACA) established a new system of state health insurance ombudsman programs, also called Consumer Assistance Programs, or CAPs. These programs are required to conduct public education about health insurance consumer protections and help people resolve problems with their health plans, including filing appeals for denied

claims. By law, private health plans, including employer-sponsored plans, are required to include contact information for CAPs on all explanation-of-benefit statements (EOB) with notice that CAPs can help consumers file appeals.

To help inform oversight, CAPs are also required to report data to the Secretary of HHS on consumer experiences and problems. The ACA permanently authorized CAPs and appropriated seed funding of $30 million in 2010. Forty state CAPs were established that year; since then, Congress has not appropriated CAP funding.

Enrollment Assistance and Outreach in the Marketplace – The Affordable Care Act also requires marketplaces to establish Navigator programs that help consumers apply for and enroll in coverage through the marketplace. And it requires marketplaces to conduct public education and outreach about the availability of coverage and financial assistance. As noted above, the Build Back Better Act would create new eligibility for marketplace coverage and financial assistance for low-income adults in states that have not expanded Medicaid.

PROVISION DESCRIPTION

Section 30603 appropriates $100 million for state consumer assistance programs (CAPs) over the 4-year period, 2022-2025.

Section 30601(d) appropriates $105 million to conduct public education and outreach in non-expansion states so people will learn about new coverage and subsidy options. $15 million is appropriated for 2022 and $30 million for each of 2023-2025. In addition, this section requires the Secretary to obligate no less than $70 million of marketplace user-fee revenues for additional Navigator funding to support enrollment assistance for the new coverage-gap population (at least $10 million in FY 2022 and at least $20 million in each of FY 2023-2025).

PEOPLE AFFECTED

CAP Funding – More than 175 million Americans (https://www.kff.org/other/state-indicator/health-insurance-coverage-of-nonelderly-0-64-multiple-sources-of-coverage-cps/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) are covered by private health insurance plans today. Consumers generally find health insurance confusing and have limited understanding (https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/) of even basic health insurance terms and concepts. Four-in-ten (https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-6-cost-conscious-health-care-shopping-behaviors/) have difficulty understanding what their health plan will cover or how much they will have to pay out-of-pocket for needed care; when faced with unaffordable bills, only one-in-ten even try to get providers to lower their price. When claims are denied, consumers rarely appeal (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/). These are the kinds of problems CAPs could help address with expanded funding. Most of the

state CAPs established in 2010 continue to operate today (https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc), though at reduced capacity without federal financial support; programs rely on state funding (many CAPs are housed in state Insurance Departments or Attorney General offices) and philanthropic support today. With recent enactment of the federal No Surprises Act, as well as amendments to the Mental Health Parity and Addiction Equity Act (MHPAEA), CAPS can help consumers understand and navigate new federal health insurance protections and inform oversight by federal and state agencies.

Marketplace Enrollment Assistance and Outreach – After years of cuts in funding for Navigator enrollment assistance and outreach, the Biden Administration took steps this year to restore federal marketplace funding (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/) for these activities. During the 2021 COVID special enrollment opportunity, when expanded subsidies enacted by ARPA first became available, more than 2.2 million people newly signed up for marketplace coverage. However, KFF found only 1 in 4 peopl (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-october-2021/)e who are uninsured or buy their own health insurance checked to see if they would qualify for affordable coverage. This finding is consistent with earlier KFF surveys that find 3 in 4 uninsured (https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/) don't look for health coverage because they assume it is not affordable. Investments in public education, outreach, and enrollment assistance can help inform the 2.2 million uninsured adults in the coverage gap of new affordable health coverage options through the marketplace.

BUDGETARY IMPACT

New appropriations for Consumer Assistance Programs would cost $100 million over 5 years.

