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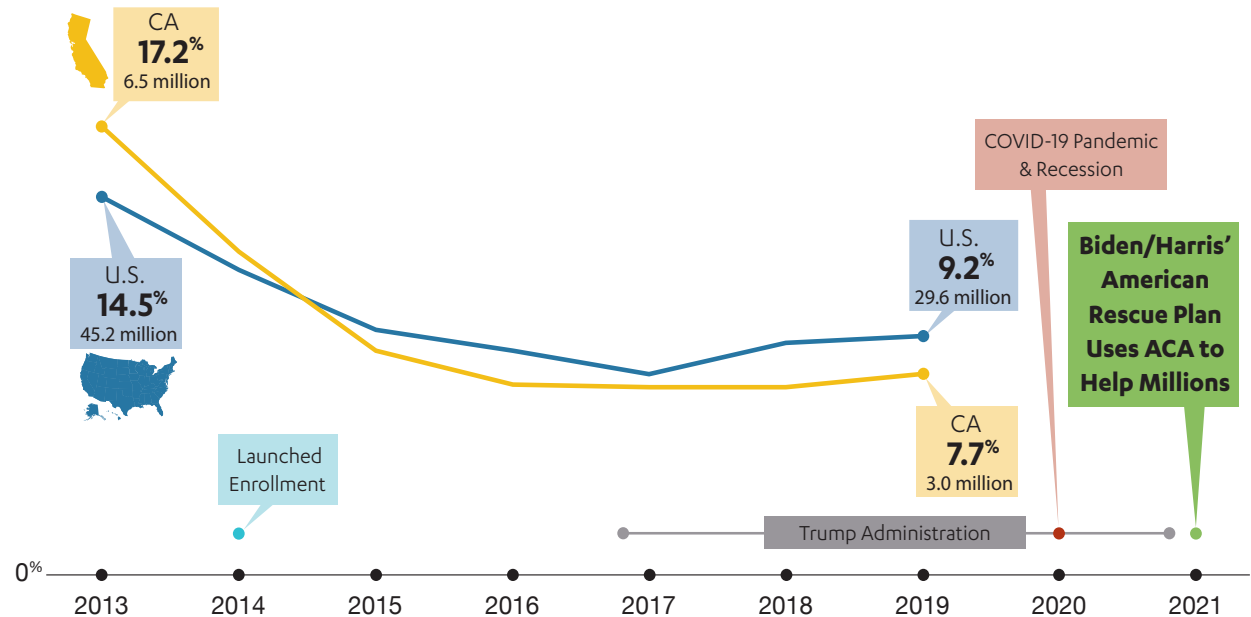


Covered California Announces American Rescue Plan Roadmap to Lower Premiums and Help Millions Get Covered

March 18, 2021

CALIFORNIA BUILDING ON ITS HISTORY OF MAKING THE AFFORDABLE CARE ACT WORK

- Since launch of ACA, California experienced the nation's largest drop in the uninsured rate.
- More than 4.7 million Californians have gained coverage since 2013.
- As of 2019, there are about 3 million uninsured, with about 60% undocumented/ineligible for federal programs.
- In 2020, California implemented state subsidies and a state penalty, which resulted in a 40% increase in new enrollment and contributed to premium increases of less than 1% for 2020 and 2021.
- COVID Special Enrollment Period in 2020 led to surge in sign-ups



Source: U.S. Census 2014-2020

WHO CAN BENEFIT FROM THE AMERICAN RESCUE PLAN'S NEW HEALTH SUBSIDIES: THE NATIONAL AND CALIFORNIA PICTURE

Landscape of the 25 Million Americans Eligible for New Assistance*

			US Total		California	
ACTION NEEDED BY CONSUMER	Currently Uninsured	Uninsured Marketplace Eligible, below 400% FPL	11.2M	45%	990,000	32%
		Uninsured Marketplace Eligible, above 400% FPL	2.1M	8%	230,000	8%
		<i>SUBTOTAL: Currently Uninsured - Action Needed to Benefit</i>	13.3M	54%	1,220,000	40%
	Currently Insured	Off-Exchange Enrollees, below 400% FPL	.8M	3%	210,000	7%
		Off-Exchange Enrollees, above 400% FPL	.7M	3%	220,000	7%
		<i>SUBTOTAL: Currently Enrolled - Action Needed to Benefit</i>	1.5M	6%	430,000	14%
NO ACTION NEEDED BY CONSUMER	Currently Insured	Marketplace Enrollees, below 400% FPL - No Action Needed to Benefit	9.1M	37%	1,270,000	42%
		Marketplace Enrollees, above 400% FPL - Newly Eligible for ARP	.9M	4%	140,000	5%
		<i>SUBTOTAL: Currently Enrolled - No Action Needed to Benefit</i>	10.0M	40%	1,410,000	46%
TOTAL		Total Eligible to Benefit from Subsidies	24.9M	100%	3,060,000	100%
ACTION NEEDED	Currently Uninsured	Uninsured Medicaid Eligible	7.3M		1.0M	
TOTAL		Total Eligible to Benefit from Affordable Coverage	32.2M		4.0M	

Average New Monthly Financial Help For Current Marketplace Enrollees, below 400% FPL	\$ 80	\$ 74
Average Monthly Financial Help for Newly Enrolling Individuals, below 400% FPL	\$ 571	\$ 527
Average Monthly Financial Help Per Newly Eligible Enrollee, above 400% FPL	\$ 335	\$ 309

* Table only shows those estimated to be eligible for subsidies based on maximum required contribution percentage of household income using available administrative data (on income, age, and benchmark premiums) from California's marketplace: the actual eligibility may differ to the extent that there are differences in the age, income, and premium costs for other states and the off-exchange from what is observed in Covered California's data. **Not shown are the estimated 1.4 million consumers who may receive higher subsidies because they are receiving unemployment insurance income.** Additionally, off-exchange estimates do not include consumers who may be enrolled in coverage that is not ACA compliant (e.g. "grandfathered" plans), who may also benefit from new subsidies.

** Federally-Facilitated Exchanges includes State-Based Exchanges utilizing the Federal Marketplace Platform.

*** The "states with largest drops in unsubsidized enrollment" reflects total of the nine States (which were all in FFE) that had 2016 to 2019 drop of unsubsidized enrollment of over 70% (AZ, GA, IA, MS, NB, NH, OK, TN, WV).



WHO CAN BENEFIT FROM THE AMERICAN RESCUE PLAN'S NEW HEALTH SUBSIDIES: 25 MILLION AMERICANS

American Rescue Plan – Landscape of the 25 Million Americans Eligible for New Assistance*

			US Total		Federally-Facilitated Exchanges		States with Large Drops in Unsubsidized Enrollment		State-Based Exchanges	
ACTION NEEDED BY CONSUMER	Currently Uninsured	Uninsured Marketplace Eligible, below 400% FPL	11.2M	45%	8.5M	49%	1.8M	54%	2.7M	37%
		Uninsured Marketplace Eligible, above 400% FPL	2.1M	8%	1.4M	8%	.3M	8%	.7M	9%
		SUBTOTAL: Currently Uninsured - Action Needed to Benefit	13.3M	54%	9.9M	57%	2.1M	62%	3.4M	46%
	Currently Insured	Off-Exchange Enrollees, below 400% FPL	.8M	3%	.4M	2%	.0M	1%	.4M	5%
		Off-Exchange Enrollees, above 400% FPL	.7M	3%	.4M	2%	.0M	1%	.4M	5%
		SUBTOTAL: Currently Enrolled - Action Needed to Benefit	1.5M	6%	.7M	4%	.0M	1%	.8M	11%
NO ACTION NEEDED BY CONSUMER	Currently Insured	Marketplace Enrollees, below 400% FPL - No Action Needed	9.1M	37%	6.4M	36%	1.1M	34%	2.7M	37%
		Marketplace Enrollees, above 400% FPL - Newly Eligible for ARP	.9M	4%	.4M	3%	.1M	3%	.5M	6%
		SUBTOTAL: Currently Enrolled - No Action Needed to Benefit	10.0M	40%	6.8M	39%	1.2M	36%	3.2M	43%
TOTAL		Total Eligible to Benefit from Subsidies	24.9M	100%	17.5M	100%	3.4M	100%	7.4M	100%
ACTION NEEDED	Currently Uninsured	Uninsured Medicaid Eligible	7.3M		4.8M		1.3M		2.5M	
TOTAL		Total Eligible to Benefit from Affordable Coverage	32.2M		22.2M		4.7M		9.9M	

Average New Monthly Financial Help For Current Marketplace Enrollees, below 400% FPL	\$ 80	\$ 85	\$ 91	\$ 70
Average Monthly Financial Help for Newly Enrolling Individuals, below 400% FPL	\$ 571	\$ 603	\$ 648	\$ 497
Average Monthly Financial Help Per Newly Eligible Enrollee, above 400% FPL	\$ 335	\$ 353	\$ 380	\$ 291

* Table only shows those estimated to be eligible for subsidies based on maximum required contribution percentage of household income using available administrative data (on income, age, and benchmark premiums) from California's marketplace: the actual eligibility may differ to the extent that there are differences in the age, income, and premium costs for other states and the off-exchange from what is observed in Covered California's data. **Not shown are the estimated 1.4 million consumers who may receive higher subsidies because they are receiving unemployment insurance income.** Additionally, off-exchange estimates do not include consumers who may be enrolled in coverage that is not ACA compliant (e.g. "grandfathered" plans), who may also benefit from new subsidies.

** Federally-Facilitated Exchanges includes State-Based Exchanges utilizing the Federal Marketplace Platform.

*** The "states with largest drops in unsubsidized enrollment" reflects total of the nine States (which were all in FFE) that had 2016 to 2019 drop of unsubsidized enrollment of over 70% (AZ, GA, IA, MS, NB, NH, OK, TN, WV).

THE AMERICAN RESCUE PLAN: PROVIDING MORE HELP TO MILLIONS AND MORE THAN COVERING CALIFORNIA'S TEMPORARY STATE SUBSIDIES

The new “required contribution curve” will significantly reduce the share of income that consumers must pay towards their premiums, fully replacing the current ACA policy design for plan years 2021 and 2022.

The Rescue Plan also includes a provision that allows anyone receiving Unemployment Income in 2021 to receive Advanced Premium Tax Credits (APTCs) at the level of eligibility at 138% FPL (meaning they pay 0% of their monthly income towards their benchmark plan and be eligible for Silver 94).



Required contribution curves are for the 2021 plan year.

AMERICAN RESCUE PLAN LOWERS PREMIUMS AS A SHARE OF INCOME

2021 Coverage Year: Percent of Household Income Paid for Benchmark Silver Premium						
Income Range		Required Contribution as Share of Income			Enrollees to be redetermined without taking action	
Income As Percent of Federal Poverty Level (FPL)	Income for Single Household	Affordable Care Act	California State Subsidy Program	American Rescue Plan	Covered California enrollees	Percent of total
Under 138%*	\$0 to \$17,609	2.07%	0.0%	0.0%	38,000	3%
138% – 150%**	\$17,609 to \$19,140	3.10% – 4.14%	N/A	0.0%	226,000	16%
150% – 200%	\$19,140 to \$25,520	4.14% – 6.52%	N/A	0.0% – 2.0%	442,000	31%
200% – 250%	\$25,520 to \$31,900	6.52% – 8.33%	6.24% – 7.80%	2.0% – 4.0%	236,000	16%
250% – 300%	\$31,900 to \$38,280	8.33% – 9.83%	7.80% – 8.90%	4.0% – 6.0%	198,000	14%
300% – 400%	\$38,280 to \$51,040	9.83%	8.90% – 9.68%	6.0% – 8.5%	192,000	13%
Over 400%	\$51,040 and up	Not eligible for subsidies	9.68% – 18.0%***	8.5%	112,000	8%

NOTES:
 *Individuals with income at or below 138% of the federal poverty level are generally eligible for Medi-Cal, California's Medicaid program. In certain limited circumstances, however, they are eligible for the federal premium tax credit and the California state subsidy program.
 ** Under the American Rescue Plan, Covered California enrollees receiving Unemployment Insurance (UI) in 2021 are treated as though their income is no more than 138.1% of the federal poverty level for the purposes of the federal premium tax credit meaning their required contribution for a benchmark plan will be 0%.
 *** Eligibility for the California state subsidy program ends at 600% of the federal poverty level.

SAVINGS TO CALIFORNIANS UNDER THE AMERICAN RESCUE PLAN

Uninsured Californians earning between \$19,000 and \$32,000 per year – comprising 2/3rds of the eligible uninsured – can enroll in a benchmark silver plan (with reduced cost sharing) for an average cost of \$61 per month, and virtually all can get a Bronze plan for \$1 per month per member.

Off-exchange consumers over 400% FPL, who enroll with Covered California in May, will receive on average of \$500 per month in federal financial assistance, for a potential savings of nearly \$10,000 if enrolled for 20 months from May 2021 through December 2022.

Current Covered California consumers who will receive subsidies, will pay an estimated \$119 less per month per household on average, which translates to \$1,428 per year.

	Income Ranges for Single Person Household	Share of Enrollment	Monthly Premiums		Savings Due to American Rescue Plan (for those who receive credits only)		
			Gross Premium	Consumer's Premium After American Rescue Plan Assistance	Monthly Savings compared to ACA	Monthly Savings compared to Gross Premium	Savings from 20 months of ARP subsidies (compared to gross)
Under 150% FPL	Under \$19,140	18%	\$734	\$55	\$59	\$679	\$13,588
150% - 250% FPL	\$19,140 - \$31,900	47%	\$766	\$61	\$93	\$704	\$14,088
250% - 400% FPL	\$31,900 - \$51,040	27%	\$964	\$228	\$144	\$736	\$14,720
Over 400% FPL	More than \$51,040	8%	\$1,100	\$507	\$593	\$593	\$11,860
Total		100%	\$820	\$118	\$119	\$702	



Note: Modeling assumes uninsured population characteristics match Covered California membership, including plan choice. Source: Covered California administrative data of effectuated enrollees' current plan selections, and only reflect those who are estimated to receive subsidies greater than \$0. Premiums are at the household level.

SCENARIO: YOUNGER UNINSURED IN LOS ANGELES CAN NOW GET SILVER PLAN FOR LESS THAN \$50 PER MONTH

Uninsured younger consumers in low-cost regions can now get even more affordable coverage: a 21 year old in LA earning \$25,520 per year (200% FPL) can purchase a benchmark plan (Enhanced Silver 94) for \$43 per month, or a Bronze plan for \$1 per month.

		ACA Baseline	American Rescue Plan
One-Person Household	Benchmark Silver Premium (monthly)	\$275	\$275
Los Angeles, CA	Cap on Share of Income for Benchmark Plan	6.52%	2%
21 year old	Net Premium (monthly)	\$139	\$43
Income: \$25,520	Federal Subsidy (monthly)	\$137	\$233
200% FPL	Federal Subsidy (if enrolled all of 2021 and 2022)	\$2,736	\$4,659

SCENARIO: MIDDLE-INCOME OFF-EXCHANGE COUPLE CAN SAVE \$14,000 IF SWITCH TO MARKETPLACE THROUGH 2022

A couple in Oakland, both 45 and earning \$77,580 (450% FPL) purchased a benchmark silver plan off-exchange.* Now, if they switch to enroll at Covered California, they can keep the exact same place and receive financial help worth \$722 per month, or over \$14,000 if enrolled from May 2021 to December 2022.

		Enrolled Off-Exchange	American Rescue Plan	Difference for Enrolling through Covered California
Couple	Benchmark Silver Premium (monthly)	\$1,271	\$1,271	
Oakland, CA	Percent of Income Spent on Premium	19.6%	8.5%	11.1% of income saved
Both Age 45	Net Premium (monthly)	\$1,271	\$550	\$722 saved
Income: \$77,580	Federal Subsidy (monthly)	\$0	\$722	\$722 new monthly credits
450% FPL	Federal Subsidy (20 months in 2021 and 2022)	\$0	\$14,438	\$14,438 savings if enrolled 20 months



* Not shown: this household would have been eligible for \$366 per month in state subsidy had they enrolled on-exchange for 2021. ⁸

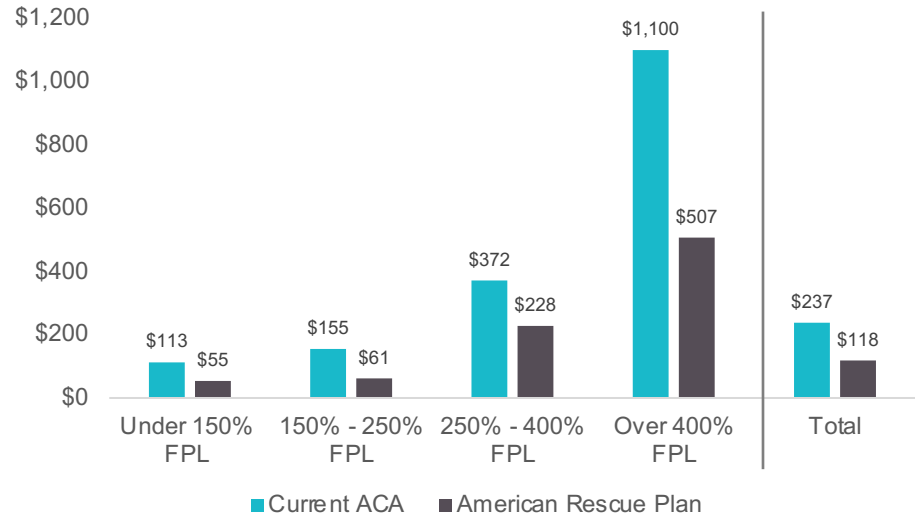
FOR THOSE RECEIVING SUBSIDIES NOW THROUGH COVERED CALIFORNIA AVERAGE “NET PREMIUMS” WILL DROP A LOT

For current Covered California members, “net premiums” – the monthly amount consumers pay after the federal subsidy – will decrease by an estimated \$119 per household per month (\$1,428 annualized) compared to what costs would be under the ACA.*

Many consumers in the lower income range will become newly eligible for \$1 Enhanced Silver premiums, while consumers over 400% of FPL will see significant reductions thanks to new federal premium assistance.

We estimate the American Rescue Plan will provide over \$1.5 Billion in new financial help *for current enrollees alone.*

Average Household Net Premium by FPL and Policy Design



Note: Modeling assumes uninsured population characteristics match Covered California membership, including plan choice. Source: Covered California administrative data of effectuated enrollees' current plan selections, and only reflect those who are estimated to receive subsidies greater than \$0. Premiums are at the household level, and net premiums do not include state subsidies.

MOST CALIFORNIANS PAYING FOR INSURANCE TODAY “OFF-EXCHANGE” CAN REDUCE THEIR COSTS IMMEDIATELY

Covered California estimates, based on income alone, that nearly three-quarters of all off-exchange households *could* be eligible to receive subsidies under the stimulus based on their income:

- Of households eligible to receive subsidies (of more than \$0), 94% could receive more than \$100/month, representing substantial benefit to these off-exchange consumers.
- For those households earning between 400% and 600% FPL, an estimated 82 percent would be eligible for financial help which would average \$690 per household – **that assistance would have a value of \$13,800 for a household that enrolled for May 2021 coverage and kept their insurance with same subsidy until December 2022.**
- Off-exchange households are ineligible due to their incomes meaning they can purchase a benchmark plan that costs less than 8.5% of income, and thus would qualify to receive subsidies.

FPL Group	Average Household Subsidy	Individuals Eligible to Receive Subsidies	Share of Total Households Eligible to Receive Subsidies
Less than 400% FPL	\$800	210,000	100%
400%-600% FPL	\$690	120,000	82%
More than 600% FPL	\$500	100,000	43%

ENROLLING AS MANY OF THE 25 MILLION ELIGIBLE NATIONALLY AND 3 MILLION IN CALIFORNIA IS THE RIGHT THING TO DO

- These provisions can provide fast and significant relief to Americans who are struggling with the pandemic and its economic repercussions. New subsidies will help uninsured GET coverage and those who have coverage without subsidies KEEP coverage while putting money in their pockets.
- The increased subsidies provide additional financial help to those currently enrolled which will help them stay covered and give financial help to lower income and those in communities of color most impacted by the COVID-10 pandemic and resulting recession.
- By enrolling consumers during 2021 and in the 2022 open enrollment period, the individual market would benefit from lower premiums in 2022 due to the healthier consumer pool. Covered California estimates effective enrollment could lead to 2022 premiums being 4 percent lower than they would otherwise be – saving the federal government over \$2 billion in reduced Premium Tax Credit spending.
- The American Rescue Plan can show how the Affordable Care Act (ACA) can meet the needs of consumers during a pandemic and recession, by delivering real results quickly through the existing infrastructure of the law. Successful implementation is critical as we look ahead to the potential of expanding coverage by making permanent improvements to the ACA.

POTENTIAL DOES NOT MEAN WILL BENEFIT: THE CONGRESSIONAL BUDGET OFFICE PROJECTS ONLY ABOUT ONE IN TEN OF ELIGIBLE UNINSURED WILL BENEFIT

The [Congressional Budget Office](#) projects that over 2021 and 2022 combined about 10 percent of uninsured eligible for the American Rescue Plan increased subsidies will enroll and 20 percent of those currently insured but unsubsidized will enroll. They think millions of Americans will leave big money on the table for good reasons:

- Most uninsured want insurance they just don't think they can afford it. The CBO does not think the Rescue Plan will change that.
- The American Rescue Plan is starting "mid-year" when consumers are less likely to switch.
- Since the program is temporary, many will just sit on the sidelines.

And there are other reasons for conservatism:

- Moving Consumers from "Off-Exchange" IS Difficult (inertia is a powerful force)
- Nationally need to rebuild awareness of Healthcare.gov and support navigators
- Danger of lower than needed marketing spending and risk that health plans don't "lean in"

BUT –THE AMERICAN RESCUE PLAN PROVIDES NEW OPPORTUNITIES BY MAKING COVERAGE MORE AFFORDABLE THAN EVER BEFORE

There are clear pathways and huge needs to be met that can help ensure consumers access subsidies:

- **Uninsured:** the new subsidies are large and make coverage MUCH more affordable than ever before for millions of Americans, IF Americans are told how much they can save.
- **Currently Insured “Off-Exchange” Consumers:** Qualified Health Plans and insurance agents can help consumers understand they can save thousands of dollars and convert to coverage that meets their needs.
- **Currently Subsidized Marketplace Consumers:** Consumers who are currently enrolled in either the Federally Facilitated Exchange (FFE) or a State Based Exchange (SBE) can gain the bigger subsidies automatically – either in the form of lower monthly premiums or by receiving a bigger tax refund at the end of the year without any action necessary on their part.
- **Health Insurance Carriers Can and Should Lean In:** New subsidies will help ensure that off-exchange enrollees in their plans will no longer terminate their plans prematurely because they can now better afford coverage.

COVERED CALIFORNIA'S CORE STRATEGIES TO MAXIMIZE ENROLLMENT AND HELP AS MANY CALIFORNIANS AS POSSIBLE



1. **Establish a NEW American Rescue Plan special-enrollment period starting April 12th through the end of 2021.**

**\$20-30
MILLION**

2. **Maintain consumer-focus, support agents and navigators, new partnerships and significant marketing investments April, May, and June.**



3. **Hold health carriers accountable by encouraging them to invest in marketing and reaching out to every consumer who is eligible for a subsidy.**

COVERED CALIFORNIA STRATEGY 1: NEW AMERICAN RESCUE PLAN SPECIAL ENROLLMENT PERIOD

Establish a NEW American Rescue Plan Special Enrollment Period – *Covered California will have a special enrollment period starting April 12th and going through the end of 2021*

- The Special Enrollment Period needs to be **NEW** because the benefits to consumers ARE NEW – need to create buzz, discussion and engagement by all interested (and disinterested) individuals so uninsured consumers “check-again.”
- A longer Special Enrollment Period allows for roll-out of effective marketing and will allow for broader word of mouth – minimum period should be through June 30, 2021.
- There is virtually no risk of “adverse risk selection” – Covered California’s 2020 COVID Special Enrollment saw same risk mix as our overall enrollment
- We do NOT want to turn away an uninsured person who is newly eligible for \$800 a month in subsidies (and many able to get virtually free coverage) in July to tell them “come back for coverage starting in January
- AND we can and must still market with the “sell” of urgency and “sign-up now” (which is often triggered by a deadline) with BIG marketing focus April through June.

COVERED CALIFORNIA STRATEGY 2: DOING ALL WE “NORMALLY” DO AND DOING IT WELL

Covered California must do all its “regular” activities and more – and we’ve got to do them well – to effectively reach and enroll all possible eligible consumers

- Consumer-centered technology to support getting the increased subsidies TO CONSUMERS as quickly as possible.
- Robust marketing – leaning in for April through June as if it were an Open Enrollment Period
 - Major spending, with current plans of spending \$20 to \$30 million in April through June.
 - Disproportionately targeting communities hardest hit by the recession: communities of color and lower income
 - Benefiting from lower cost of media buying AND we will “own” the health insurance market
- Actively reach out to subsidized members and eligible consumers in our “funnel” and provide great customer service for consumers and for those who help consumers (e.g., navigators and agents)
- Engage in partner activities with major state entities: the Employment Development Department, the Franchise Tax Board and California’s Medi-Cal Department

MARKETING TO PROMOTE THE NEW LOWER COST COVERAGE FROM THE AMERICAN RESCUE PLAN

- Covered California plans a statewide marketing campaign mirroring Open Enrollment levels with \$20-30 million investment reaching at least 97% of consumers 18 times April 12 – June 30.
- Build strong momentum out the gate with maximum media weight levels in the first three weeks of the campaign.
- Enhanced emphasis on ethnic market media across Hispanic, Asian and African-American/Black audience segments in all mediums possible within the timeline. Highlights include:
 - Dedicated digital buys on contextually relevant sites.
 - Purchase the most circulated Spanish, Black and API print publications in CA.
 - Purchase through every Black-owned radio station in the state as well as partner with influential Black, Hispanic and Asian radio personalities to deliver our message.



IN COMMUNITIES THROUGHOUT CALIFORNIA, THOUSANDS OF CERTIFIED AGENTS AND ENROLLERS ARE READY TO HELP



10,000 Certified Insurance Agents

581 Covered California Storefronts

3,753 Navigators and other Community-Based Organizations

COVERED CALIFORNIA WILL PARTNER WITH KEY STATE AND OTHER GROUPS TO MAKE A DIFFERENCE

Covered California will work to promote insurance enrollment with our public partners, including key state agency partners:

- **Employment Development Department (EDD) – for Californians receiving Unemployment Insurance:** Covered California will continue to work with the Employment Development Department (EDD), California’s unemployment insurance agency, to provide messaging that will be sent by EDD to unemployment compensation recipients. We will also work with EDD to explore any opportunities for data sharing to enable direct outreach by Covered California to unemployment compensation recipients.
- **California Franchise Tax Board (FTB) – for Californians who paid penalty for being uninsured in 2020:** By state law, California’s Franchise Tax Board will share data with Covered California to enable direct outreach to penalty payers. Covered California will develop material to make penalty payers aware of the new subsidies and the stimulus special enrollment period.
- **California Department of Health Care Services (DHCS) – for Californians leaving Medi-Cal coverage:** Covered California will partner with the Department of Health Care Services, California’s Medicaid Agency, to plan for the expected influx of newly eligible individuals coming from Medicaid when the public health emergency is lifted at the end of 2021 and early 2022.

COVERED CALIFORNIA STRATEGY 3: MAKE SURE CONTRACTED HEALTH PLANS DO THE RIGHT THING

Covered California will provide the tools and implement the policies to ensure its eleven contracted health plans do the right thing for consumers, including:

- Requiring health plans to actively reach out to all their off-exchange consumers to encourage them to see if they are eligible for assistance AND to help them “convert” if they are:
 - Covered California building “microsite” of CoveredCA.com for each carrier to facilitate these conversions and plan-based enrollment activities
- Requiring health plans to establish consumer-first conversion policies:
 - Assure any spending is carried over to credit deductibles with their new plan
 - Making sure they either keep same doctors/networks or understand the implications of changing
 - Making sure continuity of care issues are well addressed
- Do their fair share of marketing and promotion while coordinating with Covered California’s efforts.
- Support and partner with their agents (including paying fairly and being sure all transferring clients are still credited to those agents)



News Release

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FOR IMMEDIATE RELEASE

March 18, 2021

Covered California, Community Leaders and Health Plans Highlight Key American Rescue Plan Provisions and Lay Out a Roadmap to Lower Premiums and Help Millions Get Covered

- *The American Rescue Plan provides new financial assistance to help millions of people get economic relief and health insurance coverage, through Covered California and other marketplaces nationwide.*
- *An estimated 3 million Californians are among the 25 million Americans who stand to benefit from the new and expanded subsidies, which will lower premium costs and make health care coverage more affordable than ever.*
- *Covered California will open a new special-enrollment period on April 12, for May 1, coverage for the estimated 1.2 million uninsured Californians who are eligible as well as the 430,000 people currently insured off-exchange who will qualify for the new financial help.*
- *In addition, most of Covered California's currently enrolled consumers will see an average of \$119 per household in monthly premium savings that will automatically start in May.*
- *Covered California has detailed a roadmap with three strategies that includes a major marketing campaign and having its contracted health insurance companies take an active role in helping all eligible Californians get lower cost coverage.*

SACRAMENTO, Calif. — Covered California released new data and announced new partnerships to highlight how the American Rescue Plan can benefit 25 million Americans, including 3 million in California.

(more)

“The new and expanded financial help provided by the American Rescue Plan is a very big deal for millions of Americans,” said Peter V. Lee, executive director of Covered California. “These new subsidies will help more people get covered, lower premium costs and put money back into people’s pockets when they sign up for health insurance through the Affordable Care Act.”

Who benefits from the American Rescue Plan?

The American Rescue Plan lowers health care premium costs for people who get coverage through Covered California, or through other Affordable Care Act marketplaces across the nation, by providing new and expanded subsidies to make health insurance more affordable than ever before. [A Covered California analysis finds that an estimated 25 million Americans could potentially benefit from the new law](#) (see Table 1: Americans Eligible for Assistance From the American Rescue), including:

- **Covering the uninsured** - An estimated 1.2 million Californians, and more than 13 million people nationwide, are uninsured and eligible for marketplace coverage under the Affordable Care Act with even lower costs because of the American Rescue Plan.

Under the American Rescue Plan, these uninsured can get coverage that is more affordable than ever before. In California, for consumers who earn less than \$32,000 a year for an individual, they will be able to either get a benchmark Silver plan for between \$50 and \$60 a month and virtually all would be able to get Bronze plan for a \$1 a month.

“The American Rescue Plan provides the first significant boost to the Affordable Care Act in more than 10 years,” Lee said. “The new money that is available means that many people who are currently going without coverage will be able to get a high-quality plan for about the price of a few bus rides.”

- **People who are insured directly through a health insurance company** – An estimated 430,000 Californians, and 1.5 million people nationally, are insured directly through a health insurance company and not now getting subsidies. The new law ensures that everyone eligible will pay no more than 8.5 percent of their income on their health premiums.

An individual with an income of more than \$51,000 per year currently pays an average of \$1,100 a month for their coverage. Under the new and expanded subsidies provided by the American Rescue Plan, their monthly premium drops to an average of \$507 – a savings of nearly \$600 per month and a total of nearly \$12,000 between this May and the end of 2022.

“For some Californians this means they will finally be able to afford health care coverage and get the protection and peace of mind they need in the middle of a

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health crisis,” Lee said. “For others it means hundreds or even thousands of dollars back in their pockets to help them afford their housing, keep their business running, or put money away for retirement.”

Table 1: Americans Eligible for Assistance From the American Rescue Plan¹

Landscape of the 25 Million Americans Eligible for New Assistance*			US	California
ACTION NEEDED BY CONSUMER	Currently Uninsured	Covered CA Eligible, below 400% FPL	11.2M	990,000
		Covered CA Eligible, above 400% FPL	2.1M	230,000
		<i>SUBTOTAL</i>	<i>13.3M</i>	<i>1,220,000</i>
	Currently Insured	Off-Exchange, below 400% FPL	.8M	220,000
		Off-Exchange, above 400% FPL	.7M	210,000
		<i>SUBTOTAL</i>	<i>1.5M</i>	<i>430,000</i>
NO ACTION NEEDED BY CONSUMER	Currently Insured	Covered CA, below 400% FPL	9.1M	1,270,000
		Covered CA, above 400% FPL	.9M	140,000
		<i>SUBTOTAL: No Action Needed</i>	<i>10.0M</i>	<i>1,410,000</i>
TOTAL		Total Eligible to Benefit from Subsidies	24.9M	3,060,000
ACTION NEEDED	Currently Uninsured	Uninsured Medicaid Eligible	7.3M	950,000
TOTAL		Total Eligible to Benefit from Affordable Coverage	32.2M	4,010,000

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¹ Table only shows those estimated to be eligible for subsidies based on maximum required contribution percentage of household income using available administrative data (on income, age, and benchmark premiums) from California’s marketplace: the actual eligibility may differ to the extent that there are differences in the age, income, and premium costs for other states and the off-exchange from what is observed in Covered California’s data. **Not shown are the estimated 1.4 million consumers who may receive higher subsidies because they are receiving unemployment insurance income.** Additionally, off-exchange estimates do not include consumers who may be enrolled in coverage that is not ACA compliant (e.g. “grandfathered” plans), who may also benefit from new subsidies.

- **Current Covered California enrollees** – The law will also help about 10 million Americans, including 1.4 million in California, who are already enrolled through Covered California or other marketplaces and getting financial help. The analysis shows that for those in California they will see their net premiums decrease by an average of \$119 per household per month. Existing consumers in California do not need to take any action since Covered California will automatically apply the savings to their accounts. They will see lower bills starting in May.

Syd Winlock is a small-business owner in Elk Grove and a Covered California enrollee. The new financial help available through the American Rescue Plan will lower his family's \$1,100 premium by \$450 a month.

“One of the things I was looking at doing was expanding some services that we provide, and I can direct the money that we were paying for health care to that,” Winlock said. “As you guys put money back into my pocket, I'm going to put money back into the economy.”

Effectively Implementing the American Rescue Plan

In addition to its analysis, Covered California also laid out the steps it will be taking – including working with its contracted health insurance companies, agents and navigators, and community leaders – to effectively implement the American Rescue Plan.

While the law will potentially benefit 25 million Americans, many of them will need to act, requiring the need for a coordinated and targeted outreach efforts. The Congressional Budget Office estimates that only 10 percent of those uninsured and eligible for new subsidies will enroll, and only 20 percent of those currently insured but unsubsidized will sign up for the new benefits.

The main reasons cited for the projections are that many uninsured still believe they cannot afford coverage, off-exchange consumers are less likely to switch to a marketplace in mid-year, and that program is temporary.

“The challenges are real, and this will not be easy, but we can do better – not only for Californians, but for Americans across the country,” Lee said. “Covered California and our partners are ready to lean-in, to spread the word that new money is available that can help lower premium costs for millions.”

Covered California released a roadmap describing [Covered California's Approach to Promoting the American Rescue Plan: Target Groups and Strategic Approaches](#) and detailed analysis of those [eligible for American Rescue Plan benefits in each state](#), that includes an analysis of potential marketing investments for the federal marketplace and other states that would be on par with those California has historically made.

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Covered California’s approach describes three strategic approaches it will undertake to reach out to and enroll as many Californians as possible:

- **Launching a new special-enrollment period** – Covered California will open a new special-enrollment period – which will start on Monday, April 12 and run through the end of the year – to give uninsured and unsubsidized Californians time to sign up for coverage that starts as soon as May 1 and continue the outreach and enrollment effort to have marketing pay-off over time.