New appropriations for marketplace outreach would cost $105 million over 5 years. Additional funding for Navigator enrollment assistance in coverage gap states would not come from new appropriations; these resources will come from user fee revenue collected by the marketplace.
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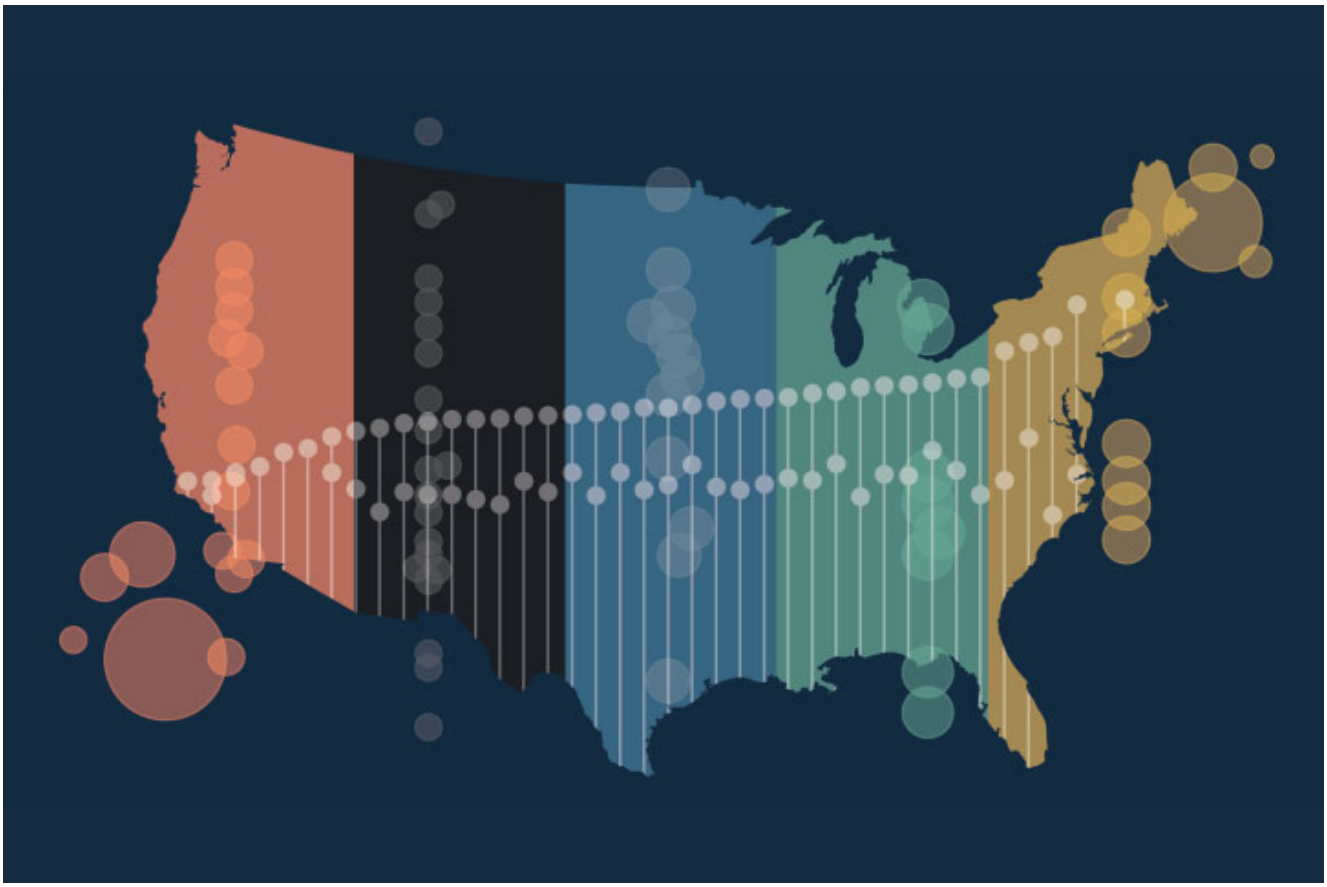
SCORECARD / NOVEMBER 18, 2021

Achieving Racial and Ethnic Equity in U.S. Health Care

A Scorecard of State Performance



TOPLINES

An extensive analysis from the Commonwealth Fund finds that health care systems are failing many people of color in every state

Even in states with high-performing health systems, many people of color receive much worse health care than white people

AUTHORS

David C. Radley, Jesse C. Baumgartner, Sara R. Collins, Laurie Zephyrin, Eric C. Schneider

Introduction

Profound racial and ethnic disparities in health and well-being have long been the norm in the United States.

Black and American Indian/Alaska Native (AIAN) people live fewer years, on average, than white people.[1] They are also more likely to die from treatable conditions; more likely to die during or after pregnancy and to suffer serious pregnancy-related complications; and more likely to lose children in infancy.[2] Black and AIAN people are also at higher risk for many chronic health conditions, from diabetes to hypertension.[3] The COVID-19 pandemic has only made things worse, with average life expectancies for Black, Latinx/Hispanic, and, in all likelihood, AIAN people falling more sharply compared to white people.[4]

People's health also varies markedly across and within states, as does access to health services and overall quality of care.[5] Large racial and ethnic health inequities, driven by factors both inside and outside the health care delivery system, are common. In many communities of color, poverty rates are higher than average, residents tend to work in lower-paying industries, and residents are more likely to live in higher-risk environments — all contributors to COVID-19's disproportionate impact.[6]

Issues around cost, affordability, and access to care also contribute to inequities. Black, Latinx/Hispanic, and AIAN populations are less likely to have health insurance, more likely to face cost-related barriers to getting care, and more likely to incur medical debt.[7] It is also less common for individuals from these groups to have a usual source of care or to regularly receive preventive services like vaccinations.[8] In addition, many people of color contend with interpersonal racism and discrimination when dealing with clinicians and more often receive lower-value or suboptimal care.[9]

Decades of policy choices made by federal, state, and local leaders have led to structural economic suppression, unequal educational access, and residential segregation, all of which have contributed in their own ways to worse health outcomes for many people of color.[10] The failure to ensure all Americans have reliable health coverage has paved the way to inequitable access to health care. Dramatic disparities in the quality of health care, meanwhile, are tolerated. And while the effects of structural racism persist in all states,[11] policy leaders in some states are reluctant to take actions that could mitigate health inequities, like expanding eligibility for Medicaid as provided for under federal law.[12]

The Commonwealth Fund's *Scorecard on State Health System Performance* has long tracked the functioning of each state's health care system, with the goal of motivating actions to improve their residents' health and health care. But assessing how well a state's health system performs on average can mask profound underlying inequities.

In this report, we evaluate health equity across race and ethnicity, both within and between states, to illuminate how state health systems perform for Black, white, Latinx/Hispanic, AIAN, and Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations. Our hope is that policymakers and health system leaders will use this tool to investigate the impact of past policies on health across racial and ethnic groups, and that they will begin to take steps to ensure an equitable, antiracist health care system for the future.

How We Measure Performance of States' Health Care Systems for Racial and Ethnic Groups

Our measurement strategy was designed to produce a state health system performance score for each of five racial and ethnic groups in every state where direct comparisons are possible among those groups as well as among groups in other states.

We started by collecting data for 24 indicators of health system performance, stratified by state and by race and ethnicity. Indicators were grouped into three performance domains: 1) health outcomes, 2) health care access, and 3) quality and use of health care services.

Scoring method. For each of the 24 indicators, we calculate a standardized z-score for each state/population group with sufficient data. As an example, for adult uninsured rates, we calculate standardized scores using point estimates for 191 pairs of state racial and ethnic groups (51 white, 48 Latinx/Hispanic, 39 Black, 37 AANHPI, 16 AIAN) with sufficient data.

Within each performance domain, we combined indicator values to create a summary score. We then combined the domain summary scores to create a composite state health system performance score for each racial and ethnic group within a state — Black (non-Latinx/Hispanic), white (non-Latinx/ Hispanic), AIAN (non-Latinx/Hispanic), AANHPI (non-Latinx/Hispanic), and Latinx/Hispanic (any race). The ability to generate these scores is dependent on having a sufficient population sample size for analysis.

Based on the overall composite scores, each racial/ethnic group within each state received a percentile score providing both national and state-level context on the performance of a state health system for that population.

The percentile scoring, from 1 (worst) to 100 (best), reflects the observed distribution of health system performance for all groups measured in this report and enables comparisons within and across states. For example, a state health system score of 50

for Latinx/Hispanic individuals in California indicates that the health system is performing better for those residents than Latinx/ Hispanic people in Florida, who have a score of 38, but worse than white residents in California, who have a score of 89. It is important to note that because scores are set relative to one another rather than to a predefined benchmark, there is still room for improvement in health system performance at or near the 100th percentile.