“Time is of the essence, because every month that goes by is a month that someone could be covered or be saving hundreds of dollars on health insurance,” Lee said.

- **Maintaining consumer commitment** – Covered California will continue to focus on the consumer-centered tactics and strategies that it has used since launching in 2014. The focus will include new investments in marketing and outreach – totaling between \$20 million and \$30 million on television, radio, print and digital ads over the next few months. The statewide campaign will reach every community, with an emphasis on Hispanic, Asian and African American media outlets which represent the groups hit hardest by the pandemic and recession. In addition, Covered California will engage with key partners – insurance agents, navigators, state agencies and others at the state and local level – to reach every eligible consumer.

“While virtually everyone in Covered California will get a significant reduction in their next premium bill, we need a major effort to ensure that hundreds of thousands more eligible Californians get this help of hundreds or even thousands of dollars,” said Anthony Wright, executive director of Health Access California, the statewide health care advocacy coalition. “The more Californians are covered and who can access quality care, the sooner we can end this pandemic, and get closer to a universal and affordable system that can better handle the next public health crisis.”

“The Latino community has been hit hard over the last year. They disproportionately work in the roles we refer to as essential, and the rate at which COVID-19 has affected them has raised the importance of ensuring access to quality health care coverage – not only in Los Angeles, but across California and the nation,” said Cástulo de la Rocha, President and CEO of AltaMed Health Services. “The funds provided by this legislation will help close gaps in coverage by making it more affordable, enabling our communities to get covered and stay covered.”

- **Holding health carriers accountable** – Covered California is also encouraging its 11 health carriers to invest in marketing and outreach to identify “off-exchange” consumers, and those who have been recently priced-out of coverage, to let them know that they are now eligible for new financial help. Covered California was joined at its announcement of its approach by three of the CEOs of its contracted health plans who committed to lean-in to foster the broadest enrollment possible:

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“This is the right action at the right time. The American Rescue Plan will provide needed resources to those communities most impacted by COVID-19, including communities of color and low-income families,” said Greg Adams, Chair and CEO of Kaiser Permanente. “This is the biggest step to making health care coverage real for all Americans since the Affordable Care Act was passed. Kaiser Permanente will do our part to ensure cost is not a barrier to coverage that all Americans deserve.”

“An effort like this requires coordination and teamwork, and Anthem is proud to be working with all of our states to make this successful,” said Gail Boudreaux, President and CEO of Anthem, Inc. “We’re committed to the successful implementation of this effort and we will be working with our partners to ensure all eligible Americans take full advantage of the new financial help available to them.”

“Blue Shield of California is committed to this effort because it is core to our non-profit mission to achieve universal health care coverage and it is the right thing to do at a time when so many Californians need that protection,” said Blue Shield of California President and CEO Paul Markovich. “We’re excited to work with Covered California to reach out to people in every region of the state who need coverage and those who could save money by switching to a similar plan on the Covered California exchange.”

“Covered California has deployed these tactics and strategies over the past seven years, and they are critical to making things work,” Lee said. “We stand ready to do everything we can to make the American Rescue Plan successful for as many Californians as possible, and we hope and expect the federal administration and other states will do the same.”

Californians Can Easily Find Out Their Benefits

Covered California will launch a new “Shop and Compare” tool on April 12 that will allow consumers to easily see exactly how they will benefit from the new law. People will be able to see how much new financial help they are eligible for in just a few minutes by entering their ZIP code, household income and the ages of the people in the household.

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

- Visit www.CoveredCA.com.
- Get free and confidential assistance over the phone, in a variety of languages, from a certified enroller.
- Have a certified enroller [call them](#) and help them for free.
- Call Covered California at (800) 300-1506.

Exhibits

- Attachment 1 - [Covered California's Approach to Promoting the American Rescue Plan: Target Groups and Strategic Approaches](#) (Word)
- Attachment 2 – [Covered California Announces American Rescue Plan Roadmap to Lower Premiums and Help Millions Get Covered](#) (PPT)
- Attachment 3 - [Landscape of the 25 Million Americans Eligible for New Assistance](#) (Excel)

About Covered California

Covered California is the state's health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

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

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Attachment 1.
Covered California's Approach to Promoting the American Rescue Plan: Target Groups and Strategic Approaches

March 18, 2021

This document summarizes Covered California's strategic framework to promote insurance enrollment to target populations that will benefit from the American Rescue Plan's individual market health insurance affordability provisions. Estimates of the target populations in California are included for reference at the end of the document and more details on estimates for California and nationally are provided in a separate excel document. In virtually all cases, the strategic approaches could be adopted, with adaptation for differences in market-mix and carriers by the Federally Facilitated Marketplace or State Based Marketplaces and by carriers across the nation.

The Target Groups Who Benefit from the American Rescue Plan

Covered California will promote enrollment to the following target consumer segments. Additional detail on the target populations are provided in Table 1. California's American Rescue Plan Key Target Populations, at the end of this document, and in Attachment 2. Landscape of 25 Million Eligible for the American Rescue Plan (which includes both eligible population data for every state and potential marketing spending).

- 1. Currently Uninsured:** Uninsured individuals who can now benefit from much lower premiums are primary targets for outreach. In many cases these individuals do not believe they can afford coverage, which is why the Congressional Budget Office (CBO) projects that only 10 percent of those eligible will enroll. CBO also projects that some of those uninsured and individuals who would otherwise have insurance coverage through COBRA will enroll for subsidies because of the greater benefits available to them if they receive any income from Unemployment Insurance. Enrollment of the uninsured requires aggressive outreach and communications. Based on pre-pandemic data, which is the most current available, California has approximately 1,220,000 uninsured Californians who were eligible for subsidized coverage, with 990,000 earning less than 400 percent of the Federal Poverty Level (FPL) and 230,000 earning more than 400 percent FPL. For the average household earning less than 400 percent FPL they would receive over \$790 per month to reduce the costs of their premium and those making over 400 percent FPL would receive over \$460 per month.
- 2. Individual Market Insured Not Through Covered California – Eligible for Subsidies:** Covered California estimates there are currently about 590,000 Californians who purchase insurance “off-exchange” – enrolling directly with insurance carriers.¹ Almost all these insured Californians are enrolled with health plans that are Qualified Health Plans offering products through Covered

¹ This estimate is based solely on income. Insured individuals will have to meet all eligibility requirements – including citizenship and immigration requirements and requirements related to offers of other minimum essential coverage – to qualify for subsidies through Covered California.

California – with most of that coverage in “mirrored products” (identical in benefit designs and networks to the products with Covered California). About 68 percent of the off-exchange enrollees are eligible for premium tax credits to lower their monthly premiums: an estimated 210,000 make less than 400 percent FPL (and could now receive on average \$790 per month) and 220,000 earn more than 400 percent FPL (and could now receive on average \$460 per month per household).

3. Covered California Enrollees – Currently with and Without Subsidies:

Covered California 1.5 million current enrollees fall in five groups of consumers who can potentially benefit from the increased financial help provided by the American Rescue Plan. In the case of all consumers in the first four groups – for whom their eligibility information is known and have completed an application – Covered California will automatically adjust their coverage, lowering their costs and informing them of the opportunity to adjust or change their plan if they chose. The last group – those who did not complete a full eligibility application – will be contacted to encourage them to complete their application: These five groups are:

- **Covered California Enrollees Receiving ACA Subsidies:** There are about 1,270,000 consumers who are currently receiving federal subsidies and will now be eligible for increased tax credits to lower their costs. About half of those individuals are also now receiving California state-subsidies that lowered their costs in 2020 and in the first few months of 2021, but the American Rescue Plan subsidies are larger and will take the place of the state subsidies.
- **Covered California Enrollees Earning More than 400 percent FPL Receiving State Subsidies:** There are about 40,000 consumers who earn over 400 percent FPL and are receiving the California state subsidies that provide support based on income for those earning between 400 and 600 percent FPL. All of these individuals benefited from lowered health care costs in 2020 and in the first few months of 2021, but the American Rescue Plan subsidies are larger and will take the place of these state subsidies.
- **Covered California Enrollees Earning More than 400 percent FPL Who Will Now Receive American Rescue Plan Subsidies:** There are about 65,000 consumers who earn over 400 percent FPL and completed an eligibility application for subsidies and were not previously eligible for either the federal or state subsidies, but – based on their completed application – will now be eligible for the American Rescue Plan subsidies.
- **Covered California Enrollees Who Earned Income from Unemployment Insurance in 2021:** There are an estimated 130,000 Covered California enrollees who reported they had received Unemployment Income in 2021. Many of these individuals are eligible for higher subsidy levels.
- **Covered California Enrollees Who Did Not Complete an Application for Financial Assistance:** There are approximately 140,000 consumers who are enrolled through Covered California but are not receiving subsidies, either because they declined them or because they need to provide more

information to confirm their eligibility. These consumers will need to be informed to take action in order to benefit from the new financial help.

Covered California's Three Strategic Approaches

Covered California's three key strategies to promote enrollment are designed to complement and reinforce each other. They are:

1. Establish a New American Rescue Plan Special Enrollment Period to Maximize Enrollment: Covered California is having the period start on April 12th and last through the end of 2021

The first step to support the new and expanded subsidies is to declare a *new* special-enrollment period (SEP). Establishing a new special enrollment period highlights and promotes the fact that premiums can be far less than they were before and encourage uninsured consumers to “check again.” The only way uninsured consumers will shop and check again to see if coverage is now affordable is to relentlessly “sell” that cost-saving benefits are on the table for the taking.

Given Covered California is having the American Rescue Plan special-enrollment window run through the end of 2021, this longer period allows the needed lead time to develop and implement a paid marketing campaign that is essential to reach the uninsured.

Covered California is on track to implement technology to support new subsidies in early April so that new and existing members will be able to receive the enhanced subsidies starting May 1.² We are paying special attention to assuring that coverage will take effect at the earliest possible effective date. While existing Covered California subsidized enrollees will be able to benefit from the enhanced subsidies for all months of 2021 – with those months not appearing in lower monthly premiums being paid at tax reconciliation – individuals who are currently insured off-exchange or uninsured are not eligible for “retroactive” benefits and will have to sign up for exchange coverage and receive the lower premiums on a go-forward basis. Covered California will allow new enrollees to sign up through the last day of the month for coverage effective on the first day of the next month (e.g., April 30 for a May 1 effective date).

A longer Special Enrollment Period is vital to have marketing and other related strategies be as effective as possible. Given the large monthly savings and simplicity of keeping the enrollment period open, Covered California is having the Special Enrollment Period run through the end of 2021.

² Implementation of enhanced subsidies for unemployment compensation recipients will occur later than the implementation of the increased tax credits due to the complexity of implementing this provision in exchange eligibility systems. Enrolled consumers will be informed of this fact and that their benefits will be retroactive to the beginning of their coverage in 2021.

2. Implement Robust Efforts Under Covered California's Control

Covered California will use a variety of marketing, outreach and technology strategies to convert or sign up target populations into subsidized coverage. Covered California's key strategies outlined below can be easily adapted by federal and state exchanges.

- **Direct communication and automatic transitions for enrolled members.** Covered California has already begun communicating with those it provides coverage that they will be automatically provided with increased subsidies that will lower their monthly premium. Covered California enrollees not receiving subsidies today will be contacted to inform them of the significant savings they can get if they return to Covered California to update their eligibility information.
- **Active outreach to consumers who have had prior contact with Covered California:** Covered California will send letters and emails to “funnel” consumers – those who have previously inquired about coverage and not enrolled – with information about the new benefits and how affordable coverage is within reach. Covered California will also outreach to those who have dropped Covered California coverage in the past year. (Note: for the FFE and some State Based Exchanges it may be important to have a longer reach-back period. Prior to 2020, survey data indicated that less than 10 percent of Covered California members who dropped coverage left without insurance, this increased to 24 percent last year. Exchanges need to decide how far back to go with “win-back” efforts informed by their understanding of the portion of consumers that left and were likely to be uninsured to assess the value proposition of these outreach efforts.)

Covered California is also developing messaging that can be used by health plans to send to their off-exchange consumers. Covered California will share its messaging points with health plans, State Based Exchanges and the federal exchange on communicating the benefits of new subsidies available through the American Rescue Plan.

- **Marketing campaign:** Covered California is developing a marketing campaign to ensure that all eligible consumers are informed of the opportunities to get coverage. The campaign will run for the duration of the stimulus special enrollment period, yet with a heavy emphasis during April, May and June. Covered California is planning a broad marketing campaign for the American Rescue Plan Special Enrollment Period that will include the following:
 - Substantial investments in all major media channels (TV, Radio, Digital, Social);
 - Doing even more than our usual focus to disproportionately target communities of color and low-income communities hardest hit by recession and the pandemic;
 - Developing new creative content – with content released in phases as informed by consumer research; and

- Conducting consumer research specific to the value of new subsidies, “American Rescue Plan” messaging, and addressing time-limited nature – this research will inform media content in June and will likely be used for 2022 Open Enrollment.
- **Effective Partnerships:** Covered California will work with other key public and private partners to promote insurance enrollment among target groups.
 - **Employment Development Department (EDD) – for Californians receiving Unemployment Insurance:** Covered California will continue to work with the Employment Development Department (EDD), California’s unemployment insurance agency, to provide messaging that will be sent by EDD to unemployment compensation recipients.
 - **California Franchise Tax Board – for Californians who paid penalty for being uninsured in 2020:** California’s Franchise Tax Board will share data with Covered California to enable direct outreach to penalty payers. Covered California will develop material to make penalty payers aware of the new subsidies and the stimulus special enrollment period.
 - **California Department of Health Care Services – for Californians leaving Medi-Cal coverage:** Covered California will partner with Department of Health Care Services, California’s Medicaid Agency, to plan for the expected influx of newly eligible individuals coming from Medicaid when the public health emergency is lifted.
- **Provide effective support to agents and navigators:** Covered California will work with its 10,000 certified agents and almost 100 directly funded navigator partners and subcontractors in a highly focused campaign to quickly build partner awareness and understanding of the many advantages of the American Rescue Plan for consumers. The outreach and communications plan will vary in intensity based on the enrollment channel partner’s potential but includes some or all of the below initiatives.
 - American Rescue Plan specific courses, content, and educational broadcasts
 - Live events, meetings, and webinars
 - Consumer-facing tools and templates
 - Enroller toolkits and job aids
 - Program to distribute enrollment opportunities
 - Messaging and tools to support “win-back” enrollment of individuals previously insured
 - Navigator tools and targeted additional resources to support in-the-field outreach and educational activities
 - Reports and dashboards to provide enrollment efficacy feedback
- **Develop and regularly articulate clear messaging to support enrollment, including framing and linkage to state and national response to COVID:** Public messaging and framing of the American Rescue Plan plays an

essential role in developing broad understanding and awareness of the important benefits it will provide to millions of Americans and how it is a critical element of state and national response to the pandemic and keeping all of us on the path to recovery.

In its developmental stage, the central message revolves around the transformational nature of the subsidies to make coverage even more affordable and bring it within greater reach of millions of Americans. Key focus areas speak to:

- The impact to both uninsured *and* those who are already insured and who stand to significantly gain from new subsidies they now are eligible for;
- How the American Rescue Plan addresses the economic impact of the recession and economic equity, taking us a step forward in addressing longstanding barriers faced by working families and communities of color who have struggled economically and also have been disproportionately impacted by COVID-19; and
- How the American Rescue Plan builds on the Affordable Care Act in ways that we have not seen since its inception bringing us closer to fulfilling the promise of coverage and the law itself.

3. Ensure Contracted Health Plans Maximize Enrollment of Those Subsidy Eligible

Covered California will work to ensure that health plans make consumers aware of the new benefits and are encouraged to take the necessary action to get the new higher subsidies by completing eligibility applications and, where eligible, switching to exchange coverage. Covered California will hold its eleven contracted health plans accountable to reach out to all target groups. Covered California expects health plans to actively promote the benefits of the American Rescue Plan in a variety of ways.

- **Convert eligible off-exchange membership into Covered California.** Health plans are expected to partner with Covered California to notify all off-exchange enrollees about the new benefits, assist all consumers in completing eligibility applications and providing enrollment support to get subsidized coverage. As part of their efforts to convert off-exchange members, health plans will be expected to assist members in transitioning their coverage including, for example, transferring amounts accrued to deductibles, reassigning primary care providers and reauthorizing treatments. Finally, health plans and exchanges need to work together to ensure that agents do not lose their “delegation” for consumers enrolled off-exchange when they convert to marketplace coverage.
- **Engage in marketing and outreach activities.** Health plans will be expected to spend on marketing and outreach activities to convert off-exchange members as well as to broadly promote the stimulus benefits and associated special enrollment period.

- **Support agents in converting off-exchange members and signing up new members.** Health plans will be expected to work with agents to ensure that they have the tools they need to participate in converting their clients to exchange coverage. They will also be expected to continue their efforts to assure adequate commissions.

- **Covered California will support and coordinate efforts with its contracted health plans:** to ensure contracted plans are successful, Covered California will support health plan efforts through a range of technology, outreach and policy initiatives to maximize the uptake of the new subsidies among existing insured and the uninsured, including:
 - **Enabling technology and policies to effectively convert off-exchange members:** Covered California is exploring technology solutions that health plans will be able to use to facilitate off-exchange enrollee transfer into subsidized exchange coverage. These solutions would leverage Covered California’s application infrastructure but would limit plan display to only show products offered by the consumer’s health plan. Covered California is assessing how best to develop a microsite of its enrollment system that would support health plans in seamlessly converting off-exchange consumers to subsidized coverage with Covered California. To the extent it uses this technology, Covered California will develop appropriate consumer-first guardrails and solutions will be implemented on a temporary basis to run the course of 2021 and 2022, with evaluation to understand consumer outcomes and business impacts.
 - **Communicating benefits to members:** Covered California will work with health plans to develop outreach material for off-exchange consumers to inform them of the new subsidies and motivate them to act.
 - **Coordinating with advertising and promoting appropriate investments by Qualified Health Plans:** Covered California has communicated its expectation that health plans invest at least 0.6 percent of gross premiums on marketing AND that at least half of that expense is on “direct response” advertising that includes a call-to-action for consumers to enroll, that they can save money and where to go (in contrast to “brand” marketing which focuses on Whatever Health Plan “is good”). Covered California is actively working with its health plans to do expanded marketing both for the period from April to June 2021 and for the 2022 Open Enrollment Period.

Table 1: California’s American Rescue Plan Key Target Populations

TARGET POPULATIONS	ESTIMATED ELIGIBLES	
	Covered California	Medi-Cal
1. Uninsuredⁱ	1,220,000	950,000
<400% FPL	990,000	N/A
>400% FPL	230,000	N/A
Target populations at risk of being uninsured		
<i>Unemployment compensation recipientsⁱⁱ</i>		
New monthly	24,000	5,000
Total	535,000	106,000
<i>Monthly disenrollment from commercial coverage (pending)ⁱⁱⁱ</i>		
<i>Monthly Medi-Cal transitioners (starting early 2022)^{iv}</i>		
Redetermination at end of public health emergency	520,000	N/A
Monthly flows	43,000	N/A
2. Insured individuals who need to take action to receive subsidies (data at individual level)^v		
Off-exchange enrollees	580,000	N/A
<i>By Off-exchange line of business</i>		
Mirror (includes mirror-like no-load Silver plans)	310,000	N/A
Non-mirror	130,000	N/A
Grandfathered	140,000	N/A
<i>By FPL</i>		
<400% FPL (avg household subsidy \$800/month)	300,000	N/A
400-600% FPL ((avg household subsidy \$690/month)	150,000	N/A
>600% FPL (avg household subsidy \$500/month)	130,000	N/A
Covered California unsubsidized enrollees	140,000	N/A
3. Covered California subsidized enrollees^{vi} - no action required	1,400,000	N/A

Data Notes and Sources

ⁱ KFF estimates of the uninsured eligible for marketplace coverage by state. FPL distributions represent the national breakdown of 72% under 400% FPL, and the remaining 28% above 400% FPL. Estimates may be overstated by the inclusion of those with an offer of ESI. We assume that 58% of the over 400% FPL uninsured will be eligible to receive APTCs, an estimate we take from the share of off-exchange consumers with incomes above 400% FPL estimated to be subsidy-eligible. At this time, we do not have better estimates of the uninsured population to adjust this estimate.

McDermott, D. Cox, C. Glaxton, G. Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach. Kaiser Family Foundation. January 27, 2021. <https://www.kff.org/report-section/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach-appendix/>

Medi-Cal eligibility includes those who are eligible for restricted scope Medi-Cal: Kaiser Family Foundation. Distribution of Eligibility for ACA Health Coverage Among Those Remaining Uninsured as of 2019. <https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

ⁱⁱ California EDD Individuals Paid Benefits Total. <https://edd.ca.gov/newsroom.htm>. Totals are adjusted based on Census Pulse Survey Data, to show the share of individuals in California that reported using UI benefits in the past week, and reporting being uninsured or no other source of insurance (excluding those with public or private insurance). Health Table 3: <https://www.census.gov/data/tables/2021/demo/hhp/hhp23.html>. Micro Data from the Week 23 PUF was used to estimate the breakdown of UI recipients without a reported source of coverage by whether their household income was above or below 138% FPL, to estimate the distribution of those eligible for Covered California or Medi-Cal.

ⁱⁱⁱ Data will be provided by commercial carriers to Covered California as required by SB 260. Current estimates take EDD new monthly unemployed in December 2020 (<https://edd.ca.gov/newsroom/unemployment-december2-2020.htm>), and assume that 48% had ESI, from Commonwealth Fund analysis of BLS data (<https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic>). Using UC Berkeley Labor center analysis of Californians with ESI at risk of job-loss, by FPL levels, we assume 8% of the newly monthly unemployed have incomes that make them eligible for Medi-Cal, and the rest will be eligible for exchange coverage (<https://laborcenter.berkeley.edu/health-coverage-ca-workers-at-risk-of-job-loss-covid-19/>).

^{iv} SB 260 will require Covered California to automatically enroll Medi-Cal transitioners into the lowest cost silver plan available to them.

Current estimates use the historical average share of monthly Medi-Cal enrollees subject to annual eligibility renewal, and the share of those that are found ineligible for Medi-Cal, as released by DHCS. These average rates are applied to the monthly 2020 Medi-Cal total enrollment for estimates on the share that had paused redeterminations during the Public Health Emergency. Redeterminations are likely higher, as Medi-Cal enrollment continues to grow in 2021 and potential economic expansion could increase the share that are ineligible for MAGI Medi-Cal.

^v Totals and APTC estimates based on modeling a hypothetical population of off-exchange enrollees weighted to estimated off-exchange FPL and issuer distributions. Distribution of income among off-exchange enrollees assumes 38% with incomes under 400% FPL, 23% 400-600% FPL, and 39% with incomes greater than 600% FPL. Estimates based on QHP issuer submissions, CalSIM & NHIS data, & Fung et al. "Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance," *Health Affairs* Vol 36.1 (2017) 21-31. Distribution of mirror, non-mirror, and grandfathered plans based on 2019 QHP issuer submissions.

^{vi} Covered California effectuated enrollment.



California Policy Perspectives on Association Health Plans

Association health plans (AHPs) are insurance arrangements that allow small businesses, associations, and self-employed workers to organize together to purchase health care coverage, potentially obtaining lower-priced coverage by spreading risk and negotiating on behalf of a larger set of enrollees. Recent federal regulatory changes have expanded the definition of AHPs to reduce the requirements and conditions under which such entities could form, while also bypassing the coverage requirements specified in the Affordable Care Act (ACA). In response, many states have issued regulations that seek to mitigate the effects that AHPs could have on other insurance products and to reinforce the consumer protections that the ACA requires.

This brief examines these developments and the current market for AHPs in California, including a related expansion of less-regulated professional employment organization (PEO) insurance products. Interviews with current market participants and observers suggest a potential need for additional oversight of both AHPs and PEOs. Absent such oversight, the spread of coverage products not fully compliant with the consumer protections codified by the ACA may lead to adverse risk selection and undermine the functioning of individual and small group markets both within and outside the Covered California health insurance exchange.

Background and Legislative History

Under federal law, AHPs are a type of multiemployer welfare arrangement (MEWA) established or maintained to provide insurance coverage for medical, surgical, hospital care, or other benefits in the event of sickness.¹ The National Association of Insurance Commissioners (NAIC) holds that states have regulatory authority over both fully insured and self-funded MEWAs, with the ability to regulate, among other things, the terms of the insurance

contract, the rates the insurer charges, and the sales practices and personnel used by the insurer.² AHPs are often fully insured because state insurance laws may establish reserve requirements for self-funded MEWAs.

AHPs have long been offered and regulated in the state of California. In 1992, State Assembly Bill 1672 set forth requirements for small group reform that applied to AHPs, including criteria for guaranteed issue, standard rating rules, defined risk corridors, specific age bands, and the number of geographic regions for the small group insurance market (see sidebar on page 2).³ In effect, AB 1672 created a pre-ACA small group insurance exchange, with products that included the Health Insurance Plan of California and its successor, PacAdvantage, along with several AHPs that included sole proprietors who would have otherwise been eligible for individual market products only.

While AB 1672 did not set insurance rates, it did require health plans to establish a standard premium rate, around which they could assign a “risk adjustment factor” that would price small groups up to 10% above or below the standard rate. However, plans were not required to price products of a similar benefit design at the same level inside and outside the exchange, which contributed to a higher-risk mix inside the exchange over time. A key lesson learned was that purchasing pools cannot be required to follow more stringent rules in the marketplace, or they will be adversely selected against.⁴

In 2010, the Affordable Care Act changed the rating rules and benefit coverage requirements in the individual and small group markets, and led to the establishment of the California Health Benefit Exchange, later named Covered California. Through Covered California, individuals and employees of participating small businesses can enroll in subsidized and unsubsidized health coverage. The

California Definition (AB 1672)

“Guaranteed association” means a nonprofit organization composed of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria that:

- ▶ Includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (q)
- ▶ Does not condition membership directly or indirectly on the health or claims history of any person
- ▶ Uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association
- ▶ Is organized and maintained in good faith for purposes unrelated to insurance
- ▶ Has been in active existence on January 1, 1992, and for at least five years prior to that date
- ▶ Has been offering health insurance to its members for at least five years prior to January 1, 1992
- ▶ Has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members
- ▶ Offers any purchased benefit plan design to all individual members and employer members in this state
- ▶ Includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments
- ▶ Covers at least 1,000 persons with the carrier with which it contracts

ACA phased in other insurance market requirements, including:

- ▶ Penalties for individuals who did not have coverage and employers who did not offer it
- ▶ A minimum set of essential health benefits
- ▶ No preexisting condition exclusions
- ▶ No annual or lifetime coverage limits
- ▶ Rating restrictions that reduced the permissible ratio of premiums across age bands

For example, age-rated bands established that premiums for the oldest group, 60- to 64-year-olds, cannot exceed three times those of younger adults. While this policy resulted in lower premiums for people age 60 to 64, it also meant higher premiums for younger people. As a consequence, the three-to-one ratio encouraged creation of AHPs that market to younger people because a product covering a younger demographic would cost less per person than one offered through Covered California or directly from carriers. Concerns over the potential for AHPs to destabilize the risk mix in the small group market in turn spawned new legislation and regulations at the state level with considerable variability in the oversight of AHPs.⁵

Meanwhile, efforts to unwind key provisions of the ACA manifested in a variety of ways. In 2018, the US Department of Labor (DOL) finalized a new regulation for AHPs that made it easier for small employers to organize for the purpose of accessing health insurance typically available only to large groups. Previously, the DOL allowed those with a shared industry or business interest to be treated as a single employer and avoid certain plan restrictions applicable to small employers. The “shared industry or business interest” requirement made it attractive for groups in life sciences, education, and technology to aggregate for the purpose of obtaining health insurance as a large group. Such groups would have more favorable rates based on demographics and direct underwriting than if they accessed insurance through the small group market that was community-rated.

The new rule also allowed for the formation of associations among small groups with a “commonality of interest” — such as geographic collocation — to purchase health insurance collectively. Working owners without direct employees were also permitted to participate in these type of AHPs. In the past, self-employed workers such as independent contractors were not permitted to participate in ERISA (Employee Retirement Income Security Act) plans that were underwritten as group coverage. The AHP rule allowed sole proprietors and small employers to more easily organize to form AHPs and buy health care coverage in the large group market. The rule expanded the circumstances under which an AHP could be considered a single employer, relaxed the standards for forming an AHP, and treated sole proprietors as both employers and “employees” so they can qualify as small employers.⁶

These changes were very controversial. Diverse stakeholders including regulators, health plans, health policy advocates, and consumer organizations weighed in actively in 722 comment letters on the new regulation, Definition of Employer – Small Health Plans RIN 1210-AB85.⁷ Many cited the troubled history of fraud, rate insufficiency, and instability among MEWAs.⁸ Others voiced concerns about the destabilizing effect of “skinny” health plans designed to cherry-pick favorable risk while putting consumers at risk for coverage gaps and limitations on benefits that were previously defined as essential health benefits under the ACA.

Opponents of the DOL rule argued that such plans would create adverse selection by driving higher-risk individuals into the state or federal health insurance marketplace options, increasing costs and ultimately undermining the stability of those risk pools. Premiums for the small group market are determined by a community rating methodology whereby the claims experience across the small group segment is pooled to determine health insurance premiums and annual rate increases.⁹ Opponents of the rule argued that an AHP could bypass the community rating process by qualifying as a large group that is rated separately based on its own claims experience, much as a large business or government entity would operate.

Meanwhile, proponents of the DOL rule argued that AHPs promote competition in increasingly consolidated insurance markets and provide more affordable options in the face of ever-escalating and unaffordable health insurance premiums. By allowing a more restrictive benefit design, such plans could also be attractive to small groups with a lower-risk profile. Such groups could design products that do not cover the essential health benefits as required for individual and small group plans under the ACA but instead comply with less stringent ERISA consumer protections. In so doing, new products could be designed with a lower actuarial value — that is, offering less protection to the consumer, and therefore be lower cost — than plan designs fully compliant with the ACA.

Recent AHP Regulation in California and Other States

In response to the new DOL rule, the California legislature passed Senate Bill 1375 in 2018 to protect the state’s individual and small group markets from potential adverse selection by specifying that the status of each distinct member of an association shall determine whether that member’s association coverage is individual, small group, or large group health coverage.¹⁰ For example, if an AHP includes 10 individuals or working owners/proprietors, three small businesses, and one large employer, the individuals would then be subject to the individual market products and rates, the small businesses would have access to the small group products, and the large employer would be underwritten based on demographics, service industry code, and claims history.

California’s Department of Managed Health Care (DMHC) issued additional regulations to health plans to limit the expansion of AHPs.¹¹ Beginning July 1, 2020, all association health plans must cease renewing existing large group contracts that include small employers. DMHC subsequently issued a second All Plan Letter (APL 20-031) to extend the AHP phase-out period to February 28, 2021, in response to the COVID-19 state of emergency.¹²

Although the future of the federal AHP rule is unclear, California law still takes precedent insofar as the Department of Labor has not changed states' authority to regulate MEWAs, including AHPs. The NAIC notes that while the DOL requested comments on potential MEWA exemptions from state regulation, the preamble to the final AHP rule indicated that the DOL views this

exemption authority as "a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule."¹³ Many states have acted swiftly to implement oversight of AHPs and to provide consumer protections, as summarized in Table 1.¹⁴

Table 1. Beyond the Federal Minimum Standards: Key Approaches States Are Taking to Regulate AHPs Under the New Pathway

POLICY OPTION	DESCRIPTION	STATES		OBJECTIVE
		FULLY INSURED AHPs	SELF-FUNDED AHPs	
Prohibit new AHPs.	New AHPs are entirely prohibited, or are prohibited from forming under the easier-to-satisfy standards of the new rule.	None	California, Washington	Reduce risk of AHP fraud and insolvency.
Require associations to satisfy additional standards before they may market health coverage.	Require that an association be formed for a purpose other than offering insurance, or be in existence for a minimum number of years, before it may market coverage.	Indiana, Iowa, Kansas, Maryland, New York, Pennsylvania, Vermont	Indiana, Iowa, Kansas, Maryland, Michigan, New York, Pennsylvania	Reduce risk of AHP fraud and insolvency.
Maintain the "look through" approach.	For purposes of determining whether association coverage is part of the individual, small group, or large group market — and therefore, which insurance rules apply to it — regulators "look through" the association and focus on its underlying members, classifying coverage based on the size of each member. That is, coverage sold through an association to individuals is part of the individual market risk pool and must comply with individual market standards, while coverage sold to small businesses is part of the small group market risk pool and must comply with small group market standards.	California, Connecticut, Kansas, Maryland, New York, Pennsylvania	Connecticut, Maryland, New York, Pennsylvania	Maintain a level regulatory playing field. Coverage sold to individuals and small businesses must follow the same rules, whether or not purchased through an association.
Do not classify a sole proprietor as a "group" for purposes of AHP enrollment.	Sole proprietors must use the traditional individual insurance market to obtain coverage and cannot qualify as a "small employer group" to join an employer-based AHP.	California, Connecticut, Kansas, New York, Pennsylvania	Connecticut, New York, Pennsylvania	Maintain a level regulatory playing field. Coverage sold to individuals must follow the same rules, whether or not purchased through an association.
Require self-funded AHPs to meet commercial licensure requirements.	AHP must satisfy the same licensure and financial standards as commercial insurers.	—	Alabama, Connecticut, Louisiana, Maryland, New York, Pennsylvania	Reduce risk of AHP fraud and insolvency.

Source: Kevin Lucia, Justin Giovannelli, and Sabrina Corlette, "In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets," *Commonwealth Foundation Blog*, November 27, 2018.

Furthermore, 11 states (including California) and the District of Columbia sued the Department of Labor, and a federal court struck down much of the federal AHP rule. The Department of Labor appealed in April 2019, and that case is still pending. The amicus briefs and court testimony document the concerns about risk segmentation in the small group market, potential for fraud and unfunded MEWAs, and the need for consumer protections.¹⁵ The Biden administration could issue new guidance, or there could be a court decision that affects the AHP rule.

AHPs in California: Current Landscape and Evolving Products

Current Landscape

Regardless of recent federal and state legislation and litigation over AHPs, reviews of DMHC filings and interviews conducted for this brief suggest they remain an enduring and evolving component of California’s health insurance coverage landscape. As of 2019, approximately 83 MEWAs, representing 151,000 enrollees, reported their enrollment data to state regulators. Commonly represented industries included agriculture, construction, education, food services, publishing and print organizations, real estate, and restaurant workers. A number of these organizations are represented by a single educational labor trust, professional employment organizations, industry-centric trusts, and brokerage firms. Some of these organizations operate as a voluntary employee beneficiary association, or VEBA (voluntary employees’ beneficiary association) trust. It should be noted that some industries, particularly construction, organize as AHPs to improve purchasing power for worker compensation coverage, which can be more costly than medical insurance plans.

Of the membership reported to DMHC, approximately 49,500 are enrolled in HMO products, 1,700 in POS (point of service) products, and 99,500 in PPO (preferred provider organization) products. The vast majority of MEWAs are underwritten by Anthem Blue Cross, with a limited number spread across additional carriers, as shown in Table 2. Table 3 shows the distribution by industry types.

A review of benefit design information available on public websites revealed a range of benefit designs, with PPO products reflecting a wide range of deductible levels. Among the publicly available benefit summaries, there did not appear to be significant adoption of non-ACA-compliant benefit designs.

However, the lack of transparency requirements for benefit designs offered through AHPs can place consumers at risk in selecting health plans that may have unexpected benefit exclusions or which are otherwise not compliant in offering the essential health benefits required by the ACA. Additionally, there are national organizations with endorsed relationships with franchise-based entities in California, but which appear not to report enrollment data to DMHC.

Table 2. MEWA Volume, by Carrier as Reported to DMHC

Aetna Health of California	4
Blue Cross of California (Anthem Blue Cross)	60
California Physicians’ Service (Blue Shield of California)	6
Health Net of California	6
Kaiser Foundation Health Plan	3
Sistemas Medicos Nacionales	1
Western Health Advantage	3

Table 3. MEWA Volume, by Industry Type

Agricultural	4
Arts/Entertainment	3
Construction	6
Education	26
Insurance Agents / Real Estate	8
Law	1
Miscellaneous	9
PEO (tech, life sciences, general)	11
Printing	3
Restaurant/Brewery	9
Technology	3

Interviews conducted for this brief suggest that AHPs in California typically offer two to four benefit designs with different point-of-service cost-sharing levels that vary with employee and family insurance premium contributions. An illustrative example includes “the Producers’ Health Benefits Plan” underwritten by Anthem Blue Cross, which offers the following four products:

- ▶ **Modified Classic HMO** with a \$10 primary care copay, \$30 specialty care, and \$250 inpatient copay per admission, with no out-of-network coverage
- ▶ **Modified Classic PPO** with a \$30 primary care / specialty copay, 20% co-insurance for other services, \$500 individual / \$1,000 family deductible, with higher cost sharing for out-of-network providers
- ▶ **Modified Classic Premier PPO** with a \$25 primary care copay, 20% co-insurance for other services including inpatient, and \$500 individual / \$1,000 family deductible, with higher cost sharing for out-of-network providers
- ▶ **Custom Anthem PPO HSA** with a \$2,700 single, \$2,800 per member, or \$5,400 per family deductible, 20% co-insurance for other services, and 50% for select services such as durable medical equipment

Other associations such as the California Association of Realtors (C.A.R.) offer a broader array of plans. Within Kaiser, C.A.R. Insurance Products offers three Bronze plans, five Silver plans including an HSA-qualified high deductible health plan, four Gold plans and two Platinum plans. Its Anthem PPO offerings include seven Bronze plans, six Silver plans, four Gold plans, two Platinum plans; its Anthem HMO coverage products include two Silver and two Gold options. The Restaurant Industry Health and Welfare Trust Fund offers five Kaiser options, including HMO plans with deductibles, and eight Anthem product coverages with varying provider network options.

Evolving Products

With the regulations and All Plan Letters issued by the DMHC, Blue Shield of California and Kaiser Foundation Health Plan indicate they no longer sell coverage for AHPs. Other health plans, however, maintain existing relationships or provide exemptions for these programs in their large group business. Additionally, some AHPs are organized out-of-state, but are offered through franchise businesses; it is unclear whether such entities are subject to California regulations. To extend their operations, some AHPs (or their broker of record) offered their membership early renewal packages as of October 2020 to extend coverage beyond the date specified in the DMHC’s initial advisory, APL-19-024. Other workarounds are potentially more troubling.

Stakeholders interviewed for this study expressed significant concern about oversight of AHPs that elect to self-fund and thereby assert ERISA exemption. Several pointed to well-documented cases of AHPs that lacked sufficient capital or underbid their premium rates to attract membership, only to go bankrupt due to excess claims or unpredicted high-cost claimants.¹⁶ One practice entails developing a competitive pricing structure, supported by reinsurance for high-cost claimants that can end up being inadequate for the volume of claims. Even though such an approach may provide near-term financial protection for an AHP, it is not sustainable if the reinsurance carriers refuse to underwrite future rating cycles.

A review of current California product offerings also suggests that brokers and associations have introduced other workarounds, such as the use of a wholly owned “captive insurer” to shield AHPs and their participants from premium fluctuations due to high-cost claimants. This takes place when a group of small employers pool their memberships to obtain a combined large group rate (i.e., self-funding) while separately contributing to a fund that provides a hedge against high-cost claimants. In such an arrangement, the association or risk-bearing entity may record a profit within that captive in a year with lower-than-expected claims volume or dollars; however, stakeholders noted that additional oversight of funding adequacy may be needed to ensure stability in an environment with higher-than-expected claims.

Key informants suggest captives may also be used to good effect. In some markets, the use of a captive could enable a group of small employers to come together and enter into direct-contracting relationships with select providers, implement targeted complex case management programs to manage population health and high-risk individuals while also adopting innovative benefit designs, such as reference pricing or centers of excellence, to steer members to higher-performing providers that the small groups would not otherwise have access to.¹⁷ Gainsharing or risk sharing based on the captive's performance can also be established to assure equitable treatment of participants. To support financial stability of the pool, such a conglomeration of small businesses might purchase additional stop-loss insurance from a reinsurance carrier, which would further fragment the risk pool.

Several stakeholders have noted with concern the reinvention of AHPs as professional employment organizations (PEOs). The California market has seen a proliferation of PEOs that qualify to offer large group insurance. Some of the existing California AHP websites are now promoting additional services as PEOs, whereby a small business purchases payroll, ancillary or voluntary benefits, or other human resources services. Legally, small businesses entering into a PEO relationship assume a dual-employment relationship such that the PEO becomes the employer of record. As a result, the PEO may qualify as a large group for purchase of health insurance, workers' compensation, and other services. PEOs can be self-funded or fully insured, and the potential for fraud and abuse that was experienced among some AHPs can be an unintended consequence.

Some states regulate PEOs more strictly than California. As a result, PEOs in California can avoid many of the consumer-friendly ACA regulations, allowing them to operate multiple large group pools with different rating criteria; operate as fully insured, self-insured, or both; collect demographic information and an organizational health history questionnaire; and apply geographic rating factors, among other rating practices. As a result, a small group with individual employees who have preexisting conditions or with women in their child-bearing years is likely to experience a higher premium than a group without such history. While the PEO negotiates an average

premium and total dollar amount with its contracting health plan(s), there is no limit to the number of rating tiers used for its clients, which in effect negates some of the consumer protections that the ACA was designed to provide.

Nationally, there is tremendous variation in how states regulate PEOs, and there may be valuable lessons to be drawn from some of these approaches.¹⁸

- ▶ Some states, such as Maine, require small groups within PEOs to be insured through the state's small group market products.¹⁹
- ▶ In Connecticut, PEOs are required to register with the state with disclosure of information about ownership, client information (name, address, state Tax ID, state unemployment registration number), financial statements (including minimum working capital of \$150,000), and itemization of group members.²⁰
- ▶ Colorado law provides explicit definitions and scope of a PEO's relationship with its individual clients, requires initial certification and annual operational reporting.²¹
- ▶ Pennsylvania law defines PEO duties and agreements with respect to benefit plans, workers' compensation, and unemployment compensation insurance and requires a broad application with supporting documents.²²

The NAIC ERISA Working Group has added guidance on the definition and role of states in oversight of PEOs, which ultimately depends on whether the PEO is a MEWA. If health coverage is fully insured, a state has the authority to regulate the carrier and establish standards if the PEO is a MEWA. Whether a self-funded benefit arrangement sponsored by a PEO is exempt from state regulation depends on whether the arrangement is an ERISA-covered single-employer plan or a MEWA: "Unlike a traditional employer, the PEO is being paid by its clients to provide this coverage, either as a separate line item or part of a global PEO service fee. Like an insurer, the PEO makes a profit or loss depending on whether the fees are sufficient to pay for the costs of the health plan, and the employer is dependent on the PEO's ability to pay all claims when due."²³

Future State Regulatory Role

There are a number of options for policymakers interested in additional oversight of the market for AHPs and PEOs in California. For example, DMHC's efforts to oversee MEWA activity through a voluntary registration process could be augmented to limit exempting of AHPs to those established before 1992 and compliant with the definition established with the initial California small group reform legislation, AB 1672. Additional disclosure requirements with respect to ownership interests, benefit plan offerings, and enrollment distribution could serve to increase transparency of AHP operations and support consumer protection.

Beyond provisions to sunset AHPs and limiting exemptions that sustain existing AHPs, policymakers in California may learn from actions undertaken by other states to oversee PEOs and evolving AHP-based products. Based on the experience of other states, potential requirements could include:

- ▶ Registration of PEOs with disclosure of ownership, financial solvency, membership, and carrier relationships for health and welfare products, including fees and incentive payments
 - ▶ Financial solvency requirements for stand-alone operations and self-funding
 - ▶ Limitations on the total number of rate tiers within a PEO consistent with state law and/or disclosure of rating tiering structure, rating criteria, and age and demographic bands
 - ▶ Definition of permissible claims history and pre-existing condition history in organization-level or individual-level health questionnaire
 - ▶ Conditions for rating small groups outside the small group market
 - ▶ Transparency requirements on benefit design offerings, including public access to benefit plan options in formats consistent with ACA-required benefit categories
 - ▶ Disclosure of actuarial value and/or proximal alignment with defined platinum, gold, silver, and bronze metal classification depicting benefit coverage levels
- ▶ Requirements for stop-loss levels commensurate with AHP size
 - ▶ Guidance on permissible use of captives and reinsurance

Pending Issues and Federal Policy

The Biden administration has already taken steps to bolster the ACA and counter recent efforts to limit subsidies and incentives to enroll in the federal marketplace and state exchanges. Policy changes could be implemented to reduce potential adverse risk selection issues for the small group market by reversing the expanded definition of AHPs or separately restricting short-term, limited-duration health plans. Additionally, although the US Court of Appeals for the District of Columbia Circuit heard oral arguments in *State of New York v. US Department of Labor*, in November 2019, review of the prior decision that invalidated the DOL rule has not been completed, and it is uncertain whether any court decision will fully address the regulation of AHPs.

Regardless of what happens in the executive, legislative, or judicial branches of the federal government in the next several years, the evolving nature of AHPs and PEOs in California necessitates a close look by state policymakers seeking to maintain the consumer protections established by the Affordable Care Act and to ensure the stability of individual and small group markets throughout the state.

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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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Supporting Insurance Affordability with State Marketplace Subsidies

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As states seek to make health insurance more affordable, they are increasingly looking to state-based subsidies to help Marketplace consumers pay for premiums, cost-sharing, or both. The Affordable Care Act (ACA) has made coverage affordable for millions of Americans, but there is broad recognition that the ACA's subsidies are sometimes not sufficient. In the past two years, California, New Jersey, and Colorado have followed Massachusetts and Vermont in establishing state-based subsidies that supplement the ACA's premium tax credit (PTC) and cost-sharing reductions (CSRs).

The \$1.9 trillion budget reconciliation package was signed into law by President Biden on March 11. This legislation substantially expands the Affordable Care Act's main health insurance subsidy, the premium tax credit (PTC), for 2021 and 2022. It would increase the PTC for those who are currently eligible and also eliminate the eligibility ceiling at 400 percent of FPL. The measure may also be further extended in future legislation. Such a change – especially if extended – would reduce the need for broad-based state premium subsidies, while potentially increasing the importance of cost-sharing subsidies and more targeted premium subsidies. A forthcoming analysis will address considerations of this new law and opportunities for state health policy decision-making.

Archives

SELECT MONTH

This piece reviews key considerations for states exploring Marketplace insurance subsidies.

WHY STATES ARE CONSIDERING STATE-BASED SUBSIDIES

The ACA does not make coverage sufficiently affordable for some consumers. The PTC and CSRs make coverage affordable for millions of Americans, but they do not guarantee universal affordability. The PTC requires some of those receiving it to pay substantial amounts towards the premium; for example, a family of four with annual income of \$80,000 must pay nearly \$7,900 for a benchmark silver plan. The PTC also ends in a cliff at 400 percent of the federal poverty level (FPL), leaving an unsubsidized group without help regardless of the premium they face. CSRs are relatively generous between 100 and 200 percent of FPL (providing coverage with a 94 percent or 87 percent actuarial value (AV)) but much less generous between 200 percent and 250 percent of FPL (73 percent AV) and gone beyond 250 percent. This leaves many families facing deductibles and other cost-sharing large enough to make their coverage difficult to use. For example, in 2021 a family of three with income of \$55,000 receives no cost-sharing assistance, despite an [average family deductible](#) of about \$10,000 for federal Marketplace silver plans. Undocumented individuals and those caught in the so-called “family glitch” also face high costs since they are excluded from both subsidies. These gaps have been especially harmful to [people of color](#) and [immigrant populations](#), who have much higher rates of uninsurance than other Americans.

State subsidies can supplement these federal subsidies to make both premiums and cost-sharing broadly affordable. New Jersey [estimated](#) that about 8 in 10 consumers purchasing coverage on Get Covered New Jersey would qualify for its new premium subsidy for 2021, contributing to a reduction in the average net premium for subsidy-eligible Marketplace enrollees of 29 percent compared to 2020.

State subsidies can help PTC-eligible consumers, who are missed by many other state tools. States have several options for making coverage more affordable for *unsubsidized* consumers. Reinsurance, lower-cost public options, individual mandates, and curbing sub-standard plans can all reduce list premiums, which helps this group. But since the PTC generally adjusts dollar-for-dollar with the list premium, these options alone do not lower net

premiums for PTC-eligible consumers. To help the subsidized group, a state-based subsidy is the most – and perhaps the only – straightforward approach. This group is also [more likely to be uninsured](#) than those with higher incomes, so helping them is key to expanding coverage. More generally, state subsidies are extremely flexible, allowing assistance to be targeted by income, age, geography, or other factors, as discussed in greater detail below.

State subsidies can expand coverage, support the risk pool, and reduce premiums. Making health insurance more affordable has several benefits for consumers and the market overall. It expands coverage: [research from Massachusetts](#) shows that enrollment decisions are highly sensitive to affordability, and the [Urban Institute](#) has estimated that a range of options to make federal subsidies more generous would increase Marketplace enrollment by about 5 million people and reduce the number of uninsured by around 13 percent. Improving affordability also creates savings for current enrollees by reducing their out-of-pocket costs. And finally it attracts healthier consumers, which improves the risk pool and lowers unsubsidized (list) premiums – creating savings for unsubsidized individuals as well.^[1] The Urban Institute estimates that, by pulling in healthier consumers over time, a generous subsidy expansion would reduce list premiums by about 16 percent.^[2] State subsidies might not be as generous as Urban’s options,^[3] but the impact on coverage and premiums could still be substantial.

The experience of states with existing subsidies bears out these benefits. Massachusetts – with the most generous subsidies of any state – has long enjoyed the nation’s [lowest uninsured rate](#) and some of the lowest premiums: in 2017, 2018, and 2019, it had the second lowest premium for [benchmark silver plans](#). The other state with long-standing subsidies – Vermont – has also consistently had among the nation’s lowest uninsured rates. And California has seen promising results from its new subsidy, with [2020](#) bringing a record low premium increase of 0.8 percent and the most new signups during open enrollment since 2016.^[4]

State subsidies can bring federal dollars into the state. To the extent they increase enrollment among state residents who are also eligible for federal subsidies, state subsidies increase take-up of federal subsidies in the state. This brings additional federal dollars to health care providers and licensed insurance carriers in the state, which in turn may increase state tax revenues. The PTC averages more than \$5,000 for each enrollee receiving it. For a

state that increased subsidized enrollment by 50,000 people, that could mean \$250 million in additional federal funding.[5]

DESIGN AND IMPLEMENTATION CONSIDERATIONS

The following considerations may be useful for states exploring how to design and implement a Marketplace subsidy. Figure 1 summarizes design parameters of the existing state subsidies.

Figure 1. Parameters of State Marketplace Subsidies

STATE	YEAR EFFECTIVE	SUBSIDY TYPE	TARGET POPULATION	PREMIUM SUBSIDY CALCULATION	FUNDING SOURCE(S)	NOTES
Massachusetts	2007	Premium and Cost-Sharing	APTC-eligible, income ≤ 300% of FPL	Subsidy schedule related to individual mandate affordability standard, with mini-cliffs between income ranges	Section 1115 waiver; state individual mandate; employer contributions; tobacco taxes	
Vermont	2014	Premium and Cost-Sharing	APTC-eligible, income ≤ 300% of FPL	Reduces PTC applicable percentages by 1.5 percentage points	Section 1115 waiver and general revenues	
California	2020-2022 only	Premium	APTC-eligible, income ≤ 138% and 200%-600% of FPL	Reduces PTC applicable percentages by various amounts	State individual mandate; general revenues	Like the PTC, implemented as an advanceable tax credit with year-end reconciliation
New Jersey	2021	Premium	APTC-eligible	Generally a flat amount that varies across certain FPL thresholds, subject to caps for consumers with little or no expected premium contribution	State health insurer fee	
Colorado	2022	TBD	TBD, but includes money for those ineligible for PTC		State health insurer fee	
Minnesota	2017 only	Premium	QHP enrollees <i>not</i> eligible for APTC	25% of premium	General revenues	Was enacted too late for Marketplace enrollment systems and so was largely administered by carriers

[Click here](#) for a download of the table.

State-Based Marketplace – Offering a state subsidy generally requires operating a state-based marketplace (SBM) to determine eligibility and make upfront subsidy payments to carriers; every existing state subsidy works this way.[6] Determining eligibility at

enrollment is important for two reasons. First, it allows consumers to account for the subsidies in making enrollment decisions, which increases enrollment and helps them choose the best plan to suit their needs. Second, paying subsidies month-by-month addresses potential cash-flow issues consumers would face if they could claim a subsidy only on the back end. These are the same reasons that the ACA's subsidies are granted by the Marketplace and paid out month-by-month. Healthcare.gov performs these tasks for the federal subsidies in states without an SBM, but it currently cannot do so for state subsidies.

Type of Subsidy – State subsidies can help pay for premiums, cost-sharing (deductibles and co-payments), or both.

Massachusetts and Vermont have subsidies for both, while the more recent subsidies in California and New Jersey help with premiums only. Colorado is currently [considering](#) both options for its subsidy, which takes effect for plan year 2022. Each type of subsidy has important benefits. Premium subsidies may be easier for consumers to understand, which could translate into a larger [impact on enrollment](#). Cost-sharing subsidies can address the strikingly large deductibles some Marketplace enrollees must pay, which may especially deter enrollment among healthier consumers who do not think they will see any payout. Both types have proven relatively straightforward to implement, even for a very small state like Vermont. Standing up a premium subsidy may pose somewhat greater challenges for Marketplace operations, while the work of a cost-sharing subsidy falls more heavily in plan management and on carriers.

Target Population – A key benefit of state subsidies is their flexibility in targeting eligibility to specific populations. The state subsidies in effect today are targeted primarily by income level, but targeting is also possible by age group, metal level, geography, and other factors.

Before considering where to target a subsidy, it may be helpful for a state to consider *how much* targeting is desired. The more funding that is available, the more people can get the subsidy while still providing a meaningful benefit. If spreading the available funding over a large segment of Marketplace enrollees would result in a subsidy of just a few dollars per month, tighter targeting may be warranted.

Targeting by Income. Most states focus on targeting by income level. There are several income ranges to consider.

Massachusetts and Vermont both start with those who are APTC-

eligible and then exclude those with incomes above 300 percent of FPL – thereby targeting help to those with the greatest financial need and most likely to be uninsured. The Massachusetts and California subsidies are both sufficient at very low incomes to zero out the premium contribution for a benchmark plan. This addresses the concern that even a small premium may deter those with the lowest incomes from enrolling or may cause them to leave money on the table by enrolling in a CSR-ineligible bronze plan. California and New Jersey’s subsidies extend to those at the upper ranges of APTC eligibility. This group is generally less likely to be uninsured (and of course has higher incomes) than those in the lower APTC range, but they may be a priority since they receive less APTC and little or no CSRs.

Finally, California’s subsidy alone extends eligibility to those with incomes above 400 percent of FPL (about \$52,000 for a single person). This group has lower rates of uninsurance and less financial hardship but can still face unaffordable premiums – especially among older people – because they are ineligible for federal subsidies. These policy considerations aside, states should be aware that extending premium subsidies above 400 percent of FPL generally adds great operational complexity. Specifically, due to interactions with federal subsidies, such subsidies must generally be implemented as an advanceable tax credit with back-end reconciliation (like the PTC itself) rather than as a front-end-only subsidy like the ones in Massachusetts, Vermont, and New Jersey.^[7] Reconciliation comes with substantial operational cost and complexity for state agencies and consumers, as evidenced by the extensive [regulations](#), [tax forms](#), [instructions](#), and [publications](#) that the IRS and California have published to implement their tax credits. Like other administrative complexity, such an approach may pose disproportionate challenges to historically disadvantaged populations, including people of color and those with limited English proficiency. There are also questions about whether a state subsidy at this higher income range might be included in income for federal income tax purposes, which would add additional complexity and potentially affect federal tax liability and eligibility for benefits like the earned income tax credit.^[8] Given these concerns, states that wish to provide relief above 400 percent of FPL might consider doing so through other means, such as a [reinsurance program](#), which is straightforward to implement and can receive federal funding through a Section 1332 state innovation waiver. To provide assistance broadly, a reinsurance program can be implemented

alongside a state subsidy, as in New Jersey and soon Colorado.

Regardless of the income range(s) chosen, states should consider phasing subsidies in and out gradually at the endpoints to avoid cliffs.

Targeting by Other Factors. States may consider factors beyond income for targeting eligibility. Maryland is [currently exploring](#) a “young adult” subsidy to help attract a group that is difficult to reach and could improve the risk pool. Initial actuarial modeling suggests that, by reducing premiums, such a subsidy could potentially reduce premium tax credit spending and thus qualify for federal funding under a Section 1332 waiver, as discussed further below. A young adult subsidy could also help rationalize premium variation overall given that unsubsidized premiums can currently vary 3:1 by age while subsidized premiums are not age-rated.

Another option is to target assistance to groups ineligible for ACA subsidies. Subsidy legislation enacted in [Colorado](#) takes this approach, setting aside funds for people with incomes up to 300 percent of FPL who do not receive the PTC, for example undocumented immigrants and those caught in the “family glitch.” Other options include limiting subsidies to silver plans (to discourage CSR-eligible individuals from leaving money on the table by purchasing a bronze plan), and targeting geographic areas with the highest cost.

Actuarial modeling can help to estimate the impact of different targeting options on coverage, premiums, and cost, as well as the impact on populations that have been disenfranchised.

Premium Subsidy Calculation – States have several options for calculating the amount of a premium subsidy. The PTC is calculated so as to set consumers’ expected contribution for a benchmark silver plan at a certain percentage of their income – the “applicable percentage.” The applicable percentage increases on a sliding scale as income increases – for 2021 it ranges from 2.07 percent to 9.83 percent. [Vermont’s subsidy](#) is calculated to reduce the applicable percentages across the board by 1.5 percentage points. This is a simple approach but also provides larger subsidies to higher-income individuals, since 1.5 percent of income is a larger amount at higher incomes. [California’s subsidy](#) is based on its own, lower schedule of applicable percentages, with the California subsidy filling in the difference between those percentages and the federal percentages. This approach can be tailored to spread assistance as desired. [Massachusetts’s subsidy](#)

is based on a schedule of individual contributions related to the affordability standard under the state's individual mandate. These contributions increase stepwise across income ranges, creating a pricing structure that is relatively easy for consumers to understand but also generosity cliffs that may distort consumer behavior. [New Jersey's subsidy](#) is generally a flat amount that varies across certain FPL thresholds, subject to caps for consumers with little or no expected premium contribution. Providing a flat amount can be simple and also progressive, since it represents a larger share of income for low-income individuals.

Interactions with other programs – A state subsidy can be an important complement to other state-level programs. For example, when combined with a state individual mandate as in Massachusetts, California and New Jersey, a subsidy can mitigate concerns about requiring coverage when it is unaffordable,^[9] while the mandate both provides revenue to help fund the subsidy and reduces premiums, thereby lowering the subsidy's cost to achieve the desired level of affordability. This combination has proven extraordinarily effective in Massachusetts, as noted above. A subsidy combined with a reinsurance program – as in New Jersey and Colorado – can address affordability across a broad range of incomes without the administrative complexity that comes with a subsidy available to those over 400 percent of FPL, as discussed above. A state subsidy could also be combined with a state public option, with the subsidy helping to make the public option affordable and the public option potentially reducing the cost of the subsidy – as is currently being considered in [Washington](#) and other states.

Financing Mechanism – Often the biggest challenge in enacting a state subsidy is paying for it. The state subsidies in place today use a variety of financing mechanisms. California's program is financed in part by general revenue and in part by penalties from the state's individual mandate. Massachusetts uses penalty revenue from its long-standing individual mandate, contributions from employers, and tobacco taxes. New Jersey and Colorado implemented [state health insurer assessments](#) following the repeal of the federal Section 9010 health insurer fee. An SBM may be able to set aside funding from its Marketplace user fee, especially if the user fee's revenue base is expanded to a broader range of insurance products.

Federal waivers may also be an option. [Massachusetts](#) and [Vermont](#) receive federal funding to support their state subsidies through long-standing Section 1115 waivers.^[10] The Trump

Administration sought to [phase out](#) waivers of this sort, and even before that, CMS had been [tightening](#) Section 1115 budget neutrality rules. Nonetheless, the option may be worth exploring with the new Administration.

Finally, Section 1332 state innovation waivers may provide a funding source in some cases. The challenge with Section 1332 waivers is that they must be deficit neutral to the federal government, while state subsidies typically (and importantly) increase federal spending by making federally subsidized coverage more affordable. That said, some subsidies may reduce federal spending. For example, as noted above, initial actuarial modeling performed for Maryland projects that a subsidy targeted to young adults could reduce federal spending by substantially reducing premiums and thus PTC amounts. Other such innovative structures could also be considered to make a Section 1332 waiver work with a state subsidy.

CONCLUSION

State Marketplace subsidies are a proven tool to make coverage more affordable, reduce uninsurance, and improve the risk pool. They are also highly flexible, allowing states to target hard-to-reach populations and tailor benefits to specific goals. The interaction of these policies with the federal landscape will require states to continually consider the best structure for their residents. As federal policy develops, state subsidies will continue to be a crucial tool to fill affordability gaps and build on the federal landscape.

[1] See, for example, footnote 7 from Council of Economic Advisors Issue Brief, "[Understanding Recent Developments in the Individual Health Insurance Market](#)," January 2017, estimating that "claims costs for individuals who leave the market when premiums rise are around 73 percent of claims costs for enrollees who remain."

[2] Personal communication with Urban Institute staff, January 28, 2021.

[3] Of the state subsidies in effect today, only Massachusetts' is approximately as generous as the Urban options, and then only at incomes up to 300% of FPL. Other state subsidies are generally less generous.

[4] California's 2021 [premium](#) and [enrollment](#) figures have also

been promising and may be driven in part by events related to the pandemic.

[5] This figure is intended to very roughly approximate the potential impact of a state subsidy in a typical state. It is derived by first dividing Urban’s nationwide estimate of 5 million additional subsidized enrollees among the 50 states, and then halving the result to account for the likelihood that a state subsidy would be less generous than Urban’s options.

[6] The one exception is Minnesota’s subsidy, which was in effect in 2017 only. It was enacted shortly before the end of the open enrollment period – too late for Marketplace systems to be updated – and so was administered directly by carriers. It served as a stop-gap until the state’s reinsurance program took effect in 2018.

[7] To see why extending eligibility for a state premium subsidy above 400% of FPL generally requires the use of an advanceable, reconciled tax credit, consider a consumer who enrolls with projected income at 410% of FPL. Assuming the state subsidy is large enough to substantially smooth the PTC cliff at 400% of FPL, the consumer might receive thousands of dollars in upfront state subsidies. But now suppose the consumer’s income for year ends up a bit lower, at 390% of FPL. The consumer can now claim the PTC on their federal tax return. If the state credit is not repaid, this individual effectively receives a double credit. Such double payment would increase the cost and would likely raise concerns about fairness and program integrity.

[8] Many state programs – including the long-standing Marketplace subsidies in Massachusetts and Vermont – are excluded from federal income under the “general welfare doctrine.” Qualifying for the general welfare doctrine generally requires that eligibility for a program be based on need. There are no clear standards for what constitutes need.

[9] Both the ACA individual mandate and every mandate enacted by a state provides an exemption for those without access to affordable coverage. That said, some without access to affordable coverage may not be aware of the exemption or may nonetheless feel pressured to comply.

[10] Massachusetts’ 1115 waiver supports both its premium and cost-sharing subsidies, while Vermont’s supports only its premium waiver.

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**Fact sheet**

American Rescue Plan and the Marketplace

Mar 12, 2021 Affordable Care Act

The New Law

- President Biden signed the American Rescue Plan Act of 2021 (ARP) into law on March 11, 2021. ARP makes major improvements in access to and affordability of health coverage through the Marketplace by increasing eligibility for financial assistance to help pay for Marketplace coverage.
- The new law will lower premiums for most people who currently have a Marketplace health plan and expand access to financial assistance for more consumers.
- Under the new law, many people who buy their own health insurance directly through the Marketplace will become eligible to receive increased tax credits to reduce their premiums. Starting April 1, 2021, consumers enrolling in Marketplace coverage through HealthCare.gov will be able to take advantage of these increased savings and lower costs.
- Premiums after these new savings will decrease, on average, by \$50 per person per month or by \$85 per policy per month. Four out of five enrollees will be able find a plan for \$10 or less/month after premium tax credits, and over 50% will be able to find a Silver plan for \$10 or less.

Background on how premium tax credits work

- For consumers who are eligible for premium tax credits to help purchase a Marketplace plan, an individual or a family's tax credit amount is calculated based on the following factors:
 - Household's total expected income for the year
 - Total number of people in the household that file taxes together
 - The premium amount of the second-lowest cost Silver plan in the consumer's area in the Marketplace. This is the "benchmark" plan cost used to calculate premium tax credits. It's not related to which plan a consumer actually chooses to enroll in.

- The tax credit calculation uses a percentage of the household's income that they need to contribute (spend) on monthly health insurance premiums. This amount is limited based on how their household income compares to federal poverty levels (FPL).
- Prior to the American Rescue Plan, households had to contribute up to 9.83% of their income to pay for health insurance premiums to be eligible for tax credits based on the cost of the benchmark plan. Consumers can choose to enroll in plans that cost more or cost less than the benchmark plan, but the amount of their tax credit is based on this percentage of their income and the cost of the benchmark plan's monthly premium. Households with incomes greater than 400% FPL weren't eligible for tax credits to help reduce the cost of purchasing a Marketplace plan.
- After the coverage year, consumers who had a Marketplace plan with premium tax credits during the year will need to file their federal income tax return for that year and reconcile the amount of tax credits they received in advance with the final premium tax credit calculation as a part of their tax return. If their house income turns out to be higher than what they estimated on their Marketplace application, the household may need to pay back some or all of the excess premium tax credit they received in advance as a part of filing their tax return. Depending on the circumstances the amount owed back may be capped.

Lower costs and expanding access

Under the American Rescue Plan:

- Individuals and families may be eligible for a temporary increase in premium tax credits for this year, with no one paying more than 8.5% of their household income towards the cost of the benchmark plan or a less expensive plan. Meaning, many consumers will be eligible for higher tax credit amounts to help cover their Marketplace health plan premiums.
 - This new lower cap on the percentage of a family's household income that goes toward premiums addresses the "subsidy cliff" for those with household incomes above 400% of the federal poverty level (FPL). Instead of no premium tax credits for individuals and families making more than 400% FPL, the new law will make premium tax credits available to these families and caps how much of a family's household income the family needs to pay towards their premiums at 8.5%, based on the cost of the benchmark plan.
 - Some consumers making more than 400% FPL may not receive tax credits if the cost of the benchmark plan is less than the 8.5% of their household income that they need to contribute toward the premium.
 - When consumers enroll, they can choose a plan that is the same, costs more or costs

less than the benchmark plan. The 8.5% cap is used to calculate this increase in premium tax credit amounts, but the cost of the plan a consumer chooses to enroll in may be higher or lower than the benchmark plan.

- Individuals and families get a temporary boost in their premium tax credits.
 - The law increases premium tax credits for all income brackets for coverage years beginning in 2021 and 2022. For 2021 and 2022, the law applies a new premium percentage owed by individuals and families at all household income levels.
 - Of note, most people across all household income levels will see lower premiums as a result of receiving more tax credits to reduce plan prices. Many consumers with household incomes from 100% to 150% FPL would have \$0 premium plans (after tax credits) available to choose from when considering their options and selecting a plan.
- Taxpayers who receive unemployment compensation during any week beginning in 2021 may be eligible to receive premium tax credits to help pay for 2021 Marketplace coverage.

Making This Work for You

- *When will the extra tax credits be available on HealthCare.gov?*

Increased premium tax credits based on the lower income contribution percentage along with expanding tax credit access to consumers with household incomes above 400%, will be available through HealthCare.gov starting on April 1. This means that new consumers and current enrollees who submit an application and select a plan on or after April 1 will receive the increased premium tax credits for 2021 Marketplace coverage.

Extra tax credits for consumers receiving unemployment compensation will be available starting this summer.

- *If I'm currently enrolled in a Marketplace plan, how do I receive the additional tax credits/lower premiums?*

Current enrollees, including those who recently enrolled through the 2021 Special Enrollment Period, can update their applications and enrollments in order to get new eligibility results starting April 1. You will need to reselect your current plan in order for the changes to take effect to reduce your premiums for the remainder of the year.

While the 2021 SEP opportunity is available through May 15, current enrollees can decide during the SEP opportunity if they may want to change to a new plan for the rest of the year. You should consider how much you've already paid toward your deductible when

deciding whether or not a change in plan makes sense for you. When you change plans, the amount you've paid already towards meeting your prior plan's deductible may be reset to zero, and you would need to start over paying out of pocket expenses to reach the deductible on your new plan. If you have made significant payments toward your deductible, check with your insurance company to see how it might impact you and what options are available to keep credit toward what you have already paid.

- *If I live in a state that operates its own Marketplace, what should I do?*

Visit your State Marketplace website or call center for more information about when these additional savings will be available through your Marketplace.

- *If I'm currently enrolled through the Marketplace, what will happen if I don't come back in?*

Consumers who enrolled in Marketplace plans prior to April 1 have the choice of waiting until they file their taxes next year in 2022 to receive the additional premium tax credit amount when they file and reconcile their 2021 taxes. However, we recommend all enrollees come in, update their application, and review their plan options during the 2021 Special Enrollment Period through May 15 because you may be able to choose a plan with lower out of pocket costs for the same price or less than what you are currently paying.

- *If I don't have coverage, when should I apply?*

Consumers who need coverage starting April 1 should still apply and select a plan by the end of March through the Special Enrollment Period (SEP) so coverage can start April 1. Then to get the added benefits, you should come back after April 1, submit your application again, and reselect your plan to have increased tax credits applied to your coverage for May 1 forward.

- *If I am already paying a very low premium, or no premium, should I take any action?*

Consumers who are already paying low or no premiums may find plans with more generous cost-sharing and lower out of pocket costs, and benefit from changing plans. Premiums after tax credits will decrease, on average, by \$50 per person per month. Four out of five enrollees will be able to find a plan for \$10 or less/month with premium tax credits, and over 50% will be able to find a Silver plan for \$10 or less with tax credits.

Meaning, you may be able to find plans with lower out of pocket expenses and lower deductibles for a similar premium to what you're currently paying.

- *If I'm receiving unemployment compensation, should I wait to apply?*

You should apply and select a plan by the end of March in order to enroll in coverage starting April 1. After April 1, you can come back in to update your application and confirm your current plan with the updated tax credits. Later this year, you may be able to receive another increase in the premium tax credits available to you. HealthCare.gov will have more information available in the summer once these additional savings are available for consumers who have received unemployment compensation during 2021. At that time, you can come back to HealthCare.gov to update your application and current plan with more tax credits to reduce your premiums for the remainder of the year.