Use of racial/ethnic data categories. The five racial and ethnic data categories we include in this report often group together populations with different experiences, cultures, immigration barriers, and other socioeconomic factors. This includes a wide range of culturally distinct Latinx/Hispanic communities and Asian American communities. Such groupings are imperfect, as they mask significant and important differences. For example, past research has shown variability in health insurance coverage rates among Asian American subpopulations and between Asian Americans and Native Hawaiians or Pacific Islanders.[13]

Use of these categories is necessary to obtain sufficient sample sizes for analysis. But states and localities should interpret the findings within the context of their own communities, using them as a starting point to help guide more targeted research and policy solutions.

Refer to the appendix for complete study methods, list of indicators, and health system performance scores for each state's and racial and ethnic populations.

Findings

Racial and ethnic inequities are pervasive across all state health systems.

Both across states and within states, health care system performance varies widely by race and ethnicity, as shown in Exhibit 1. Mirroring the nation as a whole, substantial health and health care disparities exist between white and Black, Latinx/Hispanic, and AIAN communities in nearly all states.

Even in states that achieve high performance overall, racial and ethnic disparities can be dramatic. For example, Minnesota, which ranked third in the Commonwealth Fund's most recent *State Scorecard on Health System Performance,* has some of the largest disparities between white and Black, Latinx/Hispanic, AANHPI, and AIAN communities.[14] Some states, like Mississippi, demonstrate relatively poor performance for all groups.

In the small number of U.S. states where AIAN communities represent a sizeable portion of the nonwhite population — such as South Dakota and Alaska — wide performance gaps are also apparent. While the health system in many states tends to perform better for AANHPI populations, performance is lower in New York and Texas, home to two of the country's largest AANHPI populations.

The overall health system score for each group within a state represents the aggregate performance across three dimensions: Health Outcomes, Health Care Access, and Quality and Use of Health Care Services. Below we describe findings for each of these domains.

Click through to see each race/ethnicity group on its own. 1/6

EXHIBIT 1

Profound racial and ethnic inequities in health and health care exist across and within states.

Health system performance scores, by state and race/ethnicity

All

Race/Ethnicity AANHPI AIAN Black Latinx/Hispanic White

Notes: Scores are based on the percentile distribution of each group's final composite z-score across all indicators/dimensions; rank-ordered by score of state's highest group. The 50th percentile represents the median health performance score among all the groups measured. Summary performance scores not available for all racial and ethnic groups in all states; missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: Commonwealth Fund 2021 Health System Performance Scores.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021)

Health Outcomes

Health outcomes, as measured primarily by mortality rates and the prevalence of health-related problems, differ significantly by race and ethnicity. In most states, Black and AIAN populations tend to fare worse than white, Latinx/ Hispanic, and AANHPI populations. While enduring lower life expectancies for Black and AIAN individuals in the U.S. can be attributed in large part to generations of structural racism, oppression, and other factors beyond health care delivery, the health care system nevertheless has a crucial and often unfulfilled role in mitigating disparities.[15]

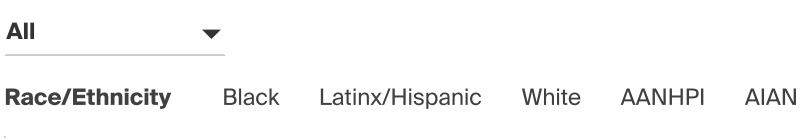
We can get a glimpse of the care delivery system's role in these unequal outcomes by looking at the frequency of deaths before age 75 from preventable and treatable conditions — a measure known as mortality amenable to health care that is highly correlated with life expectancy.[16] In nearly every state, Black people are more likely than white people to die early from preventable causes (Exhibit 2). Latinx/Hispanic individuals, however, generally have lower preventable mortality rates, despite their comparatively poor access to health care. These lower rates could be related to immigration factors, to a younger average age, or to lower rates of risky health behaviors like smoking.[17] Still, recent research shows increasing mortality and prevalence of chronic conditions for Latinx/ Hispanic populations.[18] There are also differences in outcomes between different Latinx communities.[19]

We also see distinct regional patterns. For example, preventable mortality rates are higher for both Black and white residents of many southeastern states compared to other parts of the country, while rates among AIAN people tend to be higher in the upper Midwest and northern Plains states. Among Latinx/Hispanic people, premature mortality rates are higher — and align more closely with rates among white people — in several southwestern and mountain states, including Arizona, Colorado, New Mexico, Oklahoma, Texas, and Wyoming.