- *Will HealthCare.gov automatically update premium tax credits on behalf of current enrollees?*

If consumers don't take action, they'll still receive the additional benefit as part of their premium tax credit when filing their federal income tax return next year. Beginning on April 1, consumers must come back to HealthCare.gov to update their application in order to receive these increased tax credits this year. However, we are also exploring whether tax credits can be updated on behalf of consumers during 2021.

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[Home](#) > [About](#) > [News](#) > Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities

FOR IMMEDIATE RELEASE

March 12, 2021

Contact: HHS Press Office

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Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities

The Biden-Harris Administration is reducing health care costs, expanding access to coverage, and ensuring nearly everyone who buys their own individual or family health insurance through a Marketplace can receive a tax credit to reduce their premiums. The American Rescue Plan (ARP) not only provides the resources for America to beat this pandemic, but it also expands access to health insurance coverage, lowers costs, and ensures that health care truly is a right for all Americans.

- **It's Working:** After the Biden-Harris Administration made available a Special Enrollment Period through the Federal Marketplace from February 15 to May 15 for people who needed health care coverage during the pandemic, more than 200,000 people signed up for Marketplace coverage through HealthCare.gov in the first two weeks - a three-fold year over year increase. Now following the passage of the ARP more than 14.9 million Americans who currently lack health insurance and many current enrollees will receive additional financial support to find the coverage that best meets their needs at a price they can afford.
- **More Affordable Options are Available:** Many people who enroll in health coverage through HealthCare.gov will qualify to save money on their premiums. Premiums after advance payment of these increased tax credits will decrease, on average, by \$50 per person per month and \$85 per policy per month. Four out of five enrollees (up from 69% pre-ARP) will be able to find a plan for \$10 or less per month after tax credits, and over 50% (up from 14% pre-ARP) will be able to find a Silver plan for \$10 or less per month.
- **Making it Easier for Consumers:** Starting on April 1, consumers will be able to take advantage of increased premium tax credits on high quality health care plans when they enroll in coverage through HealthCare.gov. Every day, we're working to make the consumer experience even better, streamlining

HealthCare.gov and providing the help and support consumers want in order to understand their options and pick the right plan for their families.

The American Rescue Plan:

Reduces the cost of health care coverage for 9 million consumers currently receiving financial assistance by ensuring consumers eligible for premium tax credits have at least a couple plans to choose from that won't cost more than 8.5% of their household income on their Marketplace plan premium per year.

- Many premiums will decrease, on average, by \$50 per person per month and \$85 per policy per month.
- Four out of five enrollees (up from 69% pre-ARP) will be able find a plan for \$10 or less per month after tax credits, and over 50% (up from 14% pre-ARP) will be able to find a Silver plan for \$10 or less per month.
- 1 out of 4 enrollees on Healthcare.gov will be able to upgrade to a higher plan category that offers better out of pocket costs at the same or lower premium compared to what they're paying today (excludes enrollees already at the highest health plan category available, including certain enrollees eligible for cost sharing reductions).
- For example:
 - Uninsured couples earning over \$70,000 could save more than \$1,000 per month on their monthly premium.
 - A family of four making \$90,000 will see their premiums decrease by \$200 per month.
 - An individual making \$19,000 will be able to find health insurance coverage with no monthly premium, saving roughly \$66 per month on average.

Expands the number of people eligible to save money on their health care coverage.

About 14.9 million Americans who currently lack health insurance will be able to save money on their premiums to find the coverage they need at a price they can afford:

- 3.6 million uninsured people are estimated to be newly eligible for health care coverage savings. (See state level data in table 1)
- 1.8 million uninsured people are estimated to be eligible for zero-dollar benchmark Marketplace coverage, since PTC-eligible individuals with incomes below 150% of the FPL will now qualify for a 100% premium subsidy for the benchmark Marketplace plan. (See state level data in table 1.) Millions more are eligible for zero-dollar coverage for non-benchmark plans.

- An additional 9.5 million uninsured people with incomes between 150% and 400% of the FPL are estimated to potentially qualify for additional financial support to reduce out-of-pocket costs for Marketplace premiums.

Addresses racial health inequities by expanding coverage and reducing costs. Increased affordability and health insurance coverage expansion will allow historically uninsured communities – especially those who have faced significant health disparities – to access coverage, thereby improving opportunities for health care during and beyond the COVID-19 pandemic.

- The COVID-19 pandemic has exacerbated stark health disparities among certain racial and ethnic minority populations in several areas, including infections, hospitalizations, death rates, and vaccination rates. Many of these same populations have experienced job loss or loss of health insurance coverage at disproportionately high rates.

- 48,000 uninsured American Indians and Alaska Natives will be newly eligible to save money on health care coverage and 21,000 will be eligible for zero-dollar benchmark Marketplace plans.

- 730,000 uninsured Latinos will be newly eligible to save money on health care coverage and 580,000 will be eligible for zero-dollar benchmark Marketplace plans.

- 360,000 uninsured Black and African Americans will be newly eligible to save money on health care coverage and 328,000 will be eligible for zero-dollar benchmark Marketplace plans.

- 197,000 uninsured Asian, Native-Hawaiian and Pacific Islander will be newly eligible to save money on health care coverage, and 50,000 will be eligible for zero-dollar benchmark Marketplace plans.

- The Biden-Harris administration is further expanding access to health insurance coverage and improving access to mental health services and community-based programs that address social determinants of health.

TABLE 1:		
State	Uninsured Population Newly Eligible for Tax Credits	Uninsured population now eligible for \$0 dollar benchmark Marketplace coverage (<150% FPL)
Alabama	40,400	56,600
Alaska	11,000	3,000
Arizona	89,300	17,700

TABLE 1:		
State	Uninsured Population Newly Eligible for Tax Credits	Uninsured population now eligible for \$0 dollar benchmark Marketplace coverage (<150% FPL)
Arkansas	19,500	7,700
California	394,000	57,100
Colorado	81,900	6,300
Connecticut	36,000	4,700
Delaware	8,900	1,700
District of Columbia	4,300	300
Florida	318,500	270,600
Georgia	127,100	134,900
Hawaii	9,500	1,300
Idaho	22,100	5,700
Illinois	130,500	19,600
Indiana	68,500	15,100
Iowa	22,900	1,800
Kansas	29,600	30,300
Kentucky	35,500	7,100
Louisiana	58,000	10,100
Maine	16,300	2,400
Maryland	50,100	3,200
Massachusetts	42,900	3,600

TABLE 1:		
State	Uninsured Population Newly Eligible for Tax Credits	Uninsured population now eligible for \$0 dollar benchmark Marketplace coverage (<150% FPL)
Michigan	67,300	16,100
Minnesota	44,200	3,500
Mississippi	30,100	43,200
Missouri	59,400	73,900
Montana	18,400	2,600
Nebraska	14,800	3,800
Nevada	41,000	6,100
New Hampshire	22,900	1,000
New Jersey	100,000	13,800
New Mexico	22,100	2,800
New York	174,900	17,300
North Carolina	116,500	112,600
North Dakota	13,700	700
Ohio	93,200	23,100
Oklahoma	61,000	57,300
Oregon	51,500	7,400
Pennsylvania	109,900	15,900
Rhode Island	6,700	1,000
South Carolina	59,700	55,600

TABLE 1:		
State	Uninsured Population Newly Eligible for Tax Credits	Uninsured population now eligible for \$0 dollar benchmark Marketplace coverage (<150% FPL)
South Dakota	9,300	10,100
Tennessee	64,600	70,300
Texas	565,200	501,200
Utah	32,900	6,900
Vermont	5,600	600
Virginia	77,400	13,400
Washington	79,200	10,100
West Virginia	16,900	3,900
Wisconsin	51,900	31,600
Wyoming	12,900	6,700
TOTAL	3,640,000	1,773,300

Find more information on [Estimates of the Uninsured Population in the U.S.](#)

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HHS Headquarters

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Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

On March 11, President Biden signed an approximately \$1.9 trillion COVID-19 relief bill—the [American Rescue Plan Act of 2021](#) (“the American Rescue Plan,” ARPA). The American Rescue Plan includes myriad health care provisions, focused primarily in two areas: first, it provides funding the Biden administration requested to carry out its COVID-19 response plans; second, it enacts significant but largely temporary coverage policies.

Although all health care coverage provisions of the bill are temporary, many will have a lasting impact. This timeline provides the start and end dates for key health care provisions to help states plan for implementation and future policymaking. The provisions covered include:

- Marketplace and commercial insurance. See [page 3](#).
- Medicaid. See [page 4](#).
- State and local funding. See [page 7](#).

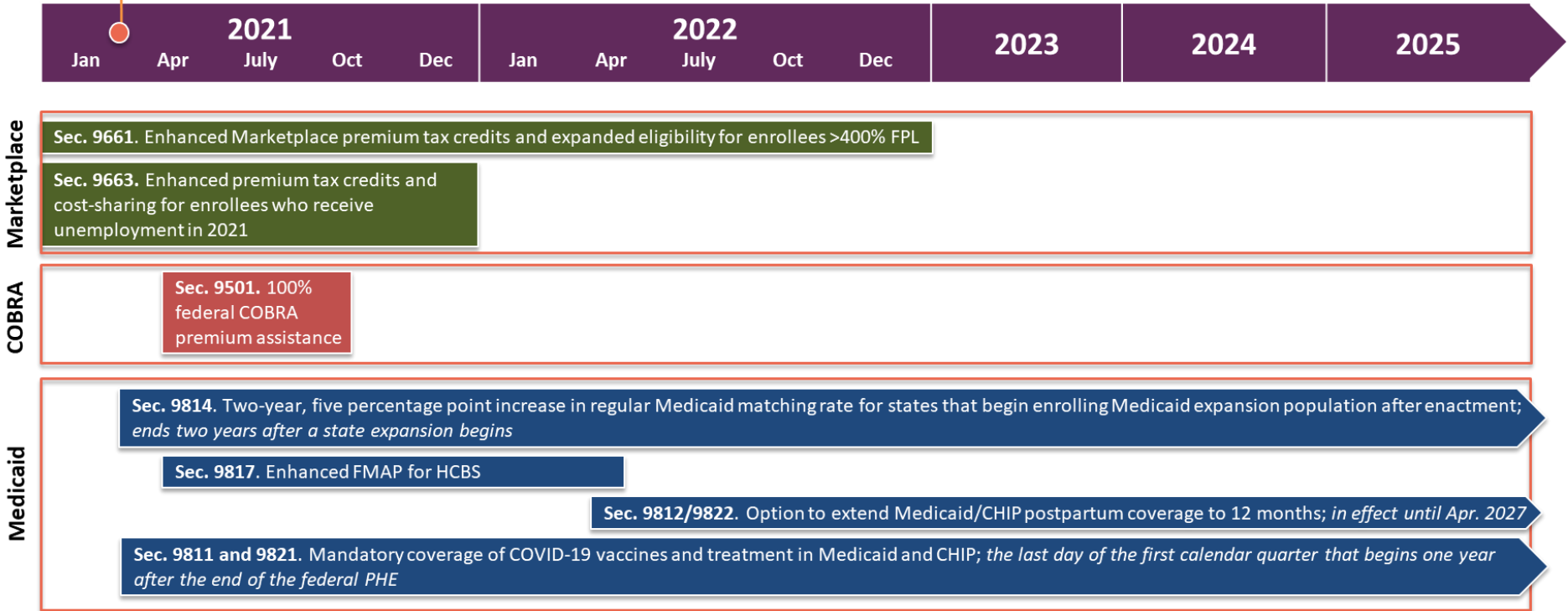
Importantly, the American Rescue Plan also includes several funds that could be made available to states and are not enumerated in this document. For example, the U.S. Department for Health and Human Services (HHS) and Centers for Disease Control and Prevention (CDC) may distribute to states and other recipients to support vaccine distribution and testing, but the law does not establish the exact dollar amount that HHS and CDC must distribute to states versus use for other purposes. Similarly, the American Rescue Plan defers to the federal government regarding the timing for distributing funds for:

- Skilled nursing facility infection control
- Community health centers
- Investment in the health care workforce
- Substance abuse disorder and mental health grant programs

Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Timeline of Key Coverage Provisions in the American Rescue Plan

Law enacted March 11, 2021



Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Provision and Relevant Section	Effective Date	End Date	Notes
Marketplace and Commercial Insurance			
Expanded Marketplace Tax Credits (Sec. 9661). Provides increased assistance for people currently eligible for tax credits across all income levels, and extends tax credits to those above 400% of the federal poverty level (FPL) (who have no other offer of affordable insurance) for the first time.	January 1, 2021 ¹	December 31, 2022	The Centers for Medicare & Medicaid Services (CMS) has announced that enhanced tax credits will be available on Healthcare.gov starting April 1.
Zero Premium Coverage for People Who Receive Unemployment in 2021 (Sec. 9663). Individuals who receive an unemployment insurance payment in 2021 would be eligible to receive premium tax credits that allow them to buy a Silver-level plan with \$0 premiums in 2021 and would be eligible for the maximum cost-sharing subsidies amount, regardless of their income.	January 1, 2021	December 31, 2021 ²	CMS has indicated that enhanced tax credits will be available on Healthcare.gov starting in “early July.”
Eliminating Requirement to Repay Premium Tax Credit in 2020 (Sec. 9662). Individuals receiving tax credits will not be required to reconcile premium tax credits if their annual income increases during 2020.	January 1, 2020	December 31, 2020	
Funding for State-Based Marketplace Modernization (Sec. 2801). Appropriates \$20 million in grants for state-based Marketplaces to modernize or update any system, program or technology to ensure compliance with Affordable Care Act (ACA) Marketplace requirements.	March 11, 2021 ³	September 30, 2022	
COBRA Subsidies (Sec. 9501). Provides federal premium assistance equal to 100% of COBRA continuation coverage premiums for COBRA-eligible individuals and families.	April 1, 2021	September 30, 2021	

¹ Taxable years beginning after December 31, 2020.

² The act does not specify a date but indicates enhanced coverage for 2021.

³ Appropriated for fiscal year 2021.

Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Provision and Relevant Section	Effective Date	End Date	Notes
Medicaid			
Enhanced FMAP for Medicaid Expansion (Sec. 9814). Provides states that implement a Medicaid expansion after the date of enactment with a two-year, five-percentage-point increase in the Medicaid matching rate (FMAP) for most <i>non-expansion</i> populations.	Enhanced FMAP available to new expansion states starting April 1, 2021 ⁴	Enhanced FMAP ends two years after a state expansion begins	States that begin enrolling adults in the Medicaid expansion group during the public health emergency (PHE) will also receive the 6.2-percentage-point bump authorized by the Families First Coronavirus Response Act.
State Option to Extend Medicaid and CHIP Coverage Postpartum. (Sec. 9812 and Sec. 9822). Provides states the option to extend Medicaid/Children’s Health Insurance Program (CHIP) eligibility for pregnant people enrolled in Medicaid/CHIP for 12 months postpartum.	State option available April 1, 2022	State option ends March 31, 2027	American Rescue Plan does not provide enhanced FMAP for this coverage extension.
Mandatory Coverage of COVID-19 Vaccines and Treatment in Medicaid and CHIP (Sec. 9811 and Sec. 9821). Requires coverage, without cost-sharing, for COVID-19 vaccines and vaccine administration for Medicaid and CHIP populations; and for drugs, biologics and other treatments for most “full benefit” Medicaid and CHIP populations, plus the optional Medicaid COVID-19 testing group.	March 11, 2021	The last day of the first calendar quarter that begins one year after the end of the federal PHE ⁵	The bill provides 100% FMAP for vaccine and vaccine administration services during this period.
State Option for Community-Based Mobile Crisis Interventions (Sec. 9813). Authorizes states to claim Medicaid matching funds for community-based mobile crisis intervention services for Medicaid enrollees experiencing a mental health or substance use	State option and enhanced FMAP available April 1, 2022 ⁶	Enhanced FMAP available for three years during the five-year period in	States can claim these intervention services at an increased 85% FMAP for the first three years.

⁴ State receipt of the enhanced FMAP is tied to when a new expansion state begins enrolling people in the Medicaid adult expansion group.

⁵ For example, if the PHE were to end on January 30, 2022, then this provision would end March 31, 2023 (the last day of the calendar quarter in which January 30, 2023, falls).

⁶ Beginning on the first day of the first fiscal-year quarter that begins one year after the date of the enactment of this act.

Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Provision and Relevant Section	Effective Date	End Date	Notes
disorder crisis. <i>Note: Section 9813 also provides the HHS Secretary with \$15 million in planning grants for states “as soon as practicable.”</i>		which the option is in effect ⁷ State option ends March 31, 2027 ⁸	
Enhanced FMAP for Urban Indian Health Organizations (Sec. 9815). Extension of 100% FMAP to Urban Indian Health Organizations and Native Hawaiian Health Care Systems.	April 1, 2021 ⁹	March 31, 2023	Under current law, services provided to American Indian and Alaska Native Medicaid enrollees are matched at 100% FMAP only if they are provided through an Indian Health Service facility; the ARPA provides the 100% matching rates to two types of health care organizations that do not currently qualify for that matching rate.
Enhanced FMAP for Home- and Community-Based Services (HCBS) (Sec. 9817). Provides a one-year, 10-percentage-point FMAP increase for Medicaid HCBS authorized by state plan or waiver as well as home health, personal care, PACE, case management, rehabilitation services and other services as specified by the Secretary of HHS.	Enhanced FMAP available April 1, 2021	Enhanced FMAP ends March 31, 2022	CMS plans to issue guidance regarding the parameters of this provision, including qualifying expenditures and standards to assure that states are supplementing, not supplanting, existing investments in HCBS.
State Nursing Home Strike Teams (Sec. 9402 and Sec. 9818). Provides Medicaid (and Medicare) funding for states to establish	March 11, 2021 ¹⁰	Funding available until expended; for	

⁷ During the first 12 fiscal quarters.

⁸ A five-year period.

⁹ Eight fiscal quarters beginning with the first fiscal-year quarter beginning after the date of the enactment of the American Rescue Plan.

¹⁰ Appropriated for fiscal year 2021.

Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Provision and Relevant Section	Effective Date	End Date	Notes
deployable strike teams to respond to COVID-19 outbreaks in skilled nursing facilities and nursing facilities.		use before one year after the end of the PHE	
Maintaining Medicaid DSH Allotments During the Emergency Period (Sec. 9819). The Families First Coronavirus Response Act (FFCRA) increased the Medicaid FMAP by 6.2 percentage points, but did not make a corresponding adjustment to Medicaid Disproportionate Share Hospital (DSH) allotments to reflect the increased FMAP, thereby reducing the total (state and federal) amount of DSH funding. The ARPA requires the HHS Secretary to recalculate DSH allotments to ensure the total DSH allotment (federal and state shares) is the same as it would have been without the enhanced match.	January 1, 2020 ¹¹	First fiscal year in which the FFCRA 6.2-percentage-point increase no longer applies	Funds are available for any fiscal year in which the FFCRA matching rate increase applies.
Elimination of Rebate Cap (Sec. 9816). Eliminates the statutory cap on Medicaid rebates that limits those rebates to 100% of the average manufacturer price (AMP).	January 1, 2024	N/A	
Rebates for COVID-19 Drugs (Sec. 9811). Specifies that the expanded coverage of COVID-19 drugs would be accompanied by new rebate obligations under the Medicaid Drug Rebate Program.	March 11, 2021	The last day of the first calendar quarter one year after the end of the federal PHE ¹²	Drugs to treat or prevent COVID-19 generally have not received full FDA approval, but have been approved under an emergency use authorization (EUA). Sec. 9811 is intended to require manufacturers to pay rebates for such drugs.

¹¹ The provision shall take effect and apply as if included in the enactment of the FFCRA. The FFCRA 6.2-percentage-point FMAP increase applies to expenditures (defined by date of payment, not date of service) beginning on January 1, 2020, and will be available to states through the last day of the calendar quarter in which the PHE ends, as long as states meet certain requirements.

¹² Ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period.

Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Provision and Relevant Section	Effective Date	End Date	Notes
State and Local Funding			
Coronavirus State Fiscal Recovery Fund and Coronavirus Local Fiscal Recovery Fund (Sec. 9901). Creates a new Coronavirus State Fiscal Recovery Fund, appropriating \$219.8 billion for payments to states, Tribal governments and territories; \$195.3 billion is specifically allocated for states and Washington, D.C.	Funds immediately available to Secretary for distribution; <u>at least</u> 50% of state funds must be distributed within 60 days of Secretary receipt of required certifications ¹³	Costs must be incurred by December 31, 2024	Secretary has discretion to distribute the full amount of state and territory funds in a single payment, or to split the payments into two tranches, up to 12 months apart.
Coronavirus Local Fiscal Recovery Fund (Sec. 9901). Creates a new Local Fiscal Recovery Fund, appropriating \$130.2 billion for payments to counties, metropolitan cities and nonentitlement units of local government.	Funds immediately available to Secretary for distribution; 50% must be distributed within 60 days of Secretary receipt of required certifications, ¹⁴ and 50% must be distributed <u>no earlier than 12 months</u> later		

¹³ The Secretary may withhold up to 50% of allocated state funding for up to 12 months.

¹⁴ Where states are responsible for distributing funds to recipients (i.e., nonentitlement units of government), the state must distribute payments within 30 days (unless granted an extension).

Timeline of Key Provisions in the American Rescue Plan Act of 2021
Effective and End Dates
March 26, 2021

Provision and Relevant Section	Effective Date	End Date	Notes
<p>Coronavirus Capital Projects Fund (Sec. 9901). Establishes a \$10 billion fund for the Department of the Treasury to make payments to states, territories and Tribal governments to carry out capital projects directly enabling work, education and health monitoring, including remote options, in response to COVID-19.</p>	<p>The Secretary shall establish a process for access no later than May 10, 2021</p>	<p>Funding available until expended</p>	

March 2021

Enrollment in Nongroup Health Insurance by Income Group

Matthew Fiedler

USC-Brookings Schaeffer Initiative for Health Policy

This report is available online at: <https://www.brookings.edu/research/enrollment-in-nongroup-health-insurance-by-income-group/>

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EDITOR'S NOTE

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Economic Studies Program at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings. The Robert Wood Johnson Foundation provided a grant to the Brookings Institution that supported the writing of this paper.

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Executive Summary

In the United States, most people obtain health insurance either through an employer or a public program like Medicare or Medicaid. But some people—about 11% of the non-elderly population in 2019 according to this paper’s estimates—lack access to public or employer coverage. These people must instead seek nongroup coverage, either through the Marketplaces established by the Affordable Care Act (ACA) or outside the Marketplaces. For many purposes, including assessing proposals to increase nongroup enrollment such as the recently enacted increases in the ACA’s subsidies for Marketplace plans, it is useful to know how many people have nongroup coverage, what forms of nongroup coverage they have, how many potential enrollees remain unenrolled, and how enrollment rates vary by income.

To that end, this paper estimates how many non-elderly people in different income groups held Marketplace coverage, off-Marketplace coverage that qualifies as minimum essential coverage (MEC) under the ACA, or non-MEC nongroup policies (e.g., short-term limited duration plans), as well as how many lacked any coverage, in 2019. I focus on enrollment among people who: (1) are ineligible for public or employer coverage; (2) are legally present in the United States; and (3) do not fall in the Medicaid “coverage gap.” This group, which I refer to as the population of “potential subsidy recipients,” is the group most likely to be targeted by efforts to increase nongroup enrollment such as the recently enacted subsidy expansions. Thus, estimates for this population are particularly policy relevant.

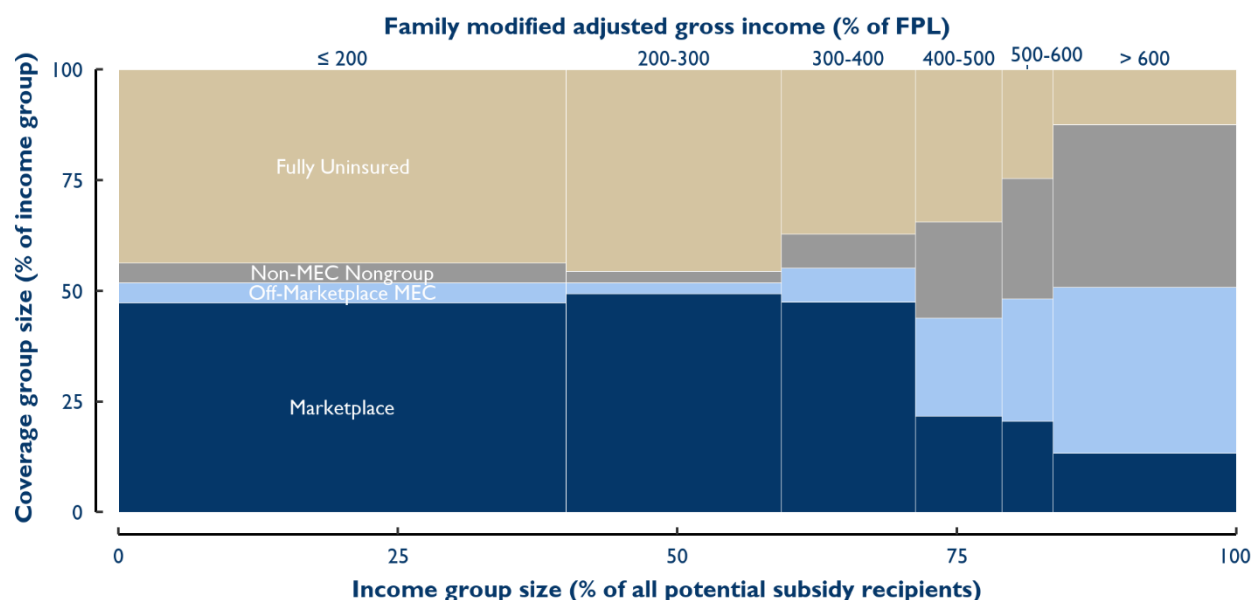
Estimating patterns of nongroup enrollment is challenging. Household surveys do a poor job of measuring nongroup coverage since respondents often report other forms of coverage as nongroup coverage and vice versa (Pascale, Fertig, and Call 2019), while administrative data lack needed detail. Thus, this paper produces estimates by blending administrative and survey data. In brief, I start with tabulations of insurance coverage by income in 2016 produced using tax data by Lurie and Pearce (2019; forthcoming), which likely offer the best available snapshot of nongroup enrollment by income. I then use a combination of survey, administrative, and other data to construct crude estimates of enrollment in non-MEC nongroup policies (which are not captured in the tax data), trend the various estimates forward to 2019, and make other needed adjustments. In doing so, I pay careful attention to the limitations of the survey data sources and mitigate those limitations to the greatest extent possible.

Findings Regarding Patterns of Nongroup Enrollment in 2019

Figure ES.1 summarizes this paper’s estimates of nongroup enrollment and uninsurance among non-elderly potential subsidy recipients in 2019. The paper highlights four principal findings, each of which has important implications for policymakers, researchers, or both.

Finding #1: Only half of potential subsidy recipients were enrolled in nongroup MEC, and take-up rates varied only modestly with income. Slightly more than half (52%) of those with incomes below 400% of the federal poverty level (FPL), the income limit for the ACA’s Marketplace subsidies as of 2019, were enrolled in nongroup policies that constitute MEC. This fraction was slightly lower (49%) among people with incomes above 400% of the FPL. These estimates indicate that there was considerable scope to increase enrollment in nongroup MEC at all income levels, including at income levels where Marketplace subsidies were already available as of 2019. This implies that the recently enacted American Rescue Plan Act, which both made subsidies more generous for people already eligible and extended them above 400% of the FPL, has the potential to increase MEC enrollment across the income distribution.

Figure ES.1: Potential Subsidy Recipients by Income and Coverage, 2019



Note: Potential subsidy recipients are people who are legally present, ineligible for public and employer coverage, and not in the Medicaid "coverage gap." Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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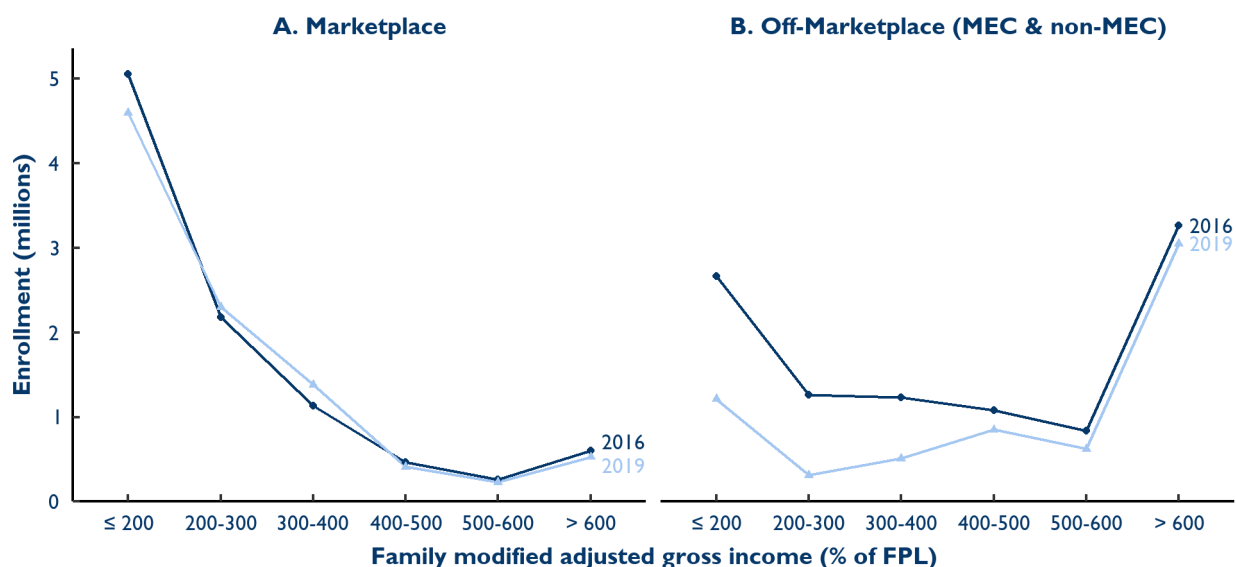
Finding #2: The large majority of potential subsidy recipients who lacked MEC had incomes below 400% of the FPL. Among potential subsidy recipients who lacked nongroup MEC, 70% had incomes below 400% of the FPL. Thus, not only is there scope to increase enrollment in nongroup MEC among people who were already eligible for subsidies, most of the opportunity to increase overall take-up is in this group.

Finding #3: At lower income levels, potential subsidy recipients who lacked MEC were typically uninsured, while at higher incomes many held non-MEC nongroup policies. Among potential subsidy recipients without nongroup MEC who had incomes below 400% of FPL, 91% were fully uninsured, while the remaining 9% held non-MEC nongroup policies. By contrast, at higher income levels, 61% held non-MEC nongroup policies and only 39% were fully uninsured. This suggests that efforts to increase MEC enrollment may do less to improve financial protection at higher income levels, although those improvements may still be substantial since non-MEC policies often offer much less robust coverage (e.g., Pollitz et al. 2018; Palanker, Curran, and Salyards 2020). It also suggests that efforts to restrict the availability of non-MEC policies would have their largest effects at higher income levels.

Finding #4: Lower-income potential subsidy recipients with MEC overwhelmingly held Marketplace coverage, while higher-income people generally held off-Marketplace MEC. Among potential subsidy recipients with nongroup MEC, 91% of those with incomes below 400% of the FPL held Marketplace coverage, whereas just 35% did above 400% of the FPL. One implication is that research that focuses only on Marketplace enrollees can paint a very misleading picture of nongroup enrollment as a whole.

Since subsidies were available below 400% of the FPL, it is notable that anyone at these income levels opted for off-Marketplace plans. This could indicate that awareness of subsidized coverage is incomplete, as some surveys suggest (Gupta and Collins 2019; Pollitz et al. 2020). Additionally, underwritten off-Marketplace policies (grandfathered and transitional MEC policies and non-MEC policies) may sometimes be less expensive than subsidized Marketplace coverage for healthier moderate-income enrollees.

Figure ES.2: Estimated Nongroup Enrollment, 2016 and 2019



Note: Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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Findings Regarding Trends in Nongroup Enrollment from 2016 to 2019

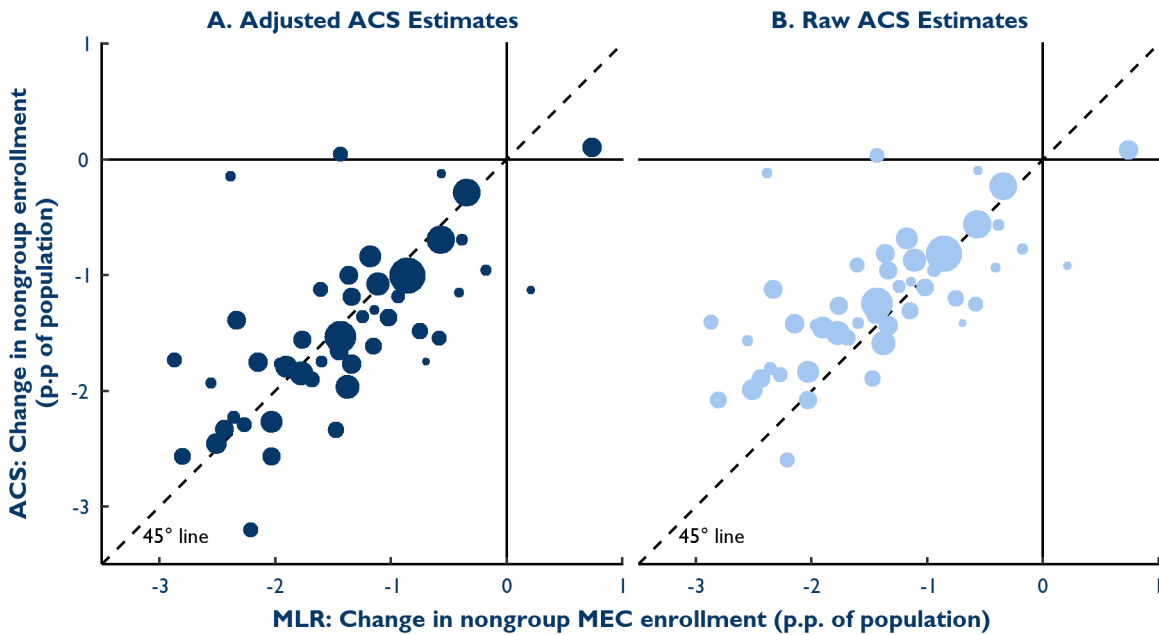
The method this paper uses to estimate enrollment in 2019 also generates estimates of how different categories of enrollment changed from 2016 to 2019. The paper highlights two main findings.

Finding #5: Off-Marketplace enrollment fell sharply over this period, particularly at lower income levels, while Marketplace enrollment was steady. Figure ES.2 depicts these trends graphically. The decline in off-Marketplace enrollment is unsurprising since premiums of ACA-compliant policies rose sharply over this period (e.g., CMS 2019) and since some healthier people with underwritten “grandfathered” or “transitional” policies churned out of the market over time and likely were not replaced. However, to the extent this decline was driven by rising premiums, it is somewhat surprising that there was no offsetting increase in Marketplace enrollment at incomes below 400% of the FPL, where subsidies were available. This could indicate that people exiting off-Marketplace plans were unaware that subsidized Marketplace coverage existed. Alternatively, it could indicate that Marketplace enrollment was stable in the aggregate because an influx of former off-Marketplace enrollees was offset by other factors that reduced Marketplace enrollment, such as the elimination of the individual mandate penalty.

Finding #6: Enrollment in non-MEC nongroup policies may have been steady from 2016 to 2019. Existing data sources do not directly measure trends in non-MEC nongroup enrollment. To fill this gap, this paper constructs an indirect measure of those trends by combining data from insurer Medical Loss Ratio (MLR) filings with data from the American Community Survey (ACS). Because the MLR data only capture enrollment in nongroup MEC, while the ACS plausibly captures all nongroup enrollment, any difference in the enrollment trends shown in the MLR and ACS data may reflect changes in non-MEC enrollment.

Figure ES.3 shows that estimates of the change in nongroup enrollment from 2016 to 2019 derived from the MLR and ACS data are very highly correlated at the state level. Furthermore, after using the results of Pascale, Fertig, and Call (2019) to adjust for known patterns of coverage misreporting in the ACS, the ACS

Figure ES.3: ACS vs. MLR Nongroup Enrollment Trends by State, 2016-2019



Note: Marker size reflects state population in 2016. Plot excludes New Hampshire, which experienced an idiosyncratic large decline in MLR-measured enrollment because it stopped covering Medicaid expansion enrollees through nongroup plans during this period. ACS = American Community Survey; MLR = medical loss ratio; MEC = minimum essential coverage.

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and MLR data show very similar enrollment trends, on average across states. This finding suggests that enrollment in non-MEC nongroup policies may have changed little over this period.

Stable enrollment in non-MEC policies may be the net effect of offsetting factors. On the one hand, premium increases for ACA-compliant plans (e.g., CMS 2019), elimination of the individual mandate policy, and federal regulatory changes favoring short-term limited duration plans may have increased non-MEC enrollment. However, many states implemented new restrictions on short-term plans during this period (Palanker, Kona, and Curran 2019), which may have worked in the opposite direction.

Opportunities to Improve Nongroup Enrollment Data

The paper closes by making two recommendations for how data on enrollment in nongroup coverage could be improved in the future. First, the Treasury Department should routinely publish tabulations of insurance coverage by income group based on tax data like those produced by Lurie and Pearce (2019; forthcoming) and consider publishing estimates that are further disaggregated by state of residence.

Second, policymakers should collect better data on enrollment in non-MEC nongroup policies. The best approach would be to extend the tax reporting regime that applies to MEC policies to non-MEC policies. Encompassing all types of non-MEC nongroup policies would likely require legislation, but it might be possible to do so for short-term limited duration policies via administrative action. If extending the tax reporting regime is not feasible, it would be valuable to at least collect aggregate information on non-MEC nongroup enrollment. The National Association of Insurance Commissioners has collected some data on enrollment in short-term limited duration policies and may collect more, but these efforts should be extended to other types of non-MEC nongroup policies. Additionally, these data should be made broadly available to researchers and policymakers, which is not currently planned (Keith 2020).

Introduction

In the United States, most people obtain health insurance either through an employer or a public program like Medicare or Medicaid. But some people—about 11% of the non-elderly population in 2019 according to this paper’s estimates—lack access to public or employer coverage. These people must instead seek nongroup coverage, either through the Marketplaces established by the Affordable Care Act (ACA) or outside the Marketplaces. For many purposes, including assessing proposals to increase nongroup enrollment such as the recently enacted increases in the ACA’s subsidies for Marketplace plans, it is useful to know how many people have nongroup coverage, what forms of nongroup coverage they have, how many potential enrollees remain unenrolled, and how enrollment rates vary by income.

To that end, this paper estimates how many non-elderly people in different income groups held Marketplace coverage, off-Marketplace coverage that qualifies as minimum essential coverage (MEC) under the ACA, or non-MEC nongroup policies (e.g., short-term limited duration plans), as well as how many lacked any coverage, in 2019. I focus on enrollment among people who: (1) are ineligible for public or employer coverage; (2) are legally present in the United States; and (3) do not fall in the Medicaid “coverage gap.”¹ This group, which I refer to as the population of “potential subsidy recipients,” is the group most likely to be targeted by efforts to increase nongroup enrollment such as the recently enacted subsidy expansions.² Thus, estimates for this population are particularly policy relevant.

Estimating patterns of nongroup enrollment is challenging. Household surveys do a poor job of measuring nongroup coverage since respondents often report other forms of coverage as nongroup coverage and vice versa (Pascale, Fertig, and Call 2019), while administrative data lack needed detail. Thus, this paper produces estimates by blending administrative and survey data. In brief, I start with tabulations of insurance coverage by income in 2016 produced using tax data by Lurie and Pearce (2019; forthcoming), which likely offer the best available snapshot of nongroup enrollment by income. I then use a combination of survey, administrative, and other data to construct crude estimates of enrollment in non-MEC nongroup policies (which are not captured in the tax data), trend the various estimates forward to 2019, and make other needed adjustments. In doing so, I pay careful attention to the limitations of the survey data sources and mitigate those limitations to the greatest extent possible.

This paper is related to earlier work that has disaggregated the uninsured population according to their eligibility for various forms of subsidized coverage or estimated take-up of subsidized Marketplace coverage (Blumberg et al. 2018; CBO 2020a; KFF 2021; KFF 2020a) and builds on that work in various ways. This paper makes two main contributions relative to this prior research. First, my estimates offer a

¹ A person falls in the Medicaid “coverage gap” if the person is ineligible for subsidized Marketplace coverage by virtue of having income below 100% of the FPL but does not qualify for Medicaid. A coverage gap only exists in states that have declined the ACA’s Medicaid expansion since Medicaid eligibility extends to (at least) 138% of the FPL in Medicaid expansion states.

² A small number of people eligible for Marketplace subsidies fall outside my definition of “potential subsidy recipient”: people who are offered employer coverage that is not “affordable” (which, in 2019, meant that the family’s required contribution for self-only coverage exceeded 9.86% of income) or that does not provide “minimum value” (meaning that the coverage fails to cover at least 60% of expected medical costs). The limitations of the data sources used in this paper make it challenging to reliably identify people in this category.

comprehensive breakdown of how many people hold each form of nongroup coverage at each income level, as well as how many are uninsured, which prior research does not.³ Second, my estimates rely more heavily on administrative data sources, particularly tax data, which may make them more accurate.

The remainder of the paper proceeds as follows. I begin by providing some background on the different types of nongroup coverage and their prevalence in 2019. I then describe the Lurie and Pearce estimates, as well as the various other survey and administrative data I use. Next, I describe my methodology and present my results. I conclude with some recommendations on how policymakers could facilitate collection of better data on nongroup enrollment. Appendices provide additional methodological detail.

Background on Types of Nongroup Coverage

For the purposes of this paper, I place nongroup policies into three different categories: (1) Marketplace coverage; (2) off-Marketplace individual market minimum essential coverage (MEC); and (3) non-MEC nongroup policies. I describe each of these categories in turn below.

Marketplace coverage

This category consists of individual market policies sold through the ACA's Marketplace. CMS' Marketplace effectuated enrollment reports (which are described further below) indicate that there were 9.8 million life-years of such coverage in 2019, as illustrated in Figure 1.

Off-Marketplace individual market MEC

This category consists of individual market policies that are sold outside the Marketplaces but nevertheless constitute MEC under the ACA.⁴ This includes both ACA-compliant individual market policies (that is, policies that comply with the ACA's requirements for individual market policies, including community rating, guaranteed issue, and essential health benefit requirements) that are sold outside the Marketplaces and grandfathered and transitional individual market plans (which are exempt from many ACA requirements). CMS administrative data indicate that there were 3.6 million life-years of such coverage in 2019, of which 63% was in ACA-compliant policies.⁵ Where there is no risk of confusion, I generally refer to these policies as "off-Marketplace MEC."

Non-MEC nongroup policies

This category consists of people who hold other types of policies that are sold to individuals but that do not constitute MEC. This category includes short-term limited duration policies, various excepted benefits policies (e.g., fixed indemnity coverage), and certain insurance-like products that are not formally

³ The Congressional Budget Office's estimates come closest to mine in the amount of detail they provide, but they are not limited to potential subsidy recipients and do not disaggregate different types of nongroup coverage.

⁴ The definition of MEC serves multiple functions in federal law. Most importantly, however, it delineated what forms of coverage satisfied the ACA's now-toothless individual mandate.

⁵ I estimate enrollment in off-Marketplace MEC by comparing the enrollment reported in CMS' Medical Loss Ratio data to enrollment reported in CMS' Marketplace effectuated enrollment reports; both data sources are described further below. The share of this coverage that is in ACA-compliant policies was estimated using CMS' risk adjustment annual reports, which provide aggregate ACA-compliant enrollment by state. These reports do not include useable data for Massachusetts and Vermont, so I assume that all individual market coverage in these states was ACA-compliant, which prior work (e.g., Fiedler 2017) suggests is a very good approximation.

Figure 1: Nongroup Enrollment by Policy Type, 2019



Note: Enrollment measured in life-years. MEC = minimum essential coverage.

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regulated as insurance (e.g., health care sharing ministries).⁶ For the purposes of this paper, I am interested only in policies that enrollees may view as substitutes for traditional health insurance, not policies that supplement some other form of coverage (e.g., Medigap policies) or policies that cover a narrow set of services (e.g., dental and vision plans).

These policies are exempt from the requirements that apply to traditional insurance policies and often differ in important ways. Notably, these policies can exclude major categories of services, exclude services related to pre-existing medical conditions, or set dollar limits on how much care they will cover. They can also deny coverage or vary premiums based on health status. While there are no comprehensive data on the characteristics of these policies, it is clear that many offer much more limited financial protection and access to care than other forms of health insurance (e.g., Pollitz et al. 2018; Palanker, Curran, and Salyards 2020). For this reason, the Congressional Budget Office (CBO) treats some people that hold these types of policies as being uninsured in its reports on insurance coverage (CBO 2020b).

There are no systematic data on how many people are enrolled in non-MEC nongroup policies. The lack of data in this area is a major challenge for my analysis, and I discuss how I handle it below.

Data

This section describes the administrative data and household survey data I use to produce this paper's estimates. I begin by describing the estimates of coverage by income group in 2016 produced using tax records by Lurie and Pearce (2019; forthcoming), which form the core of my analysis. I then describe various other survey and administrative data sources that I use to trend those estimates forward to 2019 and make various other needed adjustments. At the end of the section, I also touch briefly on the limitations of household survey data that make it inadvisable to rely solely on survey data for this analysis.

Overview of the Lurie and Pearce Estimates

Under the ACA, all providers of MEC must report annually to the Internal Revenue Service (IRS) on who they covered in each month of the year.⁷ The definition of MEC encompasses almost all types of insurance

⁶ Linke Young (2020) provides a comprehensive introduction to the various forms of insurance or insurance-like products that operate largely or entirely outside of the federal regulatory framework.

⁷ See 26 U.S.C. § 6055. The ACA's implementing regulations provide that the Marketplace, rather than the coverage provider is responsible for reporting Marketplace coverage. See 26 C.F.R. § 1.6055-1(d)(1).

coverage, including employer-sponsored coverage, most nongroup coverage, and all major forms of public coverage (including Medicare, Medicaid, and veterans coverage).⁸ Coverage providers are also required to report what type of MEC each person holds. Thus, in principle, these data offer a nearly comprehensive and quite detailed picture of coverage patterns in the United States.

Lurie and Pearce (2019; forthcoming) use the 2015 and 2016 vintages of these data to produce tabulations of insurance coverage by family (tax unit) modified adjusted gross income as a percentage of the federal poverty level (FPL) for the relevant calendar year.⁹ They obtain data on calendar year income from tax returns or, for people who do not file tax returns, from various information returns received by the IRS (e.g., W-2s).¹⁰ Modified adjusted gross income is the income concept used to determine eligibility for Marketplace subsidies, Medicaid, the Children’s Health Insurance Program (CHIP), and state Basic Health Programs (BHP), although, as discussed further below, those programs use either expected calendar year income or monthly income to determine eligibility, not realized calendar year income.

Tax records have important strengths for the present purposes. The data encompass the entire U.S. population, so they are not subject to sampling error. Additionally, because income reporting is central to tax administration and the relevant reporting processes are very well-established, the income information on tax records is likely of high quality, particularly when the income measure of interest is one used to determine eligibility for tax-based benefits like Marketplace subsidies, as it is here.

By contrast, the reliability of the insurance coverage information reported to the IRS is more uncertain since these reporting requirements are both relatively new and less central to tax administration. Lurie and Pearce examine this question in some detail, but I revisit this question below. In doing so, I focus on the specific tabulations I use in my analysis, tabulations of the number of people with: (1) Marketplace coverage; (2) off-Marketplace nongroup coverage; and (3) no coverage. I consider each in turn.

Marketplace Coverage

The Lurie and Pearce tabulations of Marketplace coverage align very closely with CMS administrative data, which suggests that tax records do a good job of capturing Marketplace coverage. For 2016, Lurie and Pearce report 9.9 million life-years of enrollment in Marketplace coverage, nearly identical to the 10.0 million life-years shown in CMS’ Marketplace effectuated enrollment reports (described further below).

The income distribution of Marketplace coverage reported by Lurie and Pearce also aligns well with estimates of enrollment by income derived from CMS’ Marketplace effectuated enrollment reports and plan selection reports (which are also described further below), as shown in Figure 2. Note that the income distributions in these two data sources would not be expected to agree exactly since the income measure used by Lurie and Pearce reflects actual income for the calendar year, whereas the CMS data generally reflect the income estimate the enrollee provided to the Marketplace at enrollment.¹¹

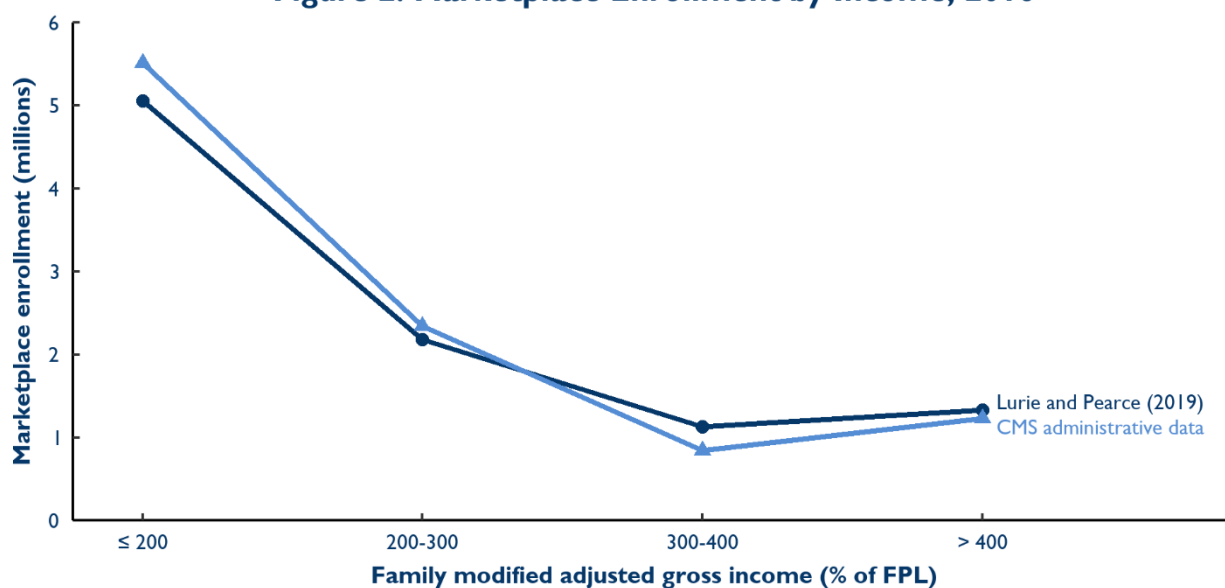
⁸ For a full list of what types of coverage constitutes MEC, see 26 C.F.R. §1.5000A-2.

⁹ Throughout, I use the term “family” as a briefer alternative to “tax unit.”

¹⁰ I rely on tabulations from the working paper version of the authors’ work since some of the necessary tables are not included in the published version. However, the estimates in the two versions are nearly identical.

¹¹ Figure 2 obscures one difference between the two data sources. In particular, the plan selection data show very little enrollment among people with incomes below 100% of the FPL, consistent with the fact that such people are

Figure 2: Marketplace Enrollment by Income, 2016



Note: Estimates include people under age 65 only. Enrollment measured in life-years.

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Off-Marketplace Nongroup Coverage

Lurie and Pearce's tabulations of off-Marketplace nongroup coverage also appear broadly consistent with other administrative data sources. However, it is difficult to make an exact comparison because the Lurie and Pearce tabulations encompass both off-Marketplace individual market MEC and "other designated MEC." The latter category encompasses student health plans, expatriate and inpatriate coverage, group coverage offered to non-employee owners of a business, and certain other forms of coverage.¹²

In detail, Lurie and Pearce report 8.9 million life-years of off-Marketplace nongroup coverage in 2016. For comparison, CMS administrative data (described further below) imply that there were 7.3 million life-years of off-Marketplace individual market MEC (as defined in this paper) in 2016. The difference between these estimates likely reflects the broader scope of the Lurie and Pearce estimates.

No Insurance Coverage

The measures of uninsurance reported by Lurie and Pearce are harder to evaluate. Indeed, Lurie and Pearce use two different methods to estimate the number of uninsured people that generate notably different results. The first counts a person as uninsured if no coverage provider reported providing MEC to that person; it results in an estimate of 52 million life-years of uninsurance in 2016. The second counts

typically ineligible for subsidized Marketplace coverage. By contrast, the Lurie and Pearce tabulations show substantial enrollment at these income levels. This likely, at least in part, reflects the fact that eligibility for subsidized Marketplace is based on *expected* income for the year, while Lurie and Pearce report tabulations based on *realized* income for the year. I discuss these timing differences in much greater detail below.

¹² The instructions for the 1095-B indicate that certain forms of public coverage, notably Basic Health Program coverage, certain pregnancy-related Medicaid coverage, and Refugee Medical Assistance are also supposed to be reported as other MEC (IRS 2016). However, the authors indicate that these forms of coverage appear to generally be reported as public coverage and, as such, are likely not included in their off-Marketplace category.

a person as uninsured if that person has no third-party-reported MEC *and* does not self-report MEC when filing a tax return; it results in an estimate of just 28 million life-years of uninsurance in 2016.

As discussed by Lurie and Pearce, this difference could arise in three main ways. First, some coverage providers may have failed to report coverage to the IRS. Second, some people with non-MEC policies may have erroneously reported those policies as MEC on their tax returns. Third, some people may have fraudulently reported MEC on their tax returns in an effort to avoid the individual mandate penalty.

For the purposes of this paper, I rely on the Lurie and Pearce estimates that incorporate self-reported coverage information. In doing so, I assume that tax filers are reporting both MEC and non-MEC policies on their tax returns but are not fraudulently reporting MEC in substantial numbers. (A corollary of this assumption is that the Lurie and Pearce uninsurance estimate that does not include self-reported coverage information is higher primarily because some coverage providers are failing to report some MEC, as there is probably not enough enrollment in non-MEC plans to explain the difference between the two metrics. However, the evidence presented above suggests that any underreporting probably predominantly affects forms of MEC other than nongroup MEC.)

This assumption has face plausibility. It seems likely that many tax filers are unable to distinguish MEC and non-MEC policies and so unwittingly report non-MEC policies on their tax returns, and it also seems likely that tax filers shy away from willful fraudulent reporting because they fear penalties for doing so. Comparisons to estimates of the number of uninsured produced using major household surveys also suggest that this assumption is reasonable. The surveys plausibly also capture both MEC and non-MEC policies (since the surveys do not distinguish the two types of policies) and likely do not elicit fraudulent misreports (since there is no incentive to misreport in surveys), and they show similar numbers of uninsured life-years in 2016: 28 million in the National Health Interview Survey, 29 million in the American Community Survey, and 35 million in Medical Expenditure Panel Survey, Household Component.^{13,14}

Description of Supplemental Data Sources

While the Lurie and Pearce estimates provide a rich—and likely highly accurate—picture of coverage status by income group (at least with respect to enrollment in nongroup coverage), they do have limitations. Notably, Lurie and Pearce do not report tabulations for years after 2016, nor can they provide estimates of enrollment in non-MEC nongroup policies (since providers of non-MEC policies are not required to report that coverage to the IRS). The Lurie and Pearce estimates are also not disaggregated by some individual characteristics that are relevant for my analysis, particularly immigration status, state of residence, and whether an individual is eligible for employer coverage. To address these limitations, I supplement the Lurie and Pearce data with other administrative data as well as survey data.

I use two supplemental administrative data sources:

- *Marketplace administrative data:* I use two types of administrative records pertaining to Marketplace enrollment in 2016 and 2019: CMS' annual reports on effectuated Marketplace

¹³ The Current Population Survey Annual Social and Economic Supplement also provides a point-in-time estimate of the number of uninsured as of the time of survey administration in early 2016 of 31 million.

¹⁴ Another concern might, of course, be measurement error in the surveys. While, as discussed further below, there is strong evidence that survey respondents frequently misreport what *type* of coverage they hold, it is plausible that they do a better job reporting whether they hold *any* insurance coverage.

enrollment (the “effectuated enrollment” data) and CMS’ annual reports on the characteristics of people who selected plans during open enrollment (the “plan selections” data).

The effectuated enrollment data report the number of people with active Marketplace coverage in each state and month, but, they do not provide the age or income distribution of Marketplace enrollees. The plan selection data do provide age and income breakdowns, but they include people who never paid premiums to effectuate their coverage and do not include people who enroll outside of open enrollment, so they do not accurately report total enrollment. Thus, I frequently combine the two data sources when estimating Marketplace enrollment.

Specifically, I use the plan selection data to estimate the share of Marketplace enrollment accounted for by each income group and then distribute the aggregate enrollment reported in the effectuated enrollment data according to these shares. In doing so, I must account for a variety of data quirks, particularly the fact that the plan selections data lack income breakdowns in 2016 for states that did not use the HealthCare.gov platform. Appendix A provides full details on my methods. As was shown above in Figure 2, the resulting estimates of Marketplace enrollment by income align well with the estimates reported by Lurie and Pearce for 2016.

- *Medical loss ratio filings:* To administer the ACA’s medical loss ratio (MLR) requirements, CMS requires insurers that offer individual market MEC (including ACA-compliant, grandfathered, and transitional policies) to annually report a wide array of financial and other information, including enrollment.¹⁵ The MLR filings thus provide information on aggregate enrollment in this universe of policies. In combination with the data on Marketplace effectuated enrollment described above, they can also be used to estimate aggregate enrollment in off-Marketplace MEC by subtraction.

I also use four major household surveys: the American Community Survey (ACS); the Current Population Survey Annual Social and Economic Supplement (CPS-ASEC); the Medical Expenditure Panel Survey, Household Component (MEPS-HC); and the Survey of Income and Program Participation (SIPP). All of these surveys provide rich information on the characteristics of household members, including their coverage status, income, demographics, and relationships to one another. Some also provide information on state of residence (ACS, CPS-ASEC, and SIPP) or whether a respondent is offered coverage by an employer (CPS-ASEC and MEPS-HC), a point I discuss at greater length below.

It is frequently useful to place survey respondents into income groups that conceptually align with the income categories reported by Lurie and Pearce. To do so, I use the family relationship and income information to group household members into tax units according to IRS rules. I then calculate each tax unit’s modified adjusted gross income for the 12-month period for which the survey reports that information.¹⁶ Code for assembling tax units and calculating income is available upon request.

¹⁵ As a technical matter, the MLR reporting requirement, unlike the IRS reporting requirements, is not linked to the definition of MEC, but in practice the MLR definition aligns with the definition of individual market MEC.

¹⁶ In the CPS-ASEC, MEPS-HC, and SIPP, this 12-month period is the calendar year. In the ACS, it is the 12-month period ending with the date on which the respondent answered the survey.

Limitations of Survey Data Sources

In light of the rich information included in the survey data sources, a natural question is why I do not rely solely on these surveys to produce the estimates in this paper. The most important problem is that the household surveys have well-documented problems measuring nongroup enrollment.

Recent research by Pascale, Fertig, and Call (2019) comparing coverage information collected using the ACS and CPS-ASEC survey instruments to linked administrative records finds that many respondents underreport nongroup coverage (i.e., fail to report nongroup coverage when they do in fact hold it) or overreport nongroup coverage (i.e., report nongroup coverage when they do not in fact hold it). In many cases, this appears to reflect respondents' confusion about what type of coverage they hold. In other cases, respondents may report narrow forms of coverage, like dental insurance, as health insurance. There is little reason to expect other survey data sources to do dramatically better in this regard.¹⁷

Where there is no alternative to drawing on survey data sources, I take steps to address their limitations whenever feasible. Most importantly, when estimating nongroup enrollment in the ACS and CPS-ASEC, I only count people who report "direct purchase" coverage and no other form of coverage, rather than counting all people who report direct purchase coverage. This approach is motivated by the findings of Pascale, Fertig, and Call (2019). As shown in Appendix B, their results imply that 93% of people who report both direct purchase and another form of coverage in the ACS do not actually hold nongroup coverage as defined in this paper. Excluding these respondents from my measure of nongroup enrollment makes a considerable difference. In the ACS in 2019, for example, excluding these people reduced measured nongroup enrollment by 27% in the non-elderly population and 55% in the full population.¹⁸

Before proceeding, I note that the survey data sources likely also do a worse job of measuring income than the tax data. This is an important reason for preferring the Lurie and Pearce tabulations of uninsurance to those derived from surveys despite the fact, discussed above, that the Lurie and Pearce tabulations may not measure uninsurance perfectly. Indeed, Lurie and Pearce show a somewhat different income distribution of uninsurance (and the overall population) than the surveys.¹⁹ One corollary of this mismatch is that prior work that has compared nongroup enrollment measured using administrative data to uninsurance measured using survey data could generate biased estimates of take-up rates.

Methodology

My ultimate goal is to estimate how many life-years non-elderly potential subsidy recipients (as defined in the introduction of this paper) contributed to each of four coverage categories in 2019: (1) Marketplace

¹⁷ The MEPS-HC is sometimes thought to do somewhat better at measuring what types of coverage people hold (e.g., Hill 2007; Banthin et al. 2019). However, in unreported analysis, I found that the MEPS-HC did a poor job of matching the income distribution of Marketplace enrollment, suggesting misreporting may be a problem there as well. The MEPS-HC also offers smaller sample sizes, particularly relative to the ACS, and it is not yet available for 2019. The MEPS-HC public use file also omits one of the fields needed for this analysis: state of residence.

¹⁸ The larger effect in the full population likely reflects the fact that few elderly people hold nongroup plans as a primary source of coverage, but many do hold Medigap plans and report these as direct purchase coverage.

¹⁹ I experimented with using the ACS to measure uninsurance rather than the Lurie and Pearce data. This would lead to moderately different quantitative estimates but would not change my main qualitative conclusions.

coverage; (2) off-Marketplace MEC; (3) non-MEC nongroup policies; and (4) fully uninsured. I produce estimates for six income groups defined based on calendar year family modified adjusted gross income as a percentage of the FPL: less than 200%, 200-300%, 300-400%, 400-500%, 500-600%, 600% or higher.

To that end, I begin with the Lurie and Pearce tabulations of the number of non-elderly life-years of Marketplace coverage, off-Marketplace MEC, and uninsurance by income group in 2016. I then make a series of adjustments to the Lurie and Pearce estimates.²⁰ Specifically, I:

- (1) Adjust for the fact that Lurie and Pearce’s estimates of off-Marketplace nongroup MEC enrollment include forms of coverage outside the definition of nongroup coverage used in this paper.
- (2) Derive crude estimates of enrollment in non-MEC nongroup policies in 2016 by income group based on the fragmentary information available on enrollment in those policies.
- (3) Trend the resulting estimates forward to 2019 using a combination of CMS Marketplace administrative data and tabulations of coverage by income in the ACS.
- (4) Adjust the resulting tallies to exclude people who are not potential subsidy recipients using estimates derived from the CPS-ASEC and MEPS-HC.

The remainder of this section describes each step in much greater detail.

Step 1: Adjust Lurie and Pearce Off-Exchange Enrollment Estimates

As described above, Lurie and Pearce’s off-Marketplace nongroup coverage category encompasses both off-Marketplace individual market MEC *and* various other minor coverage types that fall under the heading of “other designated MEC.” Consistent with this, Lurie and Pearce’s estimate of off-Marketplace nongroup enrollment in 2016 is 21% larger than the estimate of off-Marketplace individual market MEC enrollment obtained by comparing the MLR data to CMS’ Marketplace effectuated enrolment reports.

Other designated MEC is outside the scope of this analysis, so I adjust the Lurie and Pearce tabulations to exclude this form of coverage. Unfortunately, I am unaware of any information on the income distribution of other designated MEC. Thus, I make a simple proportional reduction to the off-Marketplace nongroup enrollment reported by Lurie and Pearce for each income group to align their estimates with the aggregate amount of off-Marketplace individual market MEC shown in CMS administrative tallies.²¹

Step 2: Estimate Enrollment in Non-MEC Nongroup Policies in 2016

A major challenge for this analysis is that there is little direct evidence on how many people hold non-MEC nongroup policies. Notably, the Lurie and Pearce estimates do not capture enrollment in non-MEC nongroup policies since insurers are not required to report enrollment in these policies to the IRS.

²⁰ Lurie and Pearce note that a small number of people show up in the tax data as having more than one source of coverage. I ignore any overlap in constructing my estimates, as overlap between Marketplace coverage and off-Marketplace MEC seems likely to be particularly rare in practice.

²¹ This approach could go seriously awry if there is substantial underreporting of off-Marketplace individual market MEC in the tax data and, thus, “other designated MEC” accounts for a larger fraction of the Lurie and Pearce off-Marketplace nongroup category than it appears. In principle, it should be possible to use the tax data to check whether this is, in fact, the case. Future work along these lines would be worthwhile.

To fill this gap, I proceed as follows. First, I derive a crude estimate of aggregate enrollment in non-MEC nongroup policies in 2019 based on fragmentary information that is in the public domain. Second, I trend that estimate back to 2016 by comparing coverage trends in the ACS (which plausibly captures both MEC and non-MEC policies) to coverage trends in the MLR data (which captures only MEC policies). Third, I assume that enrollment in non-MEC nongroup policies is distributed by age and income in the same way as off-Marketplace MEC. I discuss each of these steps in greater detail below.

Derive Crude Estimates of 2019 Enrollment

I am aware of just two data points on enrollment in non-MEC nongroup policies. First, an investigation by the House Committee on Energy and Commerce that obtained aggregate enrollment information from nine of the largest issuers of short-term limited duration policies found that 3.0 million people purchased such a policy from one of these insurers at some point during 2019 (House Committee on Energy and Commerce 2020). If the typical policy lasts six months (a reasonable, if somewhat arbitrary, assumption), then this would translate to 1.5 million life-years of enrollment in short-term limited duration policies during 2019. Second, the Alliance of Health Care Sharing Ministries (AHCSM), a trade association of health care sharing ministries, reported in May 2020 that 1.0 million people were members of ministries affiliated with the alliance, although it is unclear how this estimate was derived (AHCSM 2020).

Drawing on this evidence, I assume in my primary estimates that there were 3.5 million life-years of enrollment in non-MEC nongroup policies in 2019. This estimate is the sum of the two estimates described in the last paragraph plus an allowance of 1.0 million life-years for enrollment in policies that were sold by companies that are not included in these estimates, as well as enrollment in other categories of non-MEC nongroup policies, particularly fixed indemnity policies. In light of the considerable uncertainty around this estimate, I also present results from sensitivity analyses in which I assume that non-MEC nongroup enrollment in 2019 was 50% higher or 50% lower than this estimate.

Trend Estimate Back to 2016 by Comparing ACS and MLR Trends

I am aware of no data on how enrollment in non-MEC nongroup policies changed from 2016 to 2019.²² Consequently, I try to infer how enrollment in these non-MEC nongroup policies changed from 2016 to 2019 by comparing enrollment trends in the MLR data to enrollment trends in the ACS.²³

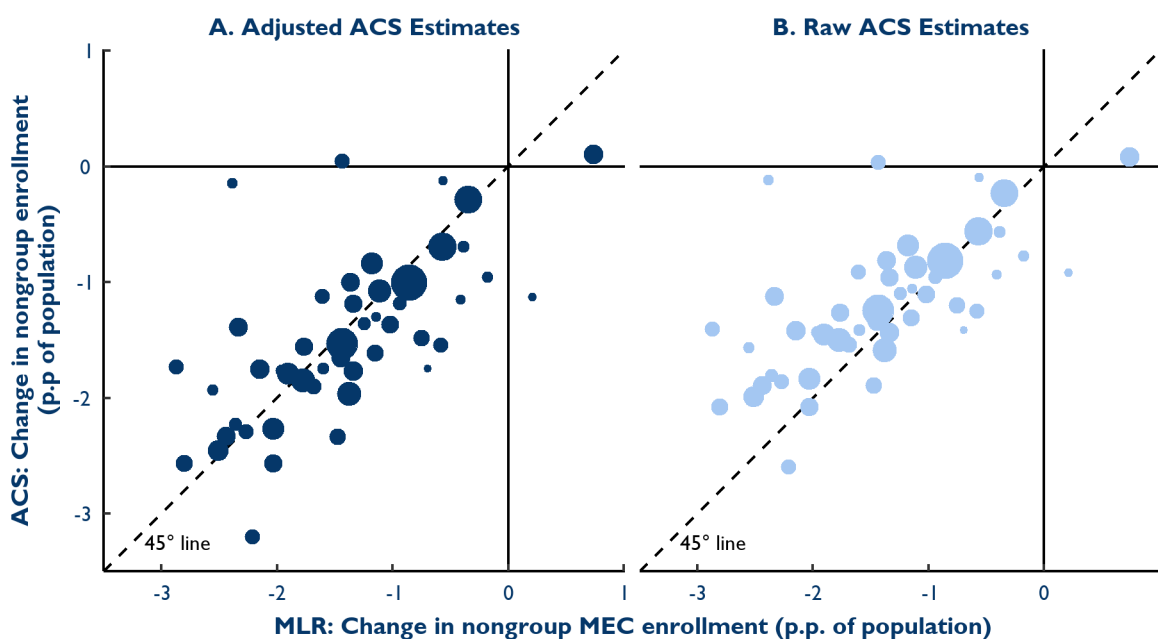
As described earlier, the MLR data only capture enrollment in nongroup MEC. By contrast, the ACS asks whether each household member was covered by “insurance purchased directly from an insurance company.” While it is unclear how respondents interpret this question, it is plausible that they report both MEC and non-MEC nongroup policies in this category. In principle, therefore, the change in non-MEC nongroup enrollment can be inferred by subtracting the change in nongroup enrollment observed in the MLR data from the change in nongroup enrollment observed in the ACS.

An important complication is that, as noted above, the ACS suffers from both under- and over-reporting of nongroup coverage, which distorts the enrollment trends observed in the ACS. Appendix B presents a

²² A partial exception is that archived versions of the AHCSM website report enrollment for earlier periods. In particular, the AHCSM reported enrollment of “more than 600,000” in June 2016 (AHCSM 2016), which suggests that health care sharing ministry enrollment may have risen from 2016 to 2019. However, it is unclear whether these earlier estimates are comparable to the AHCSM’s more recent estimates, and, in any case, enrollment in health care sharing ministries appears to account for a minority of enrollment in non-MEC nongroup policies.

²³ I use the ACS here because its large sample size makes it well suited to produce state-level estimates.