EXHIBIT 2

In most states where data are available, Black people and AIAN people are more likely than white people to die early in life from conditions that are treatable with timely access to high-quality health care.

Mortality amenable to health care, deaths per 100,000 population, by state and race/ethnicity



Notes: States arranged in rank order based on highest rate in each state. Missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS), All-County Micro Data, Restricted Use Files.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

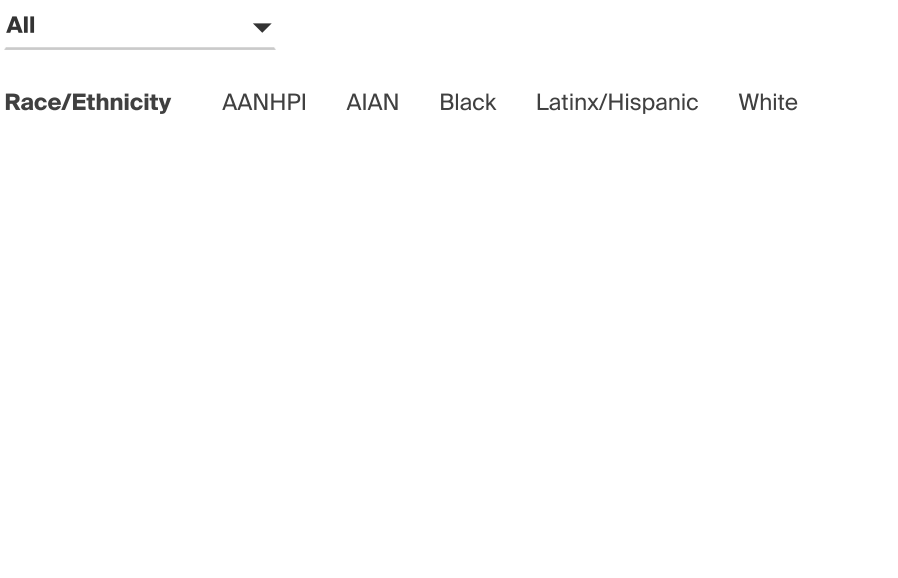
Diabetes is an example of a disease that can often be effectively managed — for example, with consistent blood glucose monitoring and proven medications — but is nonetheless associated with profound racial and ethnic disparities in outcomes. Black and AIAN individuals are much more likely to die from diabetes-related complications (Exhibit 3) than people of other races and ethnicities. Health systems striving for equity should

bolster disease management resources among these communities to achieve better outcomes.

EXHIBIT 3

In nearly all the states where data are available, Black people and AIAN people are more likely than AANHPI, Latinx/Hispanic, and white people to die from complications of diabetes.

Diabetes-related age-adjusted deaths per 100,000 population, by state and race/ethnicity



Note: Dots represent states. Missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS).

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

We also see sizeable disparities when looking at mortality rates for other treatable conditions. Breast cancer, for example, is often considered treatable when detected early but is more likely to be diagnosed at later stages in Black women, who have much higher

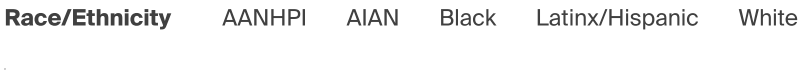
age-adjusted death rates for the disease across most states compared to other women (Exhibit 4).[20] Across all education levels, infant and maternal mortality rates are higher for Black and AIAN residents than for others.[21]

States can perpetuate disparities by not removing barriers to people receiving preventive services, getting effective treatment for chronic conditions like diabetes and high blood pressure, and receiving coordinated care. These barriers range from poor insurance coverage, lack of a usual source of care, and unaffordable medications, to clinicians who prescribe less-effective services or fail to provide timely care for a chronic disease.[22] Sometimes differential outcomes also can reflect unequal access to higher-performing providers, but disparities in care occur even within the same provider facilities.[23]

EXHIBIT 4

Black women are more likely than white women to be diagnosed at later stages and to die, even though breast cancer is often considered treatable when detected early.

Breast cancer age-adjusted deaths per 100,000 female population, by state and race/ethnicity



Notes: States arranged in rank order based on highest rate in each state. Missing dots for a particular group indicate that there is insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS).