Figure 3: ACS vs. MLR Nongroup Enrollment Trends by State, 2016-2019



Note: Marker size reflects state population in 2016. Plot excludes New Hampshire, which experienced an idiosyncratic large decline in MLR-measured enrollment because it stopped covering Medicaid expansion enrollees through nongroup plans during this period. ACS = American Community Survey; MLR = medical loss ratio; MEC = minimum essential coverage.

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simple statistical model of this classification error and derives the usual result (e.g., Aigner 1973) that classification error will tend to attenuate observed changes in nongroup enrollment. In this framework, the degree of attenuation equals the sum of the underreporting rate (i.e., the propensity of people with nongroup coverage to fail to report that coverage) and the overreporting rate (i.e., the propensity of people without nongroup coverage to report such coverage). The relevant underreporting and overreporting rates can then be estimated from the results of Pascale, Fertig, and Call (2019). Those calculations suggest an underreporting rate of 18% and an overreporting rate of 1%. Plugging those estimates into the formula derived in Appendix B then implies that the actual change in nongroup enrollment can be estimated by multiplying the change observed in the ACS by 1.23 ($=1/(1-0.18-0.01)$).

Panel A of Figure 3 displays the resulting comparison between the ACS- and MLR-based estimates of changes in nongroup enrollment at the state level. The two estimated enrollment changes are tightly correlated and very similar on average, which suggests that enrollment in non-MEC nongroup plans changed only slightly over this period. (Panel B shows that the picture would be somewhat different without the adjustment for coverage misreporting. The unadjusted ACS-based estimates typically show smaller nongroup enrollment declines than the MLR-estimates, erroneously suggesting that non-MEC enrollment rose over this period. However, the two measures would still be tightly correlated, reflecting the fact that there is substantial “signal” regarding changes in nongroup enrollment in the ACS data.)

Stepping back to the national level, the MLR data indicate that the share of people holding individual market MEC fell from 5.37% in 2016 to 4.08% in 2019, a decline of 1.29 percentage points. For comparison, after adjusting for coverage misreporting, the ACS indicates that the share of the population with nongroup coverage fell by a slightly larger 1.34 percentage points. Correspondingly, I proceed under the

assumption that the share of the population with non-MEC nongroup policies was 0.05 percentage points larger in 2016 than in 2019. Under my base estimate of non-MEC enrollment in 2019 (which was described above), this implies that 1.1% of the population was enrolled in non-MEC nongroup policies in 2016, corresponding to non-MEC nongroup enrollment of 3.6 million life-years in 2016.²⁴

As an aside, I note that the apparent stability of enrollment in non-MEC policies over this period likely reflects the effect of offsetting factors. On the one hand, the relative price of non-MEC nongroup policies fell over this period both because the premiums of ACA-compliant plans rose (e.g., CMS 2019) and because the penalty associated with the ACA's individual mandate (which, with the exception of some health care sharing ministries, non-MEC policies did not satisfy) went away starting in 2019. The Trump administration also substantially liberalized rules governing short-term limited duration plans starting in late 2018. On the other hand, many states implemented new restrictions on short-term plans during this period (Palanker, Kona, and Curran 2019), which likely worked in the opposite direction.

Distribute Across Income Groups Based on Lurie and Pearce Estimates

I am aware of no evidence on how enrollment in non-MEC nongroup policies is distributed by income. However, much like off-Marketplace MEC, non-MEC nongroup policies likely primarily appeal to people who are not eligible for subsidized Marketplace coverage or who find Marketplace coverage unattractive for some other reason.²⁵ Correspondingly, in my base estimates, I assume that the income distribution of non-MEC nongroup policies matches the distribution of off-Marketplace MEC enrollment reported by Lurie and Pearce.²⁶ I also present results from a sensitivity analysis in which I distribute half of non-MEC enrollment proportionally to *all* MEC enrollment, rather than just off-Marketplace MEC enrollment.

Step 3: Use ACS and Administrative Data to Trend Estimates Forward to 2019

Steps 1 and 2 produce estimates for 2016 since the Lurie and Pearce estimates are for that year. But the ultimate goal is to obtain estimates for 2019, so I use a combination of administrative and ACS data to trend the estimates from Steps 1 and 2 forward to 2019. I use different approaches for the Marketplace coverage, off-Marketplace coverage, and uninsured coverage categories. I discuss each in turn.

Marketplace Coverage

CMS administrative data provide direct information on trends in Marketplace enrollment by income group, so I use these data to trend Marketplace enrollment forward to 2019. To be precise, I begin with the Lurie and Pearce estimate of non-elderly Marketplace enrollment in each income group in 2016. I then add the change in non-elderly Marketplace enrollment in that income group from 2016 and 2019 derived from CMS Marketplace administrative data using the method described in Appendix A.²⁷

²⁴ In converting this percentage to a number of people, I use Lurie and Pearce's estimate of the total population in 2016, which differs slightly from the ACS estimate, in order to maintain consistency with the rest of the analysis.

²⁵ The one important difference may be that that relatively healthy people who benefit from the underwriting process are likely to prefer non-MEC policies while others may prefer off-Marketplace MEC policies.

²⁶ Technically, I assume that the distribution of non-MEC nongroup enrollment by income *and* age matches the distribution of off-Marketplace MEC enrollment reported by Lurie and Pearce. The age portion of this assumption allows me to estimate what (small) fraction of this enrollment is attributable to people over age 65.

²⁷ One complication is that the estimates derived from the CMS administrative data combine everyone with incomes above 400% of the FPL into a single group. I address this by splitting the change from 2016 to 2019 proportionally to the enrollment shown in the Lurie and Pearce data for each income group in 2016.

Off-Marketplace Coverage

Unlike Marketplace coverage, there are no administrative data that depict trends in off-Marketplace coverage by income group. Thus, I use the ACS to trend *total* nongroup enrollment (i.e., combined enrollment in Marketplace coverage, off-Marketplace MEC, and non-MEC nongroup policies) by income group forward to 2019. I then derive off-Marketplace enrollment as a residual, and I then further decompose this residual into components accounted for by MEC and non-MEC policies.

To be precise, for each income group, I use the estimates from Steps 1 and 2 to calculate the share of the overall non-elderly population that had nongroup coverage and fell in each income group in 2016. I then use the ACS to estimate how the shares for each income group changed from 2016 to 2019; in doing so, I adjust the changes observed in the ACS for coverage misreporting using the method described in Appendix B. I then add the adjusted ACS-derived change to the base 2016 shares and multiply each resulting share by the non-elderly population in 2019 to obtain an estimate of total non-elderly nongroup enrollment in each income group in 2019.²⁸ (Observe that, by construction, this approach generates an estimate of aggregate nongroup enrollment in 2019 that is consistent with the level of nongroup MEC enrollment shown in the MLR data and the estimate of non-MEC nongroup enrollment derived in Step 2.)

Given these estimates of total nongroup enrollment by income group, I then derive an estimate of off-Marketplace enrollment (including both MEC and non-MEC off-Marketplace policies) for each income group by subtracting Marketplace enrollment. Finally, I split apart MEC and non-MEC off-Marketplace enrollment by assuming that non-MEC enrollment is distributed proportionally to off-Marketplace MEC enrollment, paralleling my approach to distributing non-MEC enrollment in 2016. (Also paralleling my approach above, the sensitivity analyses consider scenarios in which half of non-MEC enrollment is distributed proportionally to total MEC enrollment, rather than just off-Marketplace MEC enrollment.)

Uninsured

There are also no administrative data that depict trends in uninsurance from 2016 to 2019, so I trend the Lurie and Pearce estimates for 2016 forward to 2019 using the ACS. To be precise, I begin with the share of the overall non-elderly population accounted for by non-elderly people who are uninsured and fall in each income group in 2016, which I calculate directly from the Lurie and Pearce estimates. I then use the ACS to estimate how the share corresponding to each income group changed from 2016 to 2019. Finally, I add the ACS-derived change to the base 2016 shares and multiply by the non-elderly population in 2019 to obtain estimates of the number of uninsured by income group in 2019.²⁹

A Note on Nongroup Coverage Trends

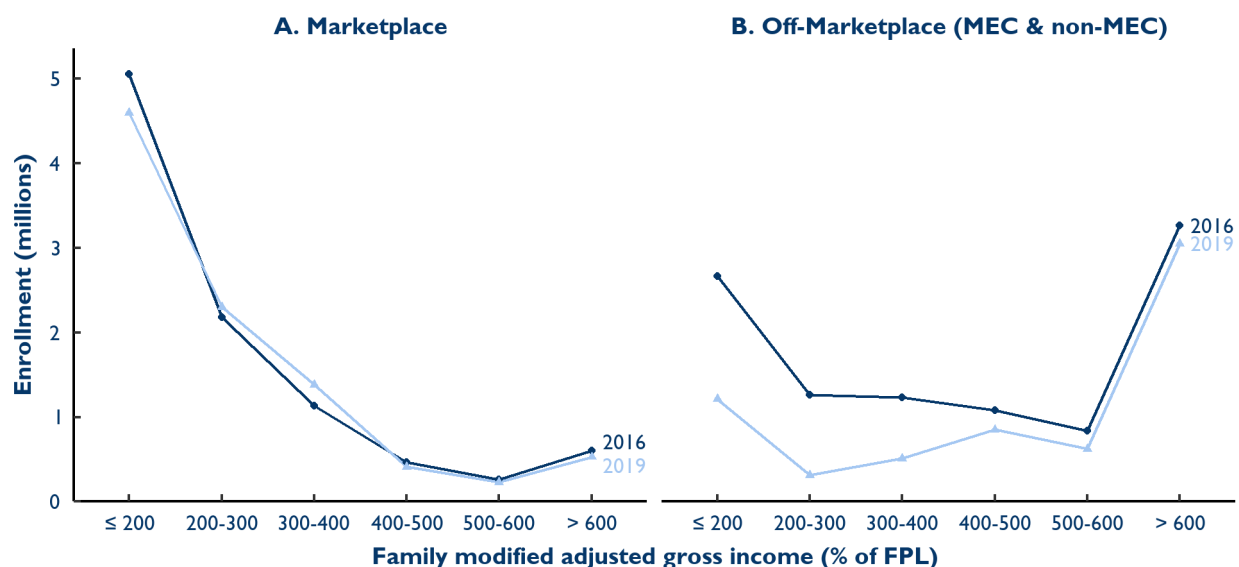
While the main focus of this paper is on coverage patterns in 2019, I want to pause briefly to remark on the estimated trends in nongroup enrollment by income depicted in Figure 4, which are a byproduct of my method. To my knowledge, estimates of enrollment trends by income group that disaggregate on- and off-Marketplace coverage have not been reported elsewhere.

The most striking feature of Figure 4 is the large decline in off-Marketplace enrollment depicted in Panel B. Since I estimate that non-MEC nongroup enrollment was roughly stable over this period, this trend is

²⁸ I assume that the total population in 2019 is the total population reported by Lurie and Pearce for 2016, trended forward to 2019 based on the percentage change in the total population shown in the ACS.

²⁹ I use the same population estimate in this calculation as in the calculation for off-Marketplace coverage above.

Figure 4: Estimated Nongroup Enrollment, 2016 and 2019



Note: Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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driven almost entirely by a decline in off-Marketplace MEC enrollment. This decline has been documented elsewhere (e.g., Fehr, Cox, and Levitt 2019). And the decline itself is not particularly surprising given the large increase in individual market premiums over this period (e.g., CMS 2019). The “churning out” of healthy people who held underwritten grandfathered or transitional policies likely also played a role.

However, to the extent this decline was driven by rising premiums, it is somewhat surprising that the large declines in off-Marketplace enrollment among people with incomes below 400% of the FPL were not matched by increases in *Marketplace* enrollment in that income range. This could indicate that some of these enrollees were unaware that subsidized coverage was available, which would be consistent with survey evidence showing that awareness of the ACA’s Marketplace subsidies is incomplete (Gupta and Collins 2019; Pollitz et al. 2020). Alternatively, it could indicate that the stability of Marketplace enrollment depicted in Panel A may be a bit of an illusion; that is, an influx of enrollees who used to hold off-Marketplace plans may have masked departures from the Marketplace attributable to elimination of the individual mandate penalty, implementation of Medicaid expansion in additional states, and other factors. Thus, this pattern does suggest caution in drawing conclusions about, for example, the effect of repealing the individual mandate based solely on trends in Marketplace enrollment over this period.

Another notable pattern depicted in Figure 4 is that Marketplace enrollment rose among people in the 200-400% of FPL income range even as it fell at other income levels. This pattern may reflect the transition to “silver loading” after the Trump administration ended cost-sharing reduction payments. Silver loading increased the value of the premium and reduced net premiums for bronze and gold plans, which greatly improved enrollees’ options in the 200-400% of the FPL range; it did not similarly improve enrollees’ options at lower income-levels since it did not reduce net premiums for silver plans, and lower-income enrollees are generally best off purchasing silver plans since only silver plans convey eligibility for cost-sharing reductions. Consistent with that, other work has found that silver loading increased enrollment differentially in the 200-400% of FPL group (Aron-Dine 2019; Sprung and Anderson 2018).

Step 4: Adjust Estimates to Exclude People Outside the Populations of Interest

Steps 1-3 produce estimates of the number of life-years of enrollment in Marketplace coverage, off-Marketplace MEC, and non-MEC nongroup policies, as well as the number of life-years of uninsurance, by income group. The final step is to adjust these estimates to exclude life-years attributable to people who were not potential subsidy recipients, that is, people who: (1) were not legally present in the United States; (2) were eligible for employer or public coverage; or (3) fell in the Medicaid “coverage gap.”

Published administrative tallies do not provide the information needed to estimate how many people fall in these groups.³⁰ Thus, I use survey data to estimate what share of uninsured and nongroup life-years in each income group are attributable to people outside the population of interest. I then use these shares to proportionally reduce the estimates of enrollment by income group that emerge from Steps 1-3.

In producing the required shares, I rely principally on the CPS-ASEC, as it comes closest to containing all of the needed data elements.³¹ I use the 2019 CPS-ASEC despite the fact that the income information and most of the coverage information it collects pertains to 2018 (rather than 2019) since the 2020 CPS-ASEC may have been distorted by the onset of the COVID-19 pandemic.³² I take different approaches to calculating the excluded shares of uninsured and nongroup life-years, so I describe each in turn.

Adjusting Estimates of Uninsured Life-Years

In calculating the share of uninsured life-years to exclude, the first step is to determine the number of uninsured life-years contributed by each CPS-ASEC respondent. To do so, I use the CPS-ASEC question on calendar year uninsurance, which reports whether the person was uninsured for the full year, part of the year, or none of the year. For these purposes, I treat people who are uninsured for part of the year as contributing 4.5 months of uninsurance, which is the mean number of months of uninsurance among non-elderly part-year uninsured people in the MEPS-HC 2018 Full-Year Consolidated File.³³

The next step is to identify respondents that have one (or more) of the characteristics that exclude a person from being considered a potential subsidy recipient. The rest of this section discusses, in turn, how I identify respondents that have each of the relevant characteristics. Panel A of Figure 5 summarizes the share of uninsured life-years excluded on the basis of each of these characteristics.

People not legally present. The CPS-ASEC directly reports citizenship status, but it does not report whether non-citizens are legally present. Thus, I impute legal status using a method adapted from Borjas (2017), which is in turn a simplified version of the method presented by Passel and Cohn (2014). The

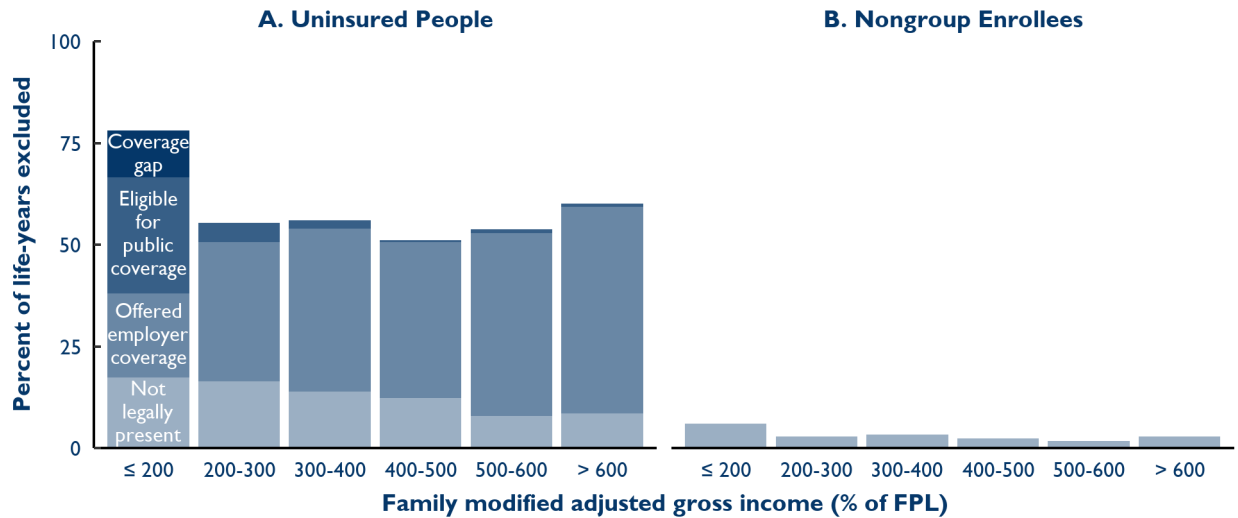
³⁰ In principle, some of these questions could be answered using the microdata used to produce the Lurie and Pearce estimates. Notably, it would be possible to simulate eligibility for public coverage, and these records would provide some information on eligibility for employer coverage, at least for people employed by large firms.

³¹ The ACS and SIPP lack information on employer coverage offers, while the MEPS-HC public use file does not report respondents’ state of residence, which makes it impossible to assess eligibility for public coverage.

³² The pandemic may have reduced data quality by reducing response rates (Census Bureau 2020). Additionally, if using the 2020 CPS-ASEC, I would have needed to rely on the variable reporting whether the respondent had an employer offer at the time of the survey, which would have been directly affected by the pandemic.

³³ In practice, the large majority of people reporting any uninsurance during 2018 in the CPS-ASEC report being uninsured for the full year, so the precise handling of the part-year uninsured is not particularly important.

Figure 5: Percent Who Are Not Potential Subsidy Recipients by Income



Note: Potential subsidy recipients are people who are legally present, ineligible for public and employer coverage, and not in the Medicaid "coverage gap." Each column segment shows the percentage of people excluded from the population of potential subsidy recipients due to the specified characteristic when exclusions are applied from bottom to top. Estimates include people under age 65 only.

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Congressional Budget Office uses a similar method to impute legal status in its health insurance microsimulation model (Banthin et al. 2019). Full details are in Appendix C.

People eligible for employer coverage: To determine who has access to employer coverage, I start with the CPS-ASEC question on whether the respondent’s employer offers coverage. The CPS-ASEC question pertains to the time of the interview (February-April 2019) rather than the calendar year period (2018) for which the CPS-ASEC provides income and the uninsurance variable I rely upon. Thus, I use a regression model estimated in the MEPS-HC to “backcast” the employer offer variable; this approach is again similar to the approach used by the Congressional Budget Office (Banthin et al. 2019).

In detail, I use the MEPS-HC Panel 22 Longitudinal File to estimate a logit model in which the outcome is whether the respondent or anyone in the respondent’s family is *currently* offered coverage at work.³⁴ The predictor variables are an indicator variable for whether the respondent or a family member has an offer early in the subsequent calendar year, as well as a restricted cubic spline in modified adjusted gross income for the current calendar year as a percentage of the FPL. I estimate the model at the person-interview level. I limit the estimation sample to interviews where the respondent is under age 65 and uninsured to match the intended imputation sample as closely as possible.

This regression model produces an estimate of the probability that each respondent had access to employer coverage at any given point in the prior calendar year. For people who otherwise appear to be potential subsidy recipients, I then exclude a share of the associated life-years equal to this probability.³⁵

³⁴ I include family offers since virtually all employers that offer coverage offer dependent coverage (KFF 2020b).

³⁵ This approach amounts to assuming that the probability a person has an employer offer is uncorrelated with the person’s other characteristics, conditional on the variables included in the prediction model. This assumption is surely not precisely correct, but also may not be a bad approximation.

People eligible for public coverage. I impute eligibility for public coverage in two steps. First, I determine whether families are income-eligible for Medicaid, CHIP, or the Basic Health Program based on the calendar year income they report on the CPS-ASEC and state and age-specific income thresholds for Medicaid and CHIP collected by the Kaiser Family Foundation (Brooks, Roygardner, and Artiga 2019), as well as the Basic Health Program eligibility thresholds in the two states that have them (Minnesota and New York).³⁶ Second, I exclude people who are not legally present, as well as legal immigrants who have held that status for less than five years, as these groups are generally not eligible for Medicaid and CHIP; in doing so, I measure immigration status the same way described above.³⁷ Due to data limitations, I do not model pregnancy- or disability-related Medicaid and CHIP eligibility pathways, nor do I model eligibility for other forms of public coverage (e.g., Medicare or Veterans Affairs coverage).

A limitation of my approach is that eligibility for public coverage is based on monthly income or, in some cases, expected calendar year income, which will generally differ from realized calendar year income.³⁸ Consequently, some people with realized calendar year income below the relevant eligibility threshold may not have been eligible for these programs in some months, and vice versa. A similar problem arises if calendar year income is measured with some error in the CPS-ASEC, as seems likely. Appendix D analyzes the potential bias and shows that it is plausibly modest. Consistent with this, when I used the 2018 SIPP (which provides monthly income information) to compare estimates in which I calculated eligibility based on calendar year income to estimates in which I calculated eligibility based on income measures closer to those actually used in eligibility determinations, I found that the income concept used has little effect on the share of uninsured people estimated to be eligible for public coverage.³⁹

People in the “coverage gap.” The final group I must identify is people who fall in the “coverage gap”; that is, people who are ineligible for Medicaid by virtue of their state’s decision not to expand Medicaid and ineligible for subsidized Marketplace coverage by virtue of having an income below 100% of the FPL. I exclude this group by excluding US citizen respondents who report calendar year income below 100% of the FPL who were not already excluded by virtue of being eligible for public coverage.⁴⁰

As with my approach to imputing eligibility for public coverage, a downside of this approach to identifying people in the coverage gap is that eligibility for subsidized Marketplace coverage is based on expected

³⁶ In making these calculations, I apply Medicaid’s definition of a household and its rules for counting income, which differ from those that apply to premium tax credit. Code is available upon request.

³⁷ An exception is that states do have the option to allow lawfully present non-citizen children and pregnant women to enroll in Medicaid and CHIP even if they have been in the United States for less than five years. I take account of this fact in my eligibility imputations using information on which states have taken up this option collected by the Kaiser Family Foundation (Brooks et al. 2020).

³⁸ Medicaid/CHIP eligibility determinations are typically based on monthly income. However, for people with monthly income too high to qualify for Medicaid/CHIP but expected calendar year income too low to qualify for subsidized Marketplace coverage (i.e., below 100% of the FPL), Medicaid/CHIP eligibility is instead based on expected calendar year income. For a brief summary of these rules, see CBPP and CLASP (2020).

³⁹ For the SIPP analyses, I calculated expected calendar year income as the income the person would receive for the calendar year if the individual’s income in each future month matched the current month’s income.

⁴⁰ It is necessary to take account of citizenship status in this step because legally present non-citizens are eligible for subsidized Marketplace coverage even if they have income below 100% of the FPL.

calendar year income, which may differ from actual calendar year income; furthermore, income may be measured with error in the CPS-ASEC.⁴¹ As above, however, the analysis in Appendix D suggest that this bias is likely to be modest. Consistent with this, when I used the 2018 SIPP to compare estimates in which eligibility for subsidized Marketplace coverage is calculated based on actual versus expected calendar year income, the share of uninsured life-years estimated to fall in the coverage gap was very similar.

Adjusting Estimates of Nongroup Life-Years

For nongroup coverage, I take a very different approach to excluding life-years belonging to people outside the universe of potential subsidy recipients. In particular, I simply assume that no one who is actually enrolled in nongroup coverage is eligible for public coverage, has access to employer coverage, or falls in the coverage gap. The rationale for this approach is that people in these categories are almost always ineligible for subsidized Marketplace coverage.⁴² People with access to public or employer coverage are likely to find that coverage much more attractive than unsubsidized Marketplace coverage since it will almost always offer lower premiums and, in many cases, more comprehensive coverage. And people with incomes low enough to fall in the coverage gap (or to qualify for public coverage) are likely to find unsubsidized Marketplace coverage hard to afford even if they lack other options.

In practice, some people with access to public or employer coverage or who fall in the coverage gap surely do enroll in nongroup coverage. To the extent that is the case, I will overstate the number of nongroup enrollees who are potential subsidy recipients under my definition and, correspondingly, overstate take-up of nongroup coverage in those populations. But this bias seems likely to be relatively small.

Moreover, the alternative of estimating these shares using the CPS-ASEC or other survey seems likely to generate much larger biases for two reasons. First, as discussed at length above, survey respondents commonly report holding nongroup coverage when they in fact hold other forms of coverage (Pascale, Fertig, and Call 2019). Consequently, some people who are eligible for public or employer coverage—and are actually enrolled in public or employer coverage—will report nongroup coverage instead. Because, as described above, people who actually have access to public or employer coverage are very unlikely to enroll in nongroup coverage, this type of misreporting is likely to create a substantial upward bias in estimates of how many nongroup enrollees have access to public or employer coverage.

Second, as also discussed above, surveys measure income with some error, and the calendar year income measure reported on the CPS-ASEC does not precisely correspond to the income measures that govern program eligibility. Appendix D shows that this is likely to create a substantial upward bias in the share of nongroup enrollees estimated to be eligible for public coverage or fall in the coverage gap. Intuitively, this is because some people who are, in fact, eligible for subsidized Marketplace coverage—and actually enroll in that coverage—will *appear* to have lower incomes that either make them eligible for public coverage

⁴¹ While eligibility for Marketplace subsidies is determined in real time based on expected income, individuals may receive additional premium tax credit or be required to repay some premium tax credit when they file their tax returns if their actual calendar year income ends up differing from their expected income, subject to some limits on how much an individual can be required to repay. See CBPP (2013) for an overview of these rules.

⁴² The exception is people offered an employer plan that is not “affordable” (meaning, in 2019, the premium for self-only coverage exceeded 9.86% of income) or that failed to provide “minimum value” (meaning it did not cover at least 60% of expected medical spending).

or put them in the coverage gap. This will substantially distort the estimated shares since people who are *actually* eligible for public coverage or in the coverage gap are unlikely to enroll in nongroup coverage.

I do rely on the CPS-ASEC to estimate the share of non-elderly nongroup enrollees who are not legally present in the United States. As depicted in Panel B of Figure 5, these shares are generally small. In applying these shares, I assume that all nongroup enrollees who are not legally present are enrolled in off-Marketplace coverage since people who are not legally present cannot enroll in Marketplace coverage.

Results

Figure 6 reports the paper's principal results. The width of each column in Figure 6 represents the share of the overall population of potential subsidy recipients accounted for by each income group, while the height of each segment within a column represents the share of potential subsidy recipients in that income group who have the listed coverage status.⁴³ These estimates have several notable features.

First, only about half of potential subsidy recipients were enrolled in nongroup MEC, and take-up rates varied only modestly with income; this fraction was 52% among people with incomes below 400% of the FPL, versus 49% above 400% of the FPL. These estimates indicate that there was considerable scope to increase enrollment in nongroup MEC at all income levels, including at income levels where Marketplace subsidies were already available as of 2019. This implies that the recently enacted American Rescue Plan Act, which both made subsidies more generous for people already eligible and extended them above 400% of the FPL, has the potential to increase MEC enrollment across the income distribution.

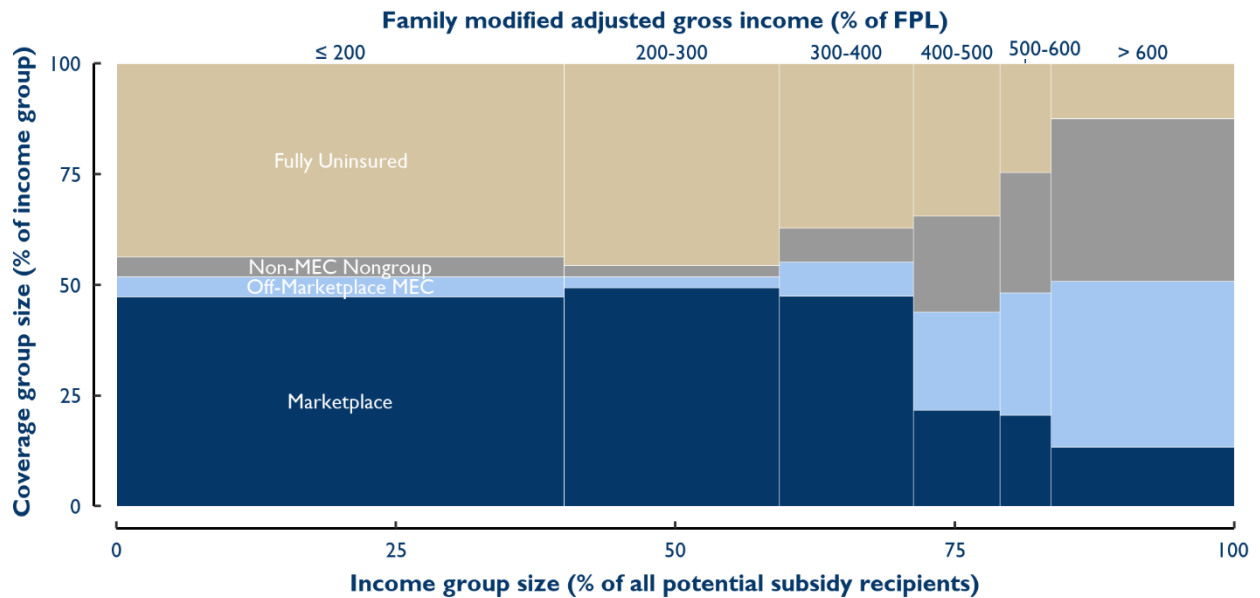
On its face, it may seem surprising that take-up rates were only weakly related to income despite the fact that higher-income people were ineligible for Marketplace subsidies. Indeed, other evidence shows that insurance enrollment decisions are reasonably price-sensitive (e.g., Hackmann, Kolstad, and Kowalski 2015; Finkelstein, Hendren, and Shepard 2019). However, there are many reasons higher-income people may have a higher willingness to pay for health insurance, such as that they have more assets to protect (e.g., Mahoney 2015). Consistent with this basic story, it is interesting to note that the share of potential subsidy recipients estimated to have any insurance policy (whether an MEC or non-MEC policy) rises sharply with income among people with incomes above 400% of the FPL.

Second, while take-up is incomplete at all income levels, the large majority of potential subsidy recipients who lack nongroup MEC—an estimated 70% of the total—have incomes below 400% of the FPL. This largely reflects the fact that there are relatively few potential subsidy recipients at higher income levels since most people at these income levels have access to employer coverage. This finding implies that not only is there scope to increase enrollment in nongroup MEC among people who were already eligible for subsidies, but most of the opportunity to increase overall take-up is in this group.

Third, the coverage status of potential subsidy recipients who *lack* MEC varies strongly with income. Among potential subsidy recipients without nongroup MEC who had incomes below 400% of FPL, 91% were fully uninsured, while the remaining 9% held non-MEC nongroup policies. By contrast, at higher income levels, 61% held non-MEC nongroup policies and only 39% were fully uninsured. This pattern suggests that increasing MEC enrollment may lead to smaller improvements in financial protection at

⁴³ For comparison purposes, Appendix E presents similar figures for two broader populations: (1) all non-elderly people; and (2) all non-elderly people ineligible for public or employer coverage.

Figure 6: Potential Subsidy Recipients by Income and Coverage, 2019



Note: Potential subsidy recipients are people who are legally present, ineligible for public and employer coverage, and not in the Medicaid "coverage gap." Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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higher income levels, although those improvements may still be substantial since non-MEC policies often offer much less robust coverage than MEC policies (e.g., Pollitz et al. 2018; Palanker, Curran, and Salyards 2020). This pattern of enrollment also suggests that efforts to restrict the availability of non-MEC policies would likely have their largest effects on enrollment patterns at higher income levels (whether those effects be to cause people to take up MEC or to forgo insurance entirely).

Fourth, lower-income potential subsidy recipients who held MEC overwhelmingly held Marketplace coverage, while higher-income people generally held off-Marketplace MEC. Among potential subsidy recipients nongroup MEC who had incomes below 400% of the FPL, 91% held Marketplace coverage, whereas just 35% held Marketplace coverage above 400% of the FPL. One implication is that focusing just on Marketplace enrollment can paint a very misleading picture of nongroup enrollment as a whole. This may be particularly important to keep in the mind in tracking the effects of the expansion of the premium tax credit included in the American Rescue Plan Act since one important effect may be to cause people who currently buy off-Marketplace plans to instead obtain coverage inside the Marketplace.

It is also notable that, while Marketplace coverage predominated among people with incomes below 400% of the FPL, there were still some people at these income levels who held off-Marketplace MEC. This could indicate that some enrollees are unaware that subsidized coverage is available, as some surveys suggest (Gupta and Collins 2019; Pollitz et al. 2020). Alternatively, some of these people may be relatively healthy and hold underwritten off-Marketplace policies (grandfathered and transitional MEC policies or non-MEC policies) that are less expensive than subsidized coverage.

Before concluding, I note once again that because of the very limited available data on enrollment in non-MEC nongroup policies, my estimates of the aggregate amount of non-MEC enrollment and how that enrollment is distributed by income are subject to considerable uncertainty. Thus, Appendix F presents the results of sensitivity analyses in which I assume that aggregate enrollment in non-MEC nongroup

policies in 2019 is 50% higher or 50% lower than in my base estimates; the appendix also presents estimates in which I assume that half of non-MEC nongroup enrollment is distributed proportionally to total MEC enrollment instead of all non-MEC nongroup enrollment being distributed proportionally to off-Marketplace MEC enrollment. While these alternative assumptions about non-MEC enrollment lead to modestly different quantitative estimates, my main qualitative conclusions continue to hold.

Recommendations to Improve Data on Nongroup Enrollment

The goal of this paper is to arrive at the best possible picture of nongroup enrollment given the available data. But if better data were available, it would be possible to produce better estimates and to do so more simply. To that end, I close with two recommendations for improving the available data.

First, and most straightforwardly, the Treasury Department should routinely publish tabulations of insurance coverage by income group based on tax records like those produced by Lurie and Pearce (2019; forthcoming).⁴⁴ In future iterations, Treasury could also consider producing tabulations of those data that disaggregate enrollment by state of residence in addition to income. State-level tabulations would make these data much more useful for monitoring state-specific developments and policy changes.⁴⁵

Second, policymakers should create a mechanism for systematically collecting information on enrollment in non-MEC nongroup policies. Indeed, as discussed earlier, the single biggest weakness of my analysis is that I am able to draw on only fragmentary information on enrollment in non-MEC nongroup policies. While non-MEC policies may play a smaller role in the nongroup market if the recent expansion of the ACA's Marketplace subsidies draws enrollees out of non-MEC policies and into the Marketplace, these policies are unlikely to disappear completely, so plugging this data gap is likely to remain valuable.

The best approach to this problem would be to expand the IRS reporting regime that currently applies to insurers that sell MEC policies to encompass non-MEC policies as well. This would be conceptually straightforward to achieve via legislation (albeit politically challenging) and could fit naturally into broader efforts to rationalize regulation of non-ACA-compliant policies (e.g., Linke Young 2020).