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Health Care Access

Large disparities in access to care between white and most nonwhite populations are apparent across states. Latinx/Hispanic people typically face the highest barriers to care,

although, as noted above, they also tend to have better health outcomes than many other groups (despite variations by geographic region).

A key contributor to these access inequities is lack of comprehensive insurance coverage, or any coverage at all. Insurance alone cannot guarantee access, but it is necessary for getting needed health care without incurring substantial or even catastrophic financial risk.

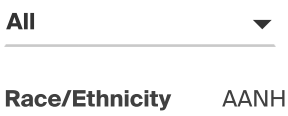
Americans get their health coverage either from commercial insurance plans offered by employers or sold in the individual market, or from public insurance programs like Medicaid, Medicare, and the Children's Health Insurance Program. Prior to the Affordable Care Act (ACA)'s major coverage expansions in 2014, limited access to employer health benefits, more restricted eligibility for Medicaid, and often unaffordable individual market plans created significant inequities in coverage among adults.

After the health law's coverage expansions, adult uninsured rates fell across all racial and ethnic groups. Still, in nearly all states, uninsured rates continue to be higher for Black, Latinx/Hispanic, and AIAN people than they are for white people (Exhibit 5).

EXHIBIT 5

Although the ACA's coverage expansion improved inequities, state uninsured rates are generally higher and more variable for Black, Latinx/Hispanic, and AIAN adults compared to AANHPI and white adults.

Percent of adults ages 19–64 who are uninsured, by state and race/ethnicity



Note: Dots represent states. Missing dots for a particular group indicate there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native. ACA = Affordable Care Act.

Data: American Community Survey Public Use Micro Sample (ACS-PUMS) 2019 1-year file.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Some Latinx/Hispanic and AANHPI populations continue to face immigration-related barriers to getting enrolled in coverage through Medicaid or the ACA marketplaces. While American Indians and Alaska Natives can obtain certain health care services through the Indian Health Service (IHS), lack of insurance coverage can hinder access to needed care outside of persistently underfunded IHS facilities.[24]

The ACA created a federal standard for comprehensive insurance and provides for subsidized coverage through marketplace plans and Medicaid. But 12 states have yet to take advantage of the law's expansion of Medicaid eligibility, which has significantly improved equity in coverage and access and has helped health care facilities in underserved communities (including IHS providers) become more financially stable.[25] Further, Black and Latinx/Hispanic communities are disproportionally represented in states that have not expanded Medicaid: 43 percent of Black and 36 percent of Latinx people live in the 12 nonexpansion states.

When people are uninsured, experience gaps in coverage, or are in private plans that do not provide comprehensive coverage, they often avoid getting care when they need it or pay high out-of-pocket costs when they do seek care.[26] This is particularly burdensome for individuals with lower income and little wealth — disproportionately people of color.[27] Because of these costs, Black, Latinx/Hispanic, and AIAN people are more likely to avoid getting care when they need it, more often have higher out-of-pocket costs, and are more prone to incur medical debt at all income levels.[28]

The proportion of white people reporting cost as a barrier to receiving needed care ranges from 6 percent in the District of Columbia and Hawaii to 14 percent in Georgia, Oklahoma, Alabama, and Mississippi. But among Latinx/ Hispanic people, state rates vary between 10 percent in Hawaii to a high of 30 percent in Tennessee (Exhibit 6).

Many people of color in the U.S. are also less likely to have a usual source of care, an important point of contact with the health system that can help people get treatment when they need it. Lack of a regular care provider often goes hand in hand with high uninsured rates and high patient cost sharing. But it also reflects low Medicaid payment rates that limit the network of participating providers and hospitals, a lower concentration of providers and health facilities in neighborhoods where people of color reside, and language and cultural communication barriers.[29] For AIAN communities in rural areas, who are among the least likely to have a usual source care, geographic barriers can also be a key factor.[30]

EXHIBIT 6

White people are less likely than other population groups to face cost-related barriers in most states.

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

Note: Dots represent states. Missing dots for a particular group indicate there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019–20.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Quality and Use of Health Care Services

Racial and ethnic disparities in the quality of care and the use of services have also been extensively documented. Across and within most states, white populations overall receive better care than Black, Latinx/Hispanic, American Indian/Alaska Native (AIAN), and, often, Asian American, Pacific Islander, and Native Hawaiian (AANHPI) individuals.