But for short-term limited duration policies, it might be possible to extend the IRS coverage reporting regime administratively.⁴⁶ In particular, the ACA's implementing regulations exclude short-term limited

⁴⁴ Due to the repeal of the individual mandate penalty effective in 2019, tabulations of the tax data for 2019 and later years would not include information on self-reported MEC; that information was collected from taxpayers as part of the process of assessing individual mandate penalties, which will no longer occur. However, repeal of the individual mandate penalty did not change *coverage providers'* obligations to report MEC to the IRS since those requirements are contained in other provisions of law, so the Lurie and Pearce estimates would continue to provide considerable useful information. The lack of self-reported coverage information might become less important over time as coverage providers gain experience with reporting coverage to the IRS and, correspondingly, the quality of third-party-reported coverage information improves.

⁴⁵ It would also be useful to disaggregate the off-Marketplace nongroup MEC category reported by Lurie and Pearce to separate individual market MEC and other designated MEC.

⁴⁶ This likely would not be possible for other types of non-MEC policies. Section 26 U.S.C. § 5000A(f)(3) explicitly excludes "excepted benefits" from the definition of MEC, which would likely make it impossible to reach fixed indemnity plans (a form of excepted benefit) through this type of approach. Similarly, 26 U.S.C. § 5000A(d)(2)(B)

duration plans from the definition of individual market MEC—and thus from the IRS’ reporting regime.⁴⁷ This exclusion served an important function when the individual mandate was still in effect since it prevented people from satisfying the mandate by purchasing short-term limited duration plans rather than ACA-compliant plans, which would have harmed the risk pool for ACA-compliant policies. But with the mandate penalty now gone, that rationale for defining MEC in this way no longer exists.

Thus, the Treasury Department could consider eliminating the exclusion of short-term limited duration plans from the definition of MEC and thereby making them subject to coverage reporting. Since the definition of MEC is used elsewhere in federal law, it would be important to ensure that this change did not have unintended consequences. Fully exploring those potential ripple effects is beyond the scope of this paper, but I note this change would not affect eligibility for the premium tax credit, which is likely the most important other provision of the ACA linked to the definition of MEC.⁴⁸

If extending the IRS reporting regime is not feasible, it would be valuable to at least collect aggregate information on enrollment in non-MEC policies. The National Association of Insurance Commissioners (NAIC) has taken some steps to collect data on aggregate enrollment in short-term limited duration plans. Notably, it collected these data from many issuers from short-term limited duration plans on a one-time basis in 2019 (NAIC 2021b), and will soon do so on an ongoing basis through the Market Conduct Annual Statement (NAIC 2021a). These data will have limitations, however. They do not encompass other types of non-MEC nongroup policies, such as fixed indemnity policies. And it is unclear whether the data the NAIC collects will ultimately become available to researchers and policymakers (Keith 2020).

exempts people enrolled in health care sharing ministries from the individual mandate penalty, which suggests that Congress did not intend health care sharing ministries to constitute MEC.

⁴⁷ See 26 C.F.R. § 1.5000A-2(d)(1) and 26 U.S.C. § 6055.

⁴⁸ In particular, while eligibility for MEC generally prevents a person from claiming the premium tax credit, section 26 U.S.C. § 36B(c)(2)(B)(i) provides an exception for MEC offered in the individual market. Short-term limited duration plans could be considered as such under the approach proposed here.

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Appendix A: Estimating Marketplace Enrollment by Income

This paper uses CMS' Marketplace effectuated enrollment and plan selections data to derive estimates of non-elderly Marketplace enrollment by income and state. I derive those estimates in three steps:

- (1) I use the plan selections data to calculate the share of plan selections accounted for by each income group in each state and year.
- (2) I distribute effectuated enrollment for each state and year according to those shares.
- (3) I proportionally reduce the state estimates based on the share of plan selections in that state accounted for by people under age 65 and sum across states to obtain national estimates.

The second two steps are straightforward, but the first step is more complex because of two limitations of the CMS data. First, in 2016, CMS only reports the income breakdown of plan selections in states that used the HealthCare.gov platform.⁴⁹ Second, the plan selections data use slightly different income categories in the two years.⁵⁰ The rest of the appendix describes how I handle both issues.

States with Missing Income Breakdowns in 2016

To fill in income breakdowns for states where those data are missing in 2016, I first try to locate income breakdowns reported directly by the state Marketplaces. Suitable data are available for California, New York, and Washington State (Covered California 2016; NYSOH 2016; Washington Health Benefit Exchange 2016), which together accounted for 66% of all enrollment in states with missing data.⁵¹

For the states where neither federal- nor state-reported data are available for 2016, I impute their 2016 Marketplace income distribution by assuming that the change in the Marketplace income distribution in these states mirrored the change in states that have data for both years and have the same Medicaid expansion status. Allowing separate trends by Medicaid expansion status is important since the income distribution of Marketplace enrollment is notably different between Medicaid expansion and non-expansion states (reflecting the fact that people with incomes in the 100-138% of FPL are eligible for subsidized Marketplace coverage in non-expansion states but Medicaid in expansion states).

Formally, I assume that the share plan of selections in state s and year t accounted for by an income group $g \in \{100-150, 150-200, 200-250, 250-300, 300-400, \text{other}\}$ takes the multinomial logit form:

$$p_{sgt} = \frac{\exp(\gamma_{sg} + 1\{t = 2016\}\delta_{M(s)g})}{\sum_k \exp(\gamma_{sk} + 1\{t = 2016\}\delta_{M(s)k})}$$

⁴⁹ Additionally, Idaho does not report the breakdown of plan selections by income in either year, so I assume that the relevant shares match the average in other states that had not adopted Medicaid expansion as of 2019.

⁵⁰ Another minor problem is that the data lack income information for enrollees who do not apply for subsidized coverage. In states using the HealthCare.gov platform, these enrollees accounted for 13% of plan selections in 2016 and 14% in 2019. Since the large majority of these enrollees likely have incomes above 400% of the FPL, I treat them all as having income in that range. For states that do not use the HealthCare.gov platform, enrollees not applying for subsidies are already combined with enrollees with incomes above 400% of the FPL.

⁵¹ Some of the income categories used by the state Marketplaces straddle multiple income categories in the federal data. In those cases, I split the state-reported shares proportionally based on the results obtained from the regression imputation procedure described below.

where $M(s)$ is a categorical variable that indicates whether state s : (1) adopted Medicaid expansion in January 2014; (2) adopted Medicaid expansion after January 2014 but on or before January 2019; or (3) either adopted Medicaid expansion after January 2019 or never adopted Medicaid expansion. I estimate this model by maximum likelihood and then use the fitted model to impute the missing shares for the states with missing data in 2016.

Differences in Income Categories Between 2016 and 2019

The second limitation of the CMS data is that they use slightly different income categories in 2016 and 2019. Specifically, in 2016, CMS separately reports the number of Marketplace plan selections by people with incomes below 100% of the FPL and incomes above 400% of the FPL, but in 2019 these two groups are collapsed into a single category. The same problem arises in 2016 for states for which I impute their 2016 income shares based on their 2019 income share. For the states with this problem in 2016, I split the combined category proportionally based on the average size of the underlying categories in 2016 in states in the same Medicaid expansion category (as defined above). In 2019, I split the combined category proportionally based on the (estimated) size of the underlying categories in the same state in 2016.

Appendix B: Coverage Misreporting in the ACS

This appendix provides additional detail on how I cope with the misreporting of nongroup coverage in the ACS. The first section of the appendix presents calculations based on the results of Pascale, Fertig, and Call (2019) that show that the overwhelming majority of people who report direct purchase coverage in combination with some other form of coverage do not actually hold nongroup coverage. These calculations provide the rationale for estimating nongroup enrollment by only counting people who report direct purchase coverage alone. The second section of the appendix describes the method I use to adjust the coverage trends observed in the ACS for the remaining coverage misreporting.

Before proceeding, I establish some notation. Let D be a binary random variable indicating whether an individual actually holds nongroup coverage. Additionally, let \tilde{D}^O be a binary random variable indicating whether a person reports *only* direct purchase coverage in the ACS, and let \tilde{D}^A be a binary random variable indicating whether a person reports *any* direct purchase coverage, either alone or in combination with some other form of coverage. Due to coverage misreporting, D need not equal either \tilde{D}^A or \tilde{D}^O .

Effect of Excluding People Who Report Both Direct Purchase and Other Coverage

As described above, I measure nongroup enrollment in the ACS by counting people who report *only* direct purchase coverage (i.e., people with $\tilde{D}^O = 1$) rather than by counting how many report *any* direct purchase coverage (i.e., people with $\tilde{D}^A = 1$). This substantially reduces measured nongroup enrollment, so a key question is what share of the excluded enrollees truly hold nongroup coverage.

I estimate this fraction for the sample of insured people examined by Pascale, Fertig, and Call (2019). Formally, the quantity of interest is $\mathbb{P}(D = 1 \mid \tilde{D}^A = 1, \tilde{D}^O = 0)$. This can be rewritten as follows:

$$\mathbb{P}(D = 1 \mid \tilde{D}^A = 1, \tilde{D}^O = 0) = \frac{\mathbb{P}(D = 1 \mid \tilde{D}^A = 1) - \mathbb{P}(D = 1 \mid \tilde{D}^O = 1)\mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1)}{1 - \mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1)}.$$

Two of the probabilities on the right-hand side of this equation are directly reported by Pascale, Fertig, and Call (2019) for their validation sample (see Table 5 or Table 6). The exception is $\mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1)$,

the share of people who report any direct purchase coverage who report *only* direct purchase coverage. I estimate this share using the 2015 ACS, limiting the sample to people under age 65 in Minnesota who do not report Medicare coverage in order to match the Pascale, Fertig, and Call sample frame as closely as possible. This yields an estimate $\mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1) = 0.785$.

Plugging these probabilities into the equation above yields $\mathbb{P}(D = 1 \mid \tilde{D}^A = 1, \tilde{D}^O = 0) = 0.07$. That is, only 7% of people who report direct purchase coverage in combination with another form of coverage actually held nongroup coverage. In light of the composition of the Pascale, Fertig, and Call sample, this estimate is likely a reasonable guide to the effect of moving from \tilde{D}^A to \tilde{D}^O when generating estimates for the non-elderly population in the ACS writ large. For the full population (including the elderly), this may even overestimate the share that actually hold nongroup coverage since very few elderly people actually hold nongroup coverage, but many likely report Medigap plans as direct purchase coverage.

Adjusting ACS Nongroup Coverage Trends for Misreporting

I now describe how I adjust raw trends measured using the ACS to remove distortions due to misreporting. I first describe my methodology for adjusting changes in the overall share of the population with nongroup coverage, and I then turn to changes in the share of the population that has nongroup population *and* falls in a particular income group. Those discussions show that adjusting for distortions created by misreporting requires knowing the rate at which respondents under- and over-report nongroup coverage, so I conclude this section by using the results of Pascale, Fertig, and Call (2019) to estimate those rates.

Overall Coverage Shares

I first consider how to adjust changes in the overall share of the population with nongroup coverage for misreporting. To do so, I first assume that the propensity to under- and over-report coverage is constant over time. Then, letting \mathbb{P}_t be the probability measure corresponding to survey samples taken time t , I can define the following parameters that are constant across all times t :

$$\alpha \equiv \mathbb{P}_t(\tilde{D}^O = 1 \mid D = 0) \text{ and } \beta \equiv \mathbb{P}_t(\tilde{D}^O = 0 \mid D = 1),$$

where α is the propensity of a person without nongroup coverage to erroneously report that they do have direct purchase coverage (i.e., over-report), while β is the propensity of a person with nongroup coverage to erroneously report that they do not have direct purchase coverage (i.e., under-report).

The share of people observed to have nongroup coverage at time t can then be written as

$$\mathbb{P}_t(\tilde{D}^O = 1) = \alpha \mathbb{P}_t(D = 0) + (1 - \beta) \mathbb{P}_t(D = 1),$$

from which it follows that the observed change in that share from a time t_0 to a time t_1 is

$$\mathbb{P}_{t_1}(\tilde{D}^O = 1) - \mathbb{P}_{t_0}(\tilde{D}^O = 1) = (1 - \beta - \alpha) [\mathbb{P}_{t_1}(D = 1) - \mathbb{P}_{t_0}(D = 1)].$$

That is, the change in the share of the population observed to have nongroup coverage is the actual change in the share with nongroup coverage discounted by a factor $1 - \beta - \alpha$; this is a standard result from the literature on classification error (e.g., Aigner 1973).⁵² It is then easy to see that, given α and β , the actual change can be recovered by dividing the observed change by this factor.

⁵² In theory, it could be the case that $\alpha > 1 - \beta$ in which case the observed change would actually have the opposite sign from the actual change. This is clearly not the case in practice.

Coverage-by-Income Shares

Next, I consider how to adjust changes in the share of the population observed to hold direct purchase coverage *and* fall in a specific income group. To that end, I let Y be a random variable denoting a respondent's income. I again assume that the propensity to misreport coverage is constant over time, and I define income-group-specific misreporting rates

$$\alpha_k \equiv \mathbb{P}_t(\tilde{D}^O = 1 \mid D = 0, Y = k) \quad \text{and} \quad \beta_k \equiv \mathbb{P}_t(\tilde{D}^O = 0 \mid D = 1, Y = k),$$

which are directly analogous to the misreporting rates α and β defined above.

The share of people who are observed to have nongroup coverage and fall in income group k at time t is

$$\mathbb{P}_t(\tilde{D}^O = 1, Y = k) = \alpha_k \mathbb{P}_t(D = 0, Y = k) + (1 - \beta_k) \mathbb{P}_t(D = 1, Y = k),$$

from which it follows that the observed change in this share from a time t_0 to a time t_1 is

$$\begin{aligned} & \mathbb{P}_{t_1}(\tilde{D}^O = 1, Y = k) - \mathbb{P}_{t_0}(\tilde{D}^O = 1, Y = k) \\ &= \alpha_k [\mathbb{P}_{t_1}(Y = k) - \mathbb{P}_{t_0}(Y = k)] + (1 - \beta_k - \alpha_k) [\mathbb{P}_{t_1}(D = 1, Y = k) - \mathbb{P}_{t_0}(D = 1, Y = k)]. \end{aligned}$$

The true change of interest can thus be calculated as

$$\begin{aligned} & \mathbb{P}_{t_1}(D = 1, Y = k) - \mathbb{P}_{t_0}(D = 1, Y = k) \\ &= \frac{1}{1 - \beta_k - \alpha_k} [\mathbb{P}_{t_1}(\tilde{D}^O = 1, Y = k) - \mathbb{P}_{t_0}(\tilde{D}^O = 1, Y = k) - \alpha_k \{\mathbb{P}_{t_1}(Y = k) - \mathbb{P}_{t_0}(Y = k)\}]. \end{aligned}$$

Relative to the case where the object of interest was the change in the overall share of the population with nongroup coverage, the true change is now a more complicated function of the observed change and now depends on the change in the share of the population that falls in that income group. But knowledge of the misreporting parameters α_k and β_k remains sufficient to recover the true change.

Calibrating the Under- and Over-reporting Rates

I estimate the misreporting rates using results reported by Pascale, Fertig, and Call (2019). The Pascale, Fertig, and Call results are not disaggregated by income, so I proceed under the assumption that misreporting rates are constant across income groups and, correspondingly, estimate a single α and β that applies to all income groups. Similarly, I assume that the values of α and β I obtain for the Pascale, Fertig, and Call sample frame are generalizable to the full US population.

In reality, α and β surely vary somewhat across population groups. However, α can vary only over a relatively small range since it is bounded below by zero and bounded above by the share of the population that reports nongroup coverage; in practice, varying α over this range has little effect on the results. It is plausible that β also varies relatively little since it is not immediately clear what would spur people who hold nongroup coverage in different population groups to report that coverage differently. Thus, the assumption that α and β are constant across the population seem like a reasonable one.

Most of the estimates reported by Pascale, Fertig, and Call concern respondents' propensity to report holding *any* direct purchase coverage (that is, \tilde{D}^A), whereas I focus on individuals' propensity to report *only* direct purchase coverage (that is, \tilde{D}^O). Thus, deriving suitable estimates of α and β requires making some calculations based on their results. I begin with β . Observe that

$$\beta = \mathbb{P}(\tilde{D}^A = 0 \mid D = 1) + \mathbb{P}(\tilde{D}^A = 1, \tilde{D}^O = 0 \mid D = 1),$$

where I use \mathbb{P} to denote the probability measure corresponding to the authors' sample frame.

Pascale, Fertig, and Call estimate that the first term on the right-hand side of this equation, the share of nongroup enrollees that completely fail to report direct purchase coverage under the ACS survey instrument, is 0.15 (see Table 2). To estimate the second term, the share of nongroup enrollees who report direct purchase coverage in combination with some other form of coverage, observe that

$$\begin{aligned} & \mathbb{P}(\tilde{D}^A = 1, \tilde{D}^O = 0 \mid D = 1) \\ &= [\mathbb{P}(D = 1 \mid \tilde{D}^A = 1) - \mathbb{P}(D = 1 \mid \tilde{D}^O = 1)] \mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1) \frac{\mathbb{P}(\tilde{D}^A = 1)}{\mathbb{P}(\tilde{D}^O = 1)}. \end{aligned}$$

All of the probabilities on the right-hand-side of this equation are directly reported by Pascale, Fertig, and Call (2019)—variously in Tables 2, 5, and 6—except for $\mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1)$, the share of people who report any direct purchase coverage who report *only* direct purchase coverage. I estimate this probability using the 2015 ACS using the same method used earlier in this appendix. Plugging the relevant probabilities into this equation implies that an additional 2.6% of nongroup enrollees report direct purchase coverage in combination with some other form of coverage, so I obtain $\beta = 0.176$.

I now turn to α . Observe that

$$\alpha = \mathbb{P}(D = 0 \mid \tilde{D}^O = 1) \mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1) \frac{\mathbb{P}(\tilde{D}^A = 1)}{\mathbb{P}(D = 0)}.$$

As above, all of the probabilities in the above equation are reported directly by Pascale, Fertig, and Call (in Table 2 or Table 6) except for $\mathbb{P}(\tilde{D}^O = 1 \mid \tilde{D}^A = 1)$, which I once again estimate using the same method as earlier in this appendix. Plugging into the equation above yields $\alpha = 0.014$.

Appendix C: Methodology for Imputing Immigration Status

To identify unauthorized immigrants in the survey data, I start with the algorithm used by Borjas (2017), which is a simplified version of the method presented by Passel and Cohn (2014). I then slightly modify the Borjas algorithm, mainly to incorporate features of the algorithm of Passel and Cohn (2018) that appear likely to improve the accuracy of the results. The Congressional Budget Office has also used a methodology based on Borjas' method to identify unauthorized immigrants in survey data when constructing its health insurance coverage microsimulation model (Banthin et al. 2019).

In detail, I treat a person as being legally present in the United States if the person reports having one of the following characteristics that implies legal status with certainty or with high probability:

- Being a U.S. citizen (unless the person reports being a naturalized citizen who is from Mexico or Central America, arrived in the United States in the last three years, or arrived in the United States in the last six years and does not have a citizen spouse);⁵³

⁵³ The CPS ASEC does not report respondents' exact year of arrival in the United States. For this reason, I treat people as having arrived in the last six years if they arrived in 2014 or later (which encompasses slightly more than five years

- Having arrived in the United States prior to 1980;
- Being enrolled in one of: Medicaid/CHIP; Medicare; Marketplace coverage; health care through the Department of Defense, TRICARE, or Department of Veterans Affairs; public housing; veterans' benefits; unemployment compensation; Supplemental Security Income; Social Security; Supplemental Nutrition Assistance Program; or any form of rental or cash assistance;⁵⁴
- Being a current member of the armed forces or a veteran of the armed forces;
- Being employed by a federal, state, or local government or in one of the following occupational categories: legal occupations; health care practitioners and technical occupations; and protective service occupations;
- Having been born in Cuba; or
- Being the spouse or child of a person that meets one of the above criteria.

My method differs from Borjas' method in a few respects. First, Borjas treats anyone who reports U.S. citizenship as being legally present. However, Passel and Cohn (2018) summarize evidence that people who recently arrived in the United States or who immigrated from Central America or Mexico often overreport naturalized citizenship in surveys. Thus, following Passel and Cohn, I do not automatically assign legal status to people in these groups who report naturalized citizenship. Second, Borjas assigns legal status to spouses of people who have another marker of legal status, but I do so for both spouses and children; in doing so, I again conform somewhat more closely to the approach used by Passel and Cohn (2018).⁵⁵ Third, relative to Borjas, I assign legal status based on participation in a somewhat broader list of public programs and a slightly different list of occupations.

Even with the modifications described above, the method I use here still differs in important respects from the more complex approach of Passel and Cohn (2018). Notably, Passel and Cohn (2018) start by assigning legal status to survey respondents based on criteria similar to (but more complex than) the criteria used here. They then probabilistically assign unauthorized status to the remaining respondents to align with estimates of the aggregate size of the undocumented population (which are themselves derived by subtracting administrative tallies of the number of lawful immigrants from the number of foreign-born individuals estimated to be present in the United States using survey data).

However, Borjas shows that his method generates very similar legal status assignments—both in the aggregate and at the individual level—to the method of Passel and Cohn (2014), which is in turn very

prior to the interview). I treat them as having arrived in the last three years if they arrived in 2016 or later (which, similarly, encompasses slightly more than the three years prior to the interview).

⁵⁴ Participation in housing programs as well as the Supplemental Nutrition Assistance Program is only observed at the household level, so I treat a person as participating in these programs if the person lives in a household in which at least one person participates.

⁵⁵ On the other hand, there is one respect in which I remain closer to Borjas. Passel and Cohn (2018) generally do not impute legal status to relatives of legal permanent residents, whereas both Borjas and I implicitly do.

similar to the updated method of Passel and Cohn (2018). It thus seems likely that the legal status assignments generated by my modified version of Borjas' method would be similar to those obtained from the method of Passel and Cohn (2018). Indeed, when applied in the 2019 CPS-ASEC, my methodology estimates that there were 11.2 million people who are not legally present in early 2019. For comparison, Passel and Cohn (2019) estimate there were 10.5 million unauthorized immigrants as of 2017.

Some other work on health insurance enrollment (e.g., SHADAC 2013; Capps et al. 2013; Garfield, Orgera, and Damico 2020) has statistically imputed immigration status using the Survey of Income and Program Participation (SIPP). This approach takes advantage of the fact that some older SIPP vintages asked non-citizens whether they were legal permanent residents at the time of interview. That makes it possible to develop a statistical model for predicting lawful status based on individual characteristics, which can then be used to impute lawful status in other survey datasets. In some analyses (e.g., SHADAC 2013; Capps et al. 2013), this type of imputation model is the sole method used to identify unauthorized immigrants. In other cases (e.g., Garfield, Orgera, and Damico 2020), the SIPP-derived imputation model is used in combination with aggregate targets derived through a method like that of Passel and Cohn (2018).

While the SIPP-based approach is quite appealing in concept, the SIPP ceased asking about current immigration status after the 2008 SIPP panel. Thus, the most recent SIPP data suitable for this type of approach are now more than a decade old, and it is thus unclear whether (and, if so, how much) imputing immigration status based on the SIPP would improve over the method used here.

Appendix D: Consequences of Imperfect Income Measurement

This paper uses survey data to estimate what share of people with a particular coverage status (variously, either uninsured or enrolled in nongroup coverage) are eligible for some form of subsidized coverage (variously, either subsidized Marketplace coverage or public coverage). As described in the main text, a limitation of my approach is that the full-year income measure reported on the CPS-ASEC differs from the income measures used to determine program eligibility (monthly income, expected annual income, or some combination of the two), and income is likely measured with some error in the CPS-ASEC. This appendix analyzes how these imperfections in income measurement might bias my results.

General Setup

Formally, I let Y_O denote the full-year income measure observed in the CPS-ASEC, Y_F the respondent's actual full-year income, and Y_P the income measure used to determine eligibility for the relevant program. I let $E(y)$ denote the event that the person would be eligible for the program in question with income y .⁵⁶ For convenience, I then define events $E_O = E(Y_O)$ and $E_P = E(Y_P)$, which capture whether the respondent would be eligible based on each of the income measures Y_O and Y_P . I use $N_j = E_j^c$ for each $j \in \{O, P\}$ to denote the complementary events where the person is ineligible for the program of interest based on each income measure. Finally, I let T denote the event in which the respondent has the coverage status of interest (either uninsured or enrolled in nongroup coverage).

⁵⁶ The values taken by the family of random variables $E(y)$ will generally differ across respondents because it depends on a respondent's other characteristics, such as the respondent's state of residence.

In this notation, my ideal estimand is $\mathbb{P}(E_P|T, Y_F \in \mathcal{A})$, where the set \mathcal{A} defines the income group being examined. However, because only Y_O (and not Y_P and Y_F) are observed, I instead obtain the alternative estimand $\mathbb{P}(E_O | T, Y_O \in \mathcal{A})$. The question is how these estimands compare. To that end, observe that

$$\mathbb{P}(E_O|T, Y_O \in \mathcal{A}) = \mathbb{P}(E_P|T, Y_F \in \mathcal{A}) + \underbrace{\mathbb{P}(E_P|T, Y_O \in \mathcal{A}) - \mathbb{P}(E_P|T, Y_F \in \mathcal{A})}_{\text{bias from averaging over the wrong population}} + \underbrace{\mathbb{P}(E_O|T, Y_O \in \mathcal{A}) - \mathbb{P}(E_P|T, Y_O \in \mathcal{A})}_{\text{bias from mismeasuring eligibility}}. \quad (*)$$

This equation demonstrates that the actual estimand equals the ideal estimand, plus two bias terms. The first bias term reflects the fact that the actual estimand averages over the wrong population: respondents with $Y_O \in \mathcal{A}$ rather than respondents with $Y_F \in \mathcal{A}$. The second bias term reflects the fact that the actual estimand is based on the wrong eligibility measure: E_O rather than E_P .

Bias from Averaging Over the Wrong Population

To assess the magnitude of the first bias term, observe that it can be written in the form

$$\begin{aligned} & \mathbb{P}(E_P|T, Y_O \in \mathcal{A}) - \mathbb{P}(E_P|T, Y_F \in \mathcal{A}) \\ &= \mathbb{P}(E_P|T, Y_F \in \mathcal{A}, Y_O \in \mathcal{A}) \frac{\mathbb{P}(Y_O \in \mathcal{A}, Y_F \in \mathcal{A}|T)}{\mathbb{P}(Y_O \in \mathcal{A}|T)\mathbb{P}(Y_F \in \mathcal{A}|T)} [\mathbb{P}(Y_F \in \mathcal{A}|T) - \mathbb{P}(Y_O \in \mathcal{A}|T)] \\ &+ \mathbb{P}(E_P|T, Y_F \notin \mathcal{A}, Y_O \in \mathcal{A}) \frac{\mathbb{P}(Y_F \notin \mathcal{A}, Y_O \in \mathcal{A}|T)}{\mathbb{P}(Y_O \in \mathcal{A}|T)} \\ &- \mathbb{P}(E_P|T, Y_F \in \mathcal{A}, Y_O \notin \mathcal{A}) \frac{\mathbb{P}(Y_F \in \mathcal{A}, Y_O \notin \mathcal{A}|T)}{\mathbb{P}(Y_F \in \mathcal{A}|T)} \end{aligned}$$

This equation implies that this bias term will be small if: (1) the probability that a person is erroneously included in the sample is similar to the probability that a person is erroneously excluded, that is, $\mathbb{P}(Y_F \notin \mathcal{A}, Y_O \in \mathcal{A}|T) \approx \mathbb{P}(Y_F \in \mathcal{A}, Y_O \notin \mathcal{A}|T)$ or, equivalently, $\mathbb{P}(Y_F \in \mathcal{A}|T) \approx \mathbb{P}(Y_O \in \mathcal{A}|T)$; and (2) the people erroneously included and erroneously excluded are eligible for the program of interest at similar rates, that is, if $\mathbb{P}(E_P|T, Y_F \notin \mathcal{A}, Y_O \in \mathcal{A}) \approx \mathbb{P}(E_P|T, Y_F \in \mathcal{A}, Y_O \notin \mathcal{A})$. Under these conditions, the first term roughly vanishes, and the last two terms offset each other.

Both of these conditions are likely to hold as long as: the boundary of the set \mathcal{A} is not close to any important eligibility thresholds; and the distribution of the measurement error $Y_O - Y_F$ conditional on Y_F is reasonably symmetric, not too large, and not too dependent the actual value of Y_F . In particular, if the boundary is not near any important eligibility thresholds, then it is likely that $\mathbb{P}(E_P|T, Y_F \notin \mathcal{A}, Y_O \in \mathcal{A}) \approx \mathbb{P}(E_P|T, Y_F \in \mathcal{A}, Y_O \notin \mathcal{A})$, and, furthermore, the density of $Y_F|T$ will not be too steeply sloped near the boundary of \mathcal{A} . This latter fact, together with the properties of the measurement error described above will tend to result in $\mathbb{P}(Y_F \notin \mathcal{A}, Y_O \in \mathcal{A}|T) \approx \mathbb{P}(Y_F \in \mathcal{A}, Y_O \notin \mathcal{A}|T)$. These assumptions are plausible in my context, so it follows that the first bias term can likely be neglected for my purposes.

Bias from Mismeasuring Eligibility

I now turn to the second bias term in equation (*), which captures the bias from mismeasuring eligibility. To assess the likely magnitude of the second bias term, observe that it can be rewritten as follows

$$\begin{aligned} & \mathbb{P}(E_O|T, Y_O \in \mathcal{A}) - \mathbb{P}(E_P|T, Y_O \in \mathcal{A}) \\ &= \frac{\mathbb{P}(T|E_O, N_P, Y_O \in \mathcal{A})}{\mathbb{P}(T | Y_O \in \mathcal{A})} \mathbb{P}(E_O, N_P|Y_O \in \mathcal{A}) - \frac{\mathbb{P}(T|N_O, E_P, Y_O \in \mathcal{A})}{\mathbb{P}(T | Y_O \in \mathcal{A})} \mathbb{P}(N_O, E_P|Y_O \in \mathcal{A}). \end{aligned}$$

The equation illustrates that this bias term will be small if: (1) the probability that a person is erroneously classified as eligible for the program in question is similar to the probability that the person is erroneously classified as ineligible, that is, $\mathbb{P}(E_O, N_P|Y_O \in \mathcal{A}) \approx \mathbb{P}(N_O, E_P|Y_O \in \mathcal{A})$; and (2) the coverage outcomes of people who are erroneously categorized as eligible are similar to those of people who are erroneously categorized as ineligible, that is, $\mathbb{P}(T|E_O, N_P, Y_O \in \mathcal{A}) \approx \mathbb{P}(T|N_O, E_P, Y_O \in \mathcal{A})$. Under these conditions, the two terms in the equation above will approximately offset each other.

The first of these conditions seems likely to hold as long as: the relevant eligibility threshold is not close to the boundary of \mathcal{A} ; and the distribution of the error $Y_O - Y_P$ conditional on Y_P is reasonably symmetric, not too large, and not too dependent on the actual value of Y_P . These assumptions are reasonable here.

The second condition clearly will not hold when the outcome of interest is nongroup enrollment. This is likely to be true regardless of whether the focus is estimating the share of nongroup enrollees eligible for public coverage or estimating the share of nongroup enrollees who fall in the coverage gap:

- *Share of nongroup enrollees eligible for public coverage:* Before proceeding, observe that, in this case, the events E_j and N_j should be taken to correspond to eligibility for *public* coverage. People eligible for public coverage are ineligible for subsidized Marketplace coverage, so very few people in the relevant income range are likely to opt for unsubsidized coverage over public coverage. Hence, $\mathbb{P}(T|N_O, E_P, Y_O \in \mathcal{A}) \approx 0$. Furthermore, the adding-up constraint then implies that $\mathbb{P}(T|E_O, N_P, Y_O \in \mathcal{A})$ is likely to be similar to or greater than $\mathbb{P}(T | Y_O \in \mathcal{A})$. It follows that the second bias term may be strongly positive, and the share of nongroup enrollees estimated to be eligible for public coverage may be far larger than the true share.
- *Share of nongroup enrollees in the coverage gap:* In this case, the events E_j and N_j should be taken to correspond to eligibility for *Marketplace* coverage. People who fall in the coverage gap are, by definition, ineligible for subsidized Marketplace coverage, so few are likely to enroll in nongroup coverage. Hence, $\mathbb{P}(T|E_O, N_P, Y_O \in \mathcal{A}) \approx 0$. Furthermore, the adding up constraint then implies that $\mathbb{P}(T|N_O, E_P, Y_O \in \mathcal{A})$ is likely to be greater than $\mathbb{P}(T | Y_O \in \mathcal{A})$. It follows that the second bias term may be strongly negative, so the share of nongroup enrollees in this income range estimated to be eligible for subsidized Marketplace coverage may be far smaller than the true share, and, correspondingly, the share estimated to fall in the coverage gap may be far larger.

By contrast, the second condition above may be more reasonable when the outcome of interest is uninsurance. Once again, this is true regardless of whether the focus is estimating the share of uninsured people who are eligible for public coverage or the share who fall in the coverage gap:

- *Share of uninsured enrollees eligible for public coverage:* In this case, the events E_j and N_j should once again be taken to correspond to eligibility for *public* coverage. For almost all of the public coverage eligibility thresholds of interest in this paper, a person is eligible for *some* form of subsidized coverage regardless of what side of the eligibility threshold the individual falls on. Moreover, take-up of Medicaid is known to be incomplete, and the estimates in this paper

demonstrate that the same is true of subsidized Marketplace coverage. That implies that the difference between $\mathbb{P}(T|E_0, N_p, Y_0 \in \mathcal{A})$ and $\mathbb{P}(T|N_0, E_p, Y_0 \in \mathcal{A})$ must be much smaller than in the nongroup enrollment case, suggesting that bias is likely to be much smaller as well.

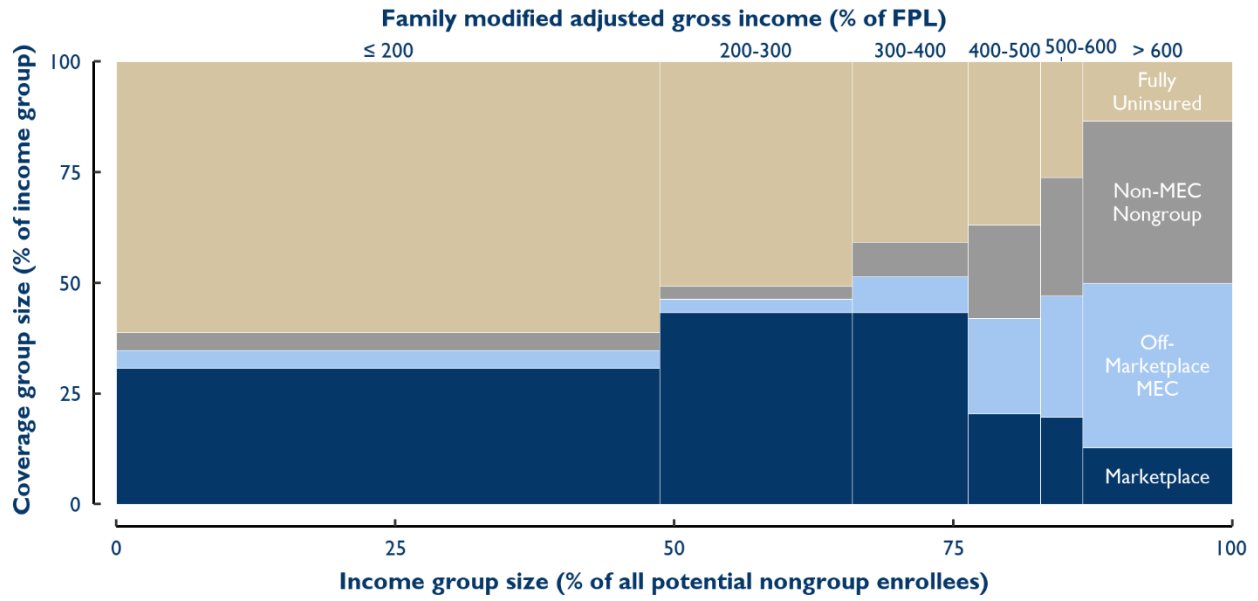
- *Share of uninsured in the coverage gap:* In this case, the events E_j and N_j should be taken to correspond to eligibility for *Marketplace* coverage. Paralleling the reasoning above, the fact that take-up of subsidized Marketplace coverage is incomplete implies that $\mathbb{P}(T|N_0, E_p, Y_0 \in \mathcal{A})$ is meaningfully greater than zero. Since $\mathbb{P}(T|E_0, N_p, Y_0 \in \mathcal{A})$ is also positive (albeit presumably larger), this implies that the spread between $\mathbb{P}(T|E_0, N_p, Y_0 \in \mathcal{A})$ and $\mathbb{P}(T|N_0, E_p, Y_0 \in \mathcal{A})$ may be meaningfully smaller than in the nongroup enrollment case, and the bias smaller as well.