Primary care clinicians play an especially critical role in providing people with high-value services, including preventive care like cancer screenings and vaccines, as well as chronic disease management. When there are barriers to obtaining primary care, people are more likely to get care in more intense and costly care settings, particularly an emergency department (ED).

On two measures of primary care effectiveness, Black Medicare beneficiaries are more likely than white beneficiaries to be hospitalized for acute exacerbations of treatable and manageable chronic illnesses and to seek and receive care in an ED for conditions that are nonurgent or treatable by a primary care provider (Exhibit 7). For both Black and white Medicare beneficiaries, more primary care spending is associated with less use of the ED for treatable conditions and fewer hospital admissions.[31]

EXHIBIT 7

Black Medicare beneficiaries are more likely than white beneficiaries to be admitted to a hospital or to seek care in an emergency department for conditions typically manageable through good primary care.

Per 1,000 Medicare beneficiaries

All

Notes: Dots represent states. Missing dots for a particular group indicates that there are insufficient data for that state. Race data only available for Black and white populations—ethnicity is unknown.

Data: Centers for Medicare and Medicaid Services, 2019 Limited Data Set (LDS) 5% sample. Analysis by Westat.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Primary care settings are also where the majority of vaccinations in the U.S. have taken place, and they play an important role in COVID-19 vaccination efforts. On average, Black and Latinx people are less likely than white people to have received recommended vaccines. In 2019, Black and Latinx children were less likely than white children to have received all of seven key vaccines by age 35 months, but differences were relatively small. Conversely, less than half of all adults received an annual flu shot

in 2019–20, and racial/ethnic inequities are apparent (Exhibit 8). Strong federal policy can help close these gaps. For example, the Vaccines for Children program run by the Centers for Disease Control and Prevention (CDC) promotes early childhood vaccination and makes vaccines available at no cost to a partner network of state and local health departments. This, along with state polices regulating vaccination, have proven successful for raising vaccination levels for all children.[32]

Expanded access to primary care improves health outcomes. And given the relatively lower use of primary care by Black, Latinx/Hispanic, and AIAN people, these groups in particular are likely to see a greater health impact from improved access and quality.

EXHIBIT 8

Black, AIAN, and Latinx/Hispanic adults are less likely than AANHPI and white adults to receive an annual flu shot.

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

Notes: Dots represent states. Missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019–20.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Discussion

Racial and ethnic disparities in health outcomes and health care are pervasive both across and within states. Transformative change will depend on policy and practice changes to make access to care more equitable and to ensure equal treatment in the delivery of care.

What Policy Changes Are Needed to Bridge the Gap?

While health systems alone cannot address all the structural inequities that contribute to differential health outcomes, there are a number of policy options for addressing unequal access to care and unequal treatment within health care facilities.

We group these federal and state policy priorities into four areas:

Ensuring universal, affordable, and equitable health coverage. Nearly 30 million people in the United States are still uninsured, and they are disproportionately people of color. Even those who have some coverage face rising levels of financial risk. Policy options include:

- *Make the marketplace premium subsidies provided by the American Rescue Plan Act (ARPA) permanent and close the Medicaid coverage gap in the 12 states that have not expanded eligibility for the program.* These two reforms, which are included in the Build Back Better bill currently before Congress, are estimated to reduce the number of uninsured people overall by 7 million,[33] the number of uninsured Black Americans under age 65 by 1.2 million, and the number of uninsured Latinx/Hispanic people under age 65 by 1.7 million.

- *Reduce deductibles and out-of-pocket costs for marketplace insurance plans.* The pending legislation would reduce cost-sharing to almost zero for people with incomes under 138 percent of poverty in the marketplaces, lowering household spending on health care and improving access to needed care. Another bill, currently in the Senate, would increase eligibility for marketplace subsidies and eliminate or reduce deductibles for some marketplace plan enrollees by as much as $1,650.[34]

- *Allow more workers in expensive employer health plans to become eligible for subsidized marketplace plans.* Under current law, enrollees in employer coverage whose premiums exceed 9.8 percent of income are eligible for subsidized marketplace plans. The Build Back Better bill lowers that threshold to 8.5 percent of income.

- *Mount aggressive, targeted outreach and enrollment efforts to reach the remaining uninsured, most of whom are eligible for Medicaid or subsidized private insurance.*[35] Tracking low enrollment by demographic group, like California does, could help in targeting outreach efforts more effectively.

- *Lower immigration-related barriers to coverage.* An estimated 3 million uninsured cannot enroll in Medicaid or subsidized marketplace plans because of their immigration status.[36] The federal government could allow certain groups of undocumented, low-income immigrant adults and children to enroll in Medicaid or other affordable coverage, as several states already have done.[37]

- *Promote more equitable treatment of enrollees in commercial insurance plans.* Policymakers could require commercial insurers to: collect and report information on race and ethnicity during enrollment and make it linkable to claims data;[38] meet ACA requirements for including essential community providers in their networks;[39] and obtain health equity accreditation.

Strengthening primary care and improving the delivery of services. Communities that are predominantly Black and Latinx/Hispanic tend to have fewer primary care providers and lower-quality health care facilities than communities that are mostly white.[40] Federal and state policymakers could start to reverse these inequities by raising payment for primary care providers and transitioning primary care reimbursement to value-based payment that enables investment in health promotion, disease prevention, and chronic disease management.[41] For example, North Carolina now has a prospective Medicaid payment model that emphasizes primary care–based population health management, while Oregon and Washington are linking Medicaid payments to performance on equity measures.[42]

There are also opportunities to change how care is delivered and who delivers it:

- *Ensure that telemedicine remains an option.* The pandemic has already shown that telemedicine is an effective strategy for providing patients with convenient access to care.[43]

- *Modernize medical licensing.* Allow health care professionals to more easily practice across state lines.[44]

- *Develop community-based health care workforces focused on team care.* Offer financial assistance, such as loan repayment, to providers who serve in medically underserved communities. Expand community health worker programs to train individuals to provide basic health-related services and support within their communities.

Reducing inequitable administrative burdens affecting patients and providers. Americans seeking health care face far higher administrative hurdles than residents of other high-income nations.[45] Recent research points to the negative impact these barriers have on access to care for lower-income individuals, including many people of color.[46] Autoenrollment is one reform that could reduce the application burden associated with state Medicaid programs; it could help people get, and stay enrolled in, public coverage.[47] If poorly designed, the quality reporting, care management, utilization review, and prior authorization programs instituted by public and private insurers can create unnecessary red tape and even financial penalties for underresourced providers. Administrators could audit oversight and accountability programs for their disproportionate impact on providers serving communities of color.

Investing in social services. The U.S. spends less on economic and social supports for children and working- age adults than most other high-income countries, and the lack of adequate investment in this area likely contributes significantly to racial and ethnic inequities in health outcomes.[48] Federal and state policymakers could expand economic support for lower-income families by implementing unemployment compensation and Earned Income Tax Credit and child tax credit programs, as well as childcare, food security, and targeted wealth-building programs.[49] Additional investments in affordable housing, public transportation, early childhood development, and affordable higher education also could help reduce racial and ethnic health inequities.[50]

Conclusion

Racial and ethnic equity in health care should be a top priority of federal and state policymakers. A good start would be to identify policies and proposed legislation that impede progress toward health equity.

Given that structural racism has played a significant role in shaping those policies that have spawned widespread health inequities, leaders at the federal, state, and local levels should reexamine existing laws and regulations for their impact on people of color's access to quality care. And new reforms to ensure good insurance coverage and timely access to primary and specialty care need to target communities across the United States that have long been ignored.

Equally important is the development and use of equity- focused measures to monitor the progress of efforts intended to advance health equity and to engender accountability for achieving desired outcomes. And systems are needed to track whether states, health systems, and health plans are reducing racial disparities in clinical outcomes, coverage, access to clinicians, and a host of other health-related gaps.

Too often in the U.S., race and ethnicity are correlated with access to health care, quality of care, health outcomes, and overall well-being. This is a legacy of structural, institutional, and individual racism that predated the country's founding and that has persisted to the present day, in large part through federal and state policy. By pursuing new policies that center racial and ethnic equity, expand access to high-quality, affordable care, and bolster the primary care workforce, we as a nation can ensure that the health care system fulfills its mission to serve all Americans.

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