The conclusion that bias in estimating the uninsurance-related shares may be modest is consistent with the evidence from the SIPP discussed in the main text that indicates that using full-year income versus monthly or expected income to impute program eligibility makes little difference in practice.

Appendix E: Estimates for Broader Populations of Enrollees

This appendix reports estimates of nongroup enrollment and uninsurance for populations broader than the population of potential subsidy recipients examined in this paper's main analyses. Figure E.1 reports estimates for all non-elderly people who are ineligible for public or employer coverage (who I term potential nongroup enrollees), while Figure E.2 reports estimates for the full non-elderly population.

Figure E.1: Potential Nongroup Enrollees by Income and Coverage, 2019

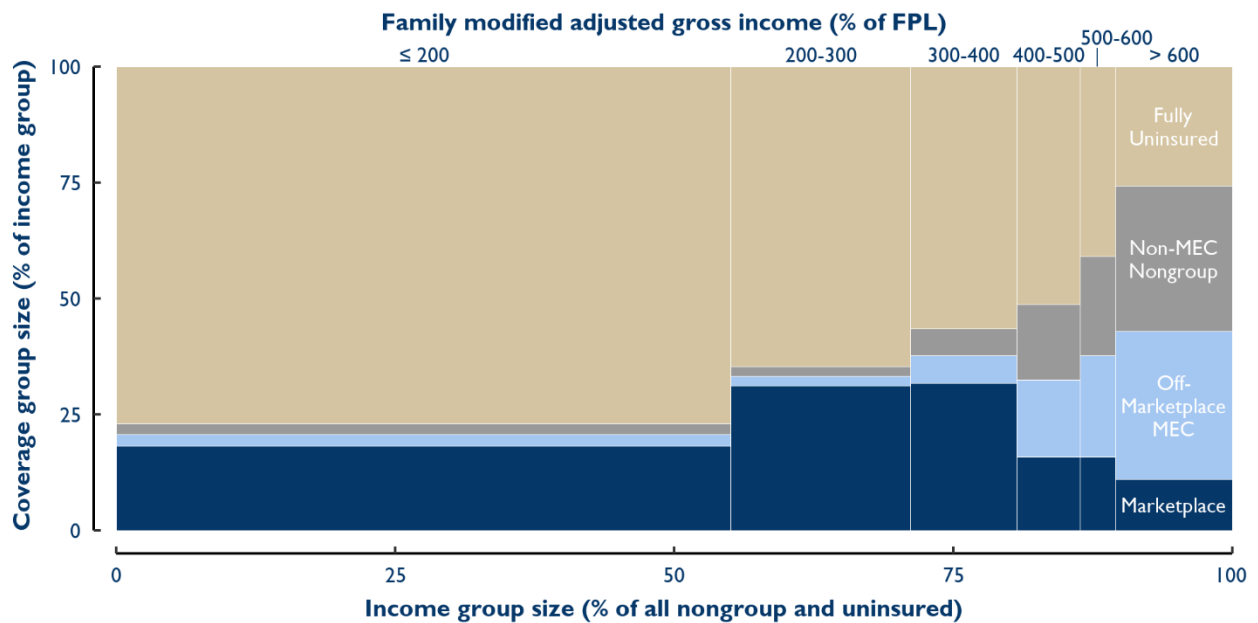


Note: Potential nongroup enrollees are people ineligible for public and employer coverage. Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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Figure E.2: Nongroup Enrollment and Uninsurance by Income, 2019



Note: Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

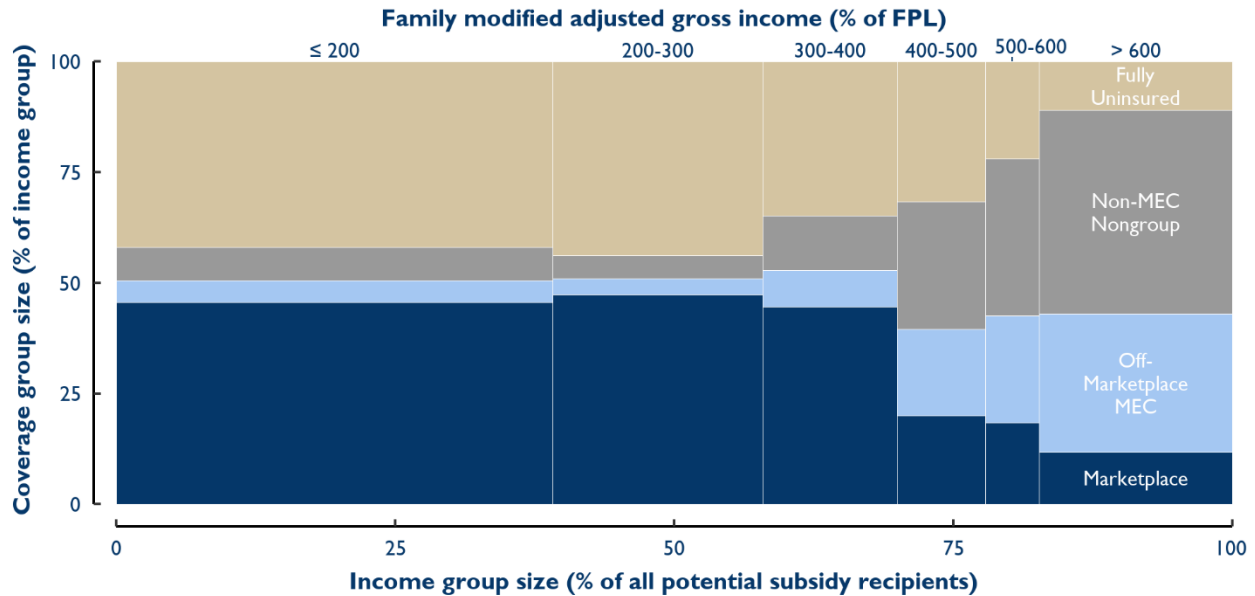
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Appendix F: Sensitivity Analyses

This appendix presents the results of sensitivity analyses in which I assume that aggregate enrollment in non-MEC nongroup policies in 2019 is 50% higher or 50% lower than in my base estimates or, alternatively, that half of non-MEC nongroup enrollment is distributed proportionally to total MEC enrollment rather than all of that enrollment being distributed proportionally to off-Marketplace MEC enrollment.

Figure F.1: Non-MEC Enrollment 50% Higher

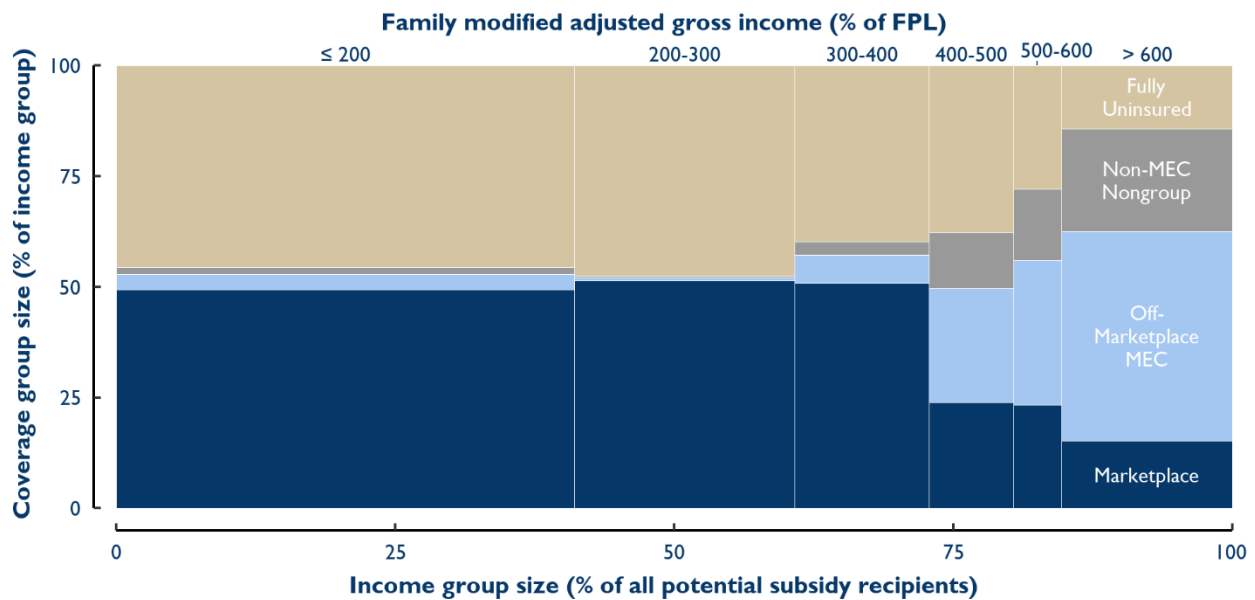


Note: Potential subsidy recipients are people who are legally present, ineligible for public and employer coverage, and not in the Medicaid "coverage gap." Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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Figure F.2: Non-MEC Enrollment 50% Lower

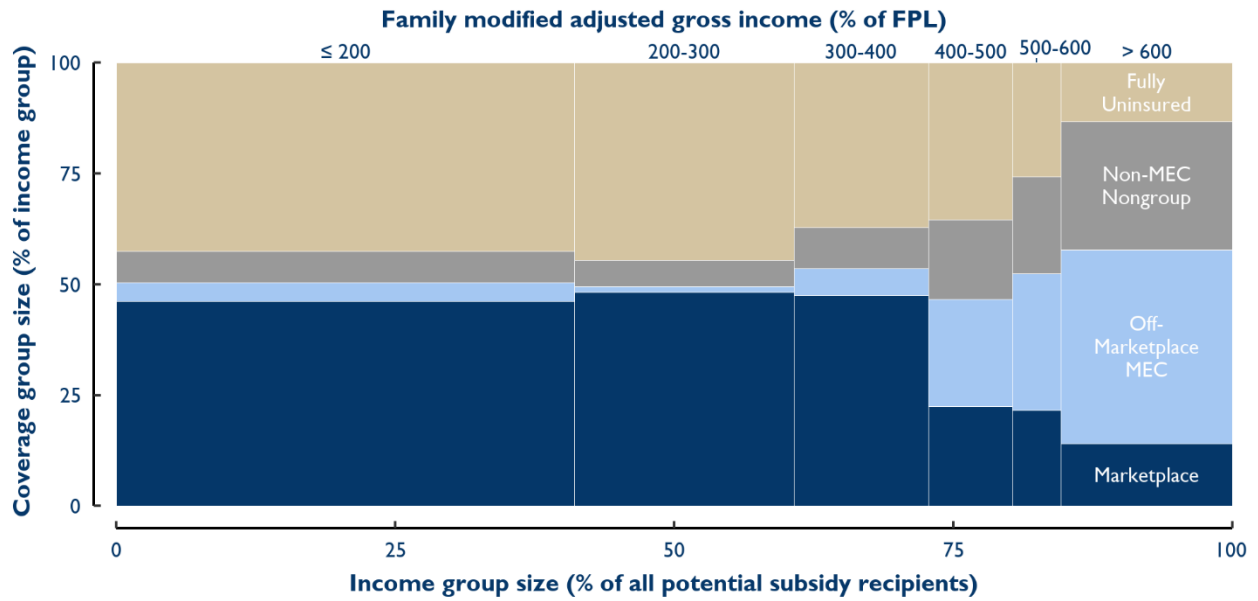


Note: Potential subsidy recipients are people who are legally present, ineligible for public and employer coverage, and not in the Medicaid "coverage gap." Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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Figure F.3: Distribute Half of Non-MEC Enrollment Using MEC Enrollment



Note: Potential subsidy recipients are people who are legally present, ineligible for public and employer coverage, and not in the Medicaid "coverage gap." Estimates include people under age 65 only. Enrollment measured in life-years. MEC = minimum essential coverage.

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Building an Equitable Recovery Requires Investing in Children, Supporting Workers, and Expanding Health Coverage

By Sharon Parrott, Chuck Marr, Arloc Sherman, and Judith Solomon

The pandemic and its economic fallout have exposed glaring weaknesses in our nation's economy that leave millions of people unprotected in bad economic times and prevent them from fully benefiting from a strong economy in good times. The recovery legislation that policymakers will consider later this year (which might consist of one or multiple bills) provides a historic opportunity to build toward an equitable recovery where all children can reach their full potential, where workers in low-paid jobs and those with fewer job prospects have the supports to help them meet their needs and get ahead, and where everyone has access to affordable health coverage. Achieving these goals requires attacking long-standing disparities in our nation, deeply rooted in racism and discrimination, that have led to starkly unequal opportunities and outcomes in education, employment, health, and housing.

The recently enacted American Rescue Plan, along with relief measures enacted in 2020, will provide substantial help during this crisis to tens of millions of people struggling to make ends meet and access health care. But it is important to consider *why* such large-scale stopgap measures were needed. The reason is clear and sobering: our underlying policies tolerate very high levels of poverty and hardship when households lose jobs or have low incomes, whether this occurs because the economy enters a recession, their employer goes out of business, a family member cannot work due to illness, or the jobs people hold pay low wages. Millions of people face these situations every year, though the impacts of our policy gaps fall disproportionately on people of color.

Indeed, because of the weaknesses in our underlying policies and gaps in our relief measures particularly during 2020, the current crisis has exacted a particularly heavy toll on people working in low-paid jobs and low-income households with children — both groups with disproportionate numbers of people of color. For example, Census Bureau data collected in early February found that nearly 20 percent of households of color with children reported not getting enough to eat sometimes or often in the previous seven days, nearly double the 10 percent figure for non-Latino white households with children (which is also too high).

The Rescue Plan is designed to address the high levels of hardship created by the pandemic and economic crisis. But its measures are temporary, so the considerable progress they will make against

poverty, racial disparities, and the number of people lacking health coverage will reverse once they begin to expire unless policymakers invest in measures to create an equitable recovery that allows everyone to share in its benefits.

This nation underinvests in low-income children, tolerates high levels of poverty and economic insecurity, and entered the pandemic with 29 million people lacking health coverage despite enormous progress under the Affordable Care Act (ACA). These investment deficits hold us back as a country and allow gaping disparities to remain — and to widen during a crisis.

Other wealthy nations do far more to invest in children, to support workers and their households both when they are working for low pay and after a job loss, to ensure more adequate minimum wages, and to give everyone access to health care. The United States can afford these kinds of policies as well. Failure to make these kinds of investments and policy changes has real costs, to individuals and the nation as a whole. Research shows that poverty and the hardships that come with it — housing instability, food insecurity, and high levels of family stress that can become toxic to developing children — can have negative long-term impacts on children’s health, education, and earnings. There are negative impacts on adults, as well, when they don’t have enough to eat, face eviction, and don’t have access to health care.

If policymakers don’t take this opportunity to create a more equitable recovery, and craft a legislative package focused only on physical infrastructure and climate technology, future economic growth may be somewhat higher than if no package were enacted at all, but millions of households will see little benefit from that growth.¹ Most people working in low-paid jobs will continue to struggle to make ends meet, those who lose their jobs will not have help to tide them over, tens of millions of people will still lack health coverage, and child poverty and its attendant hardships will remain high, robbing children of the future they deserve.

The American Rescue Plan demonstrates that we have the policy know-how to achieve meaningful advances in these areas. The question is whether we will make the commitment needed for lasting improvements or instead will adopt a “go-small” approach that costs less and achieves far less in charting the course to a more equitable recovery and nation.

This paper outlines recommendations for a recovery package in three areas:

- **Investing in children**, such as by permanently extending the Rescue Plan’s Child Tax Credit improvements, expanding rental assistance, investing in good-quality child care and early education, and strengthening the federal food assistance programs.
- **Supporting workers and those struggling in the labor market**, such as by permanently extending the Rescue Plan’s Earned Income Tax Credit (EITC) expansion for low-paid adults without minor children at home, reforming unemployment insurance, and creating subsidized jobs.

¹ Chye-Ching Huang and Roderick Taylor, “Any Federal Infrastructure Package Should Boost Investment in Low-Income Communities,” CBPP, updated June 28, 2019, <https://www.cbpp.org/research/federal-budget/any-federal-infrastructure-package-should-boost-investment-in-low-income>.

- **Expanding health coverage**, such as by enhancing financial assistance to help people afford marketplace coverage.

In addition, the recovery package should raise substantial revenue and begin to build toward a more adequate and equitable revenue system that can support the investments necessary to broaden opportunity and improve well-being. After decades of tax cuts, creating such a revenue system will likely take a multi-year effort, and this year represents a historic opportunity to start. But we must not shortchange high-payoff investments in the meantime. Thus the recovery package should include robust revenue measures and responsible health care cost savings, but it should also make critical investments even if some need to be financed over a longer time horizon through borrowing.

Investing in Children

Providing stronger, more equitable supports for children — particularly children experiencing financial hardship and disadvantage — can make an important difference in their lives and benefit the nation as a whole. Supports such as income assistance, housing assistance, food assistance, and child care and early education can build opportunity for all children, promoting equity across lines of race, ethnicity, and immigration status and adding to our nation’s collective future prosperity.

Strong evidence links economic support for families with better outcomes for children, ranging from healthier birthweights and lower maternal stress to better academic performance, higher rates of high school graduation and college entry, higher future earnings, and other benefits.

The risks of failing to provide adequate support, on the other hand, are substantial. Even short periods of food insecurity pose long-term health and developmental risks for children. Housing insecurity adds to stress on parents and children and can result in frequent moves that disrupt schooling. Intense financial worries can interfere with parenting, adversely influence children’s mental health and behavior, and in some cases contribute to toxic stress, which is associated with measurable changes in brain structure, cognitive damage, and lifelong health problems such as diabetes and heart disease. As a congressionally chartered report that a National Academy of Sciences (NAS) panel issued in 2019 explained:

The weight of the causal evidence indicates that *income poverty itself causes negative child outcomes*, especially when it begins in early childhood and/or persists throughout a large share of a child’s life. Many programs that alleviate poverty either directly, by providing income transfers, or indirectly, by providing food, housing, or medical care, have been shown to improve child well-being.² [Emphasis added.]

Particularly compelling evidence of the impact of income support comes from a series of cross-program comparisons of several anti-poverty and employment-related pilot programs in the United States and Canada in the 1990s. When programs provided more generous income assistance, they consistently led to better academic performance among young children starting school. Every \$1,000 in added annual income brought a significant increase in school achievement relative to peers

² National Academies of Sciences, Engineering, and Medicine, “A Roadmap to Reducing Child Poverty,” National Academies Press, 2019, <https://www.nap.edu/read/25246>.

receiving less generous assistance.³ Similarly, studies of the introduction of food stamps (later renamed the Supplemental Nutrition Assistance Program or SNAP) found that children from disadvantaged families that had access to food stamps in utero or early childhood had better health outcomes as children and adults, were more likely to graduate from high school, and earned more than their peers from counties that had not yet implemented SNAP.⁴

By expanding opportunities for children to thrive, income support programs — including the EITC and Child Tax Credit, which work through the tax code, and SNAP and rental assistance, which are provided in kind rather than in cash — can thus help level the playing field for all children regardless of race, parental education, where they live, and the wide income gaps between rich and poor.

Income support programs have become increasingly effective in recent decades at reducing children's poverty while narrowing the nation's long-standing gaps in poverty by race. Between 1970 and 2017, by one measure, poverty rates among Black and Latino children fell by 32 and 35 percentage points, respectively, compared to 10 percentage points for white children. More than half of these declines reflected the increasing poverty-reducing effectiveness of government assistance at lifting families' incomes above the poverty line.⁵ (See Figure 1.)

Poverty remains high, however, especially among Black, Latino, and Indigenous children. Columbia University researchers recently estimated that poverty rates in 2021 will be 9.7 percent for Black children and 9.2 percent for Latino children, compared to just 3.1 percent for white children. These estimates, moreover, account for the Rescue Plan's assistance for families. *Without* the Rescue Plan, these groups' poverty rates would be 21.5, 19.5, and 8.3 percent, respectively, the researchers estimate. Put another way, the Rescue Plan is projected to cut child poverty by more than half for all racial groups this year and shrink racial gaps in child poverty by about half.⁶ Official poverty rates are also very high for American Indian and Alaska Native children — similar to those of Black children — but are measured with less precision due to smaller sample size.

³ Greg Duncan, Pamela Morris, and Chris Rodrigues, "Does Money Really Matter? Estimating Impacts of Family Income on Young Children's Achievement with Data from Random-Assignment Experiments," *Developmental Psychology*, Vol. 47, No. 5, 2011, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3208322/>.

⁴ Hilary Hoynes, Diane Whitmore Schanzenbach, and Douglas Almond, "Long-Run Impacts of Childhood Access to the Safety Net," *American Economic Review*, Vol. 106, No. 4, April 2016 (an earlier version of the paper is at <http://www.nber.org/papers/w18535>); Martha Bailey *et al.*, "Is the Social Safety Net a Long-Term Investment? Large-Scale Evidence from the Food Stamps Program," Goldman School of Public Policy Working Paper, April 2020, <https://gspp.berkeley.edu/assets/uploads/research/pdf/w26942.pdf>; Chloe N. East, "The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility," *Journal of Human Resources*, September 2018, <http://jhr.uwpress.org/content/early/2018/09/04/jhr.55.3.0916-8197R2.abstract>.

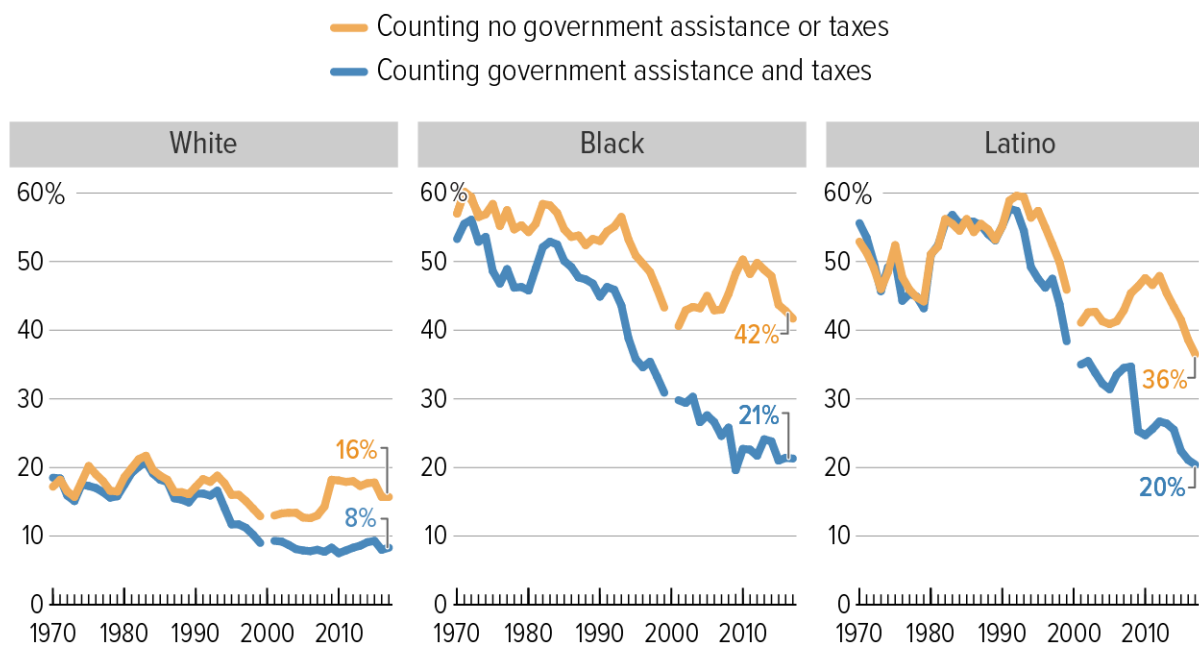
⁵ Figures correct for underreporting of benefits from SNAP, Temporary Assistance for Needy Families, and Supplemental Security Income in the survey data; 2017 is the latest year for which these corrections are available. Danilo Trisi and Matt Saenz, "Economic Security Programs Reduce Overall Poverty, Racial and Ethnic Inequities," CBPP, January 28, 2021, <https://www.cbpp.org/research/poverty-and-inequality/economic-security-programs-reduce-overall-poverty-racial-and-ethnic>.

⁶ Zachary Parolin *et al.*, "The Potential Poverty Reduction Effect of the American Rescue Plan," Columbia University Center on Poverty and Social Policy, March 11, 2021, <https://www.povertycenter.columbia.edu/publications>.

FIGURE 1

Economic Security Programs Increasingly Effective at Reducing Child Poverty, But Disparities Persist

Percent of children in poverty, by race and ethnicity, 1970-2017



Note: Figures use Supplemental Poverty Measure (SPM) and 2019 SPM poverty line adjusted for inflation. Figures for 1993 and on correct for underreporting of benefits from SNAP, Supplemental Security Income, and Temporary Assistance for Needy Families (TANF). Figures for 2000 omitted due to data limitations.

Source: CBPP analysis of SPM data from Columbia Center on Poverty and Social Policy (before 2009) and U.S. Census Bureau (2009 and on, accessed via IPUMS-CPS). Corrections for underreported benefits from Department of Health and Human Services/Urban Institute Transfer Income Model (TRIM).

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Moreover, U.S. anti-poverty policies remain weak by the standards of other wealthy nations. Before factoring in economic security programs, nations such as France, Germany, the United Kingdom, Canada, and the Nordic countries have poverty rates similar to the United States or even higher. But these countries have lower poverty rates — sometimes much lower — after counting benefits from government programs. Prior to the pandemic, these figures show, our children were poorer than others not so much because U.S. families earn less but because other nations do more when families don't earn enough to make ends meet.⁷

In addition to income assistance programs, we know that other careful investments in children, such as child care and early education, matter as well. As a Federal Reserve Bank of Minneapolis analysis explains, “the literature is clear: Dollars invested in ECD [Early Childhood Development] yield extraordinary public returns,” such as fewer years of repeated schooling, higher future earnings,

⁷ CBPP, “U.S. Poverty Rate Is High After Taxes and Transfers Compared to Similarly Wealthy Countries,” <https://www.cbpp.org/us-poverty-rate-is-high-after-taxes-and-transfers-compared-to-similarly-wealthy-countries-1>.

and less crime.⁸ Early education appears to have even greater positive effects when high-quality preschool is followed by better-funded K-12 schools. (Similarly, K-12 spending is even more effective at boosting students' future earnings and other outcomes when preceded by early childhood education.)⁹

A 2020 paper examining causal studies on 133 public policies over the last 50 years finds a “clear and persistent pattern” that investments in children, from birth up to their teen years, consistently yield the largest long-run gains for society of any form of social spending. Many policies for children even pay for themselves in budgetary terms as governments recoup their initial cost through higher tax revenues and lower social spending, say the authors, Harvard economists Nathaniel Hendren and Ben Sprung-Keyser. Many other investments in childhood may not be self-financing from a narrow budgetary perspective but still add to society's wealth by advancing future productivity, health, equal opportunity, social cohesion, and other important goals.

The upcoming recovery package should make critical investments in children, including steps to:

Make the American Rescue Plan expansions in the Child Tax Credit permanent. Before the Rescue Plan temporarily expanded the Child Tax Credit, some 27 million children — including roughly half of Black children, half of Latino children, and half of children living in rural areas — received a partial Child Tax Credit or nothing at all because their parents' earnings were too low or they were out of work during the year. The Rescue Plan makes the full credit available to children in families with little or no earnings in a year and increases the credit's maximum amount to \$3,000 per child (\$3,600 for children under age 6). These expansions should become a permanent feature of our tax code. Doing so would keep an estimated 4.1 million children from falling below the poverty level.

Expand housing vouchers toward the goal of ensuring that all households that need rental assistance can receive it. Housing vouchers lower the likelihood that a low-income family lives in crowded housing (by 52 percent) or is homeless (by 74 percent) and reduce their frequency of moving (by 35 percent)¹⁰ — important steps for reducing school disruption and other harmful outcomes for children. But just 1 in 4 eligible households receive any federal rental assistance due to limited funding. Providing vouchers to *all* eligible households would lift 9.3 million people above the poverty line and cut the child poverty rate by one-third, according to a recent Columbia University study.¹¹ It also would narrow the gap in poverty rates between white and Black households by over a third and the gap between white and Latino households by nearly half.

⁸ Arthur J. Rolnick and Rob Grunewald, “Early Childhood Development: Economic Development with a High Public Return,” Federal Reserve Bank of Minneapolis, March 1, 2003, <https://www.minneapolisfed.org/article/2003/early-childhood-development-economic-development-with-a-high-public-return>.

⁹ Cortney Sanders, “Research Note: Combining Early Education and K-12 Investments Has Powerful Positive Effects,” CBPP, February 28, 2019, <https://www.cbpp.org/research/state-budget-and-tax/research-note-combining-early-education-and-k-12-investments-has>.

¹⁰ Michele Wood, Jennifer Turnham, and Gregory Mills, “Housing Affordability and Family Well-Being: Results from the Housing Voucher Evaluation,” *Housing Policy Debate*, Vol. 19, No. 2, January 2008, pp. 367-412.

¹¹ Sophie Collyer *et al.*, “Housing Vouchers and Tax Credits: Pairing the Proposals to Transform Section 8 with Expansions to the EITC and Child Tax Credit Could Cut the National Poverty Rate by Half,” Columbia University Center on Poverty and Social Policy, October 7, 2020,

Well-targeted investments to build or preserve affordable housing are also important, especially in communities with significant housing supply challenges. But supply-side investments often won't make housing affordable to those most in need unless they are accompanied by vouchers or similar rental assistance, as explained in more detail below.

Invest in good-quality child care and early education. Expanding child care subsidies, increasing the reach of Head Start, Early Head Start, and other high-quality preschool programs, and investing in efforts to boost the quality of care can advance equity and opportunity for children, promote future economic growth, and help make work possible for parents.¹² Investing in the early care and education workforce and boosting their pay would also promote equity for these badly underpaid workers, who are overwhelmingly female and disproportionately women of color, and whose wages average only one-third those of elementary school teachers.¹³ (See below for more on expanding child care for working families.)

Strengthen federal food assistance programs to reduce food hardship among children, especially children of color. As noted, the high levels of food hardship emerging in the pandemic highlighted gaps in the federal food assistance programs. Food hardship among low-income children typically rises in the summer, when students do not receive free or reduced-price meals at school. But thanks to the Pandemic EBT program, which has replaced missed school meals during the pandemic and will continue through the coming summer, for the first time low-income children in every state could receive grocery benefits to replace school meals this summer. Adopting this approach *every* summer could avert periods of food hardship.

Other investments in SNAP, WIC, and the Child Nutrition programs could improve children's access to food year round. For example, extending the temporary SNAP and WIC benefit increases enacted in COVID relief legislation would ensure adequate benefit levels until the adequacy of the SNAP benefit is studied and adjusted based on evidence of food costs and dietary guidelines (as the Administration has committed to doing pursuant to a provision in the last farm bill) and the Administration updates WIC's food benefits to reflect science-based recommendations and dietary guidelines. Also, making it easier for schools to enroll low-income students for free school meals automatically and for high-poverty schools to serve meals at no charge to all students under the Community Eligibility Provision would enable low-income children to benefit fully from the school meal programs while targeting federal resources appropriately to those most in need.

Supporting Workers Earning Low Wages and Those Out of Work

The current crisis has highlighted the fact that millions of people who work in jobs essential for society to function receive little pay and limited or no benefits while often facing uncertain hours and scheduling. Many have trouble affording the basics; they often struggle to afford rent, cannot

<https://static1.squarespace.com/static/5743308460b5e922a25a6dc7/t/5f7dd00e12dfe51e169a7e83/1602080783936/Housing-Vouchers-Proposal-Poverty-Impacts-CPSP-2020.pdf>.

¹² Christine Johnson-Staub, "Equity Starts Early: Addressing Racial Inequities in Child Care and Early Education Policy," Center for Law and Social Policy, December 2017, https://www.clasp.org/sites/default/files/publications/2017/12/2017_EquityStartsEarly_0.pdf.

¹³ Caitlin McLean *et al.* "Early Childhood Workforce Index – 2020," Center for the Study of Child Care Employment, University of California, Berkeley, 2021, <https://csce.berkeley.edu/workforce-index-2020/>.

afford decent-quality child care, and lack paid sick or family leave and access to affordable health coverage. For example:

- **In 2019 (before the current crisis), 34 million people, including 10 million children, lived in families where someone worked but the family’s earnings were below the poverty line.**¹⁴ This included 24 percent of Black children, 23 percent of Latino children, and 8 percent of white children.
- **Low-paid workers are less likely to have health coverage through their jobs than better-paid workers.** Also, Black and Latino workers are less likely to have employer coverage than white workers; due to structural barriers such as income and wealth inequities, they are disproportionately likely to work in lower-paid jobs, which often don’t come with health benefits. Yet a number of states where people of color disproportionately reside haven’t adopted the ACA’s Medicaid expansion, a key tool to narrow racial and ethnic disparities in health coverage.
- **Due to lack of funding, just 1 in 6 children eligible for child care assistance received any, before the temporary investments in child care enacted in response to the current crisis.**
- **Workers in low-paid jobs and workers of color are less likely to have access to *any* family and medical leave, paid or unpaid.** They also are more likely to have to forgo taking needed time away from work. Low-wage workers are 50 percent more likely to report an unmet need for leave, primarily because they cannot afford to take an unpaid leave.¹⁵
- **Before the American Rescue Plan temporarily expanded the EITC for workers without minor children at home (see below), some 5.8 million such workers were taxed into, or deeper into, poverty, in part because their EITC was too small to offset the other taxes they pay.**
- **Some 5.7 million working renter households — nearly 1 in 5 — paid more than half their income for housing in 2018.** Housing cost burdens this high are linked to lower household spending on other essentials such as food and transportation and higher risk of housing instability.¹⁶

Moreover, workers often get little help when they lose their job or are out of work. Prior to enactment of temporary relief measures during the current crisis, the unemployment insurance (UI) system did not work well for those who lost a low-paid job. States have considerable discretion over UI benefit levels, eligibility criteria, and duration of benefits, and changes to state UI laws after the Great Recession made it harder for jobless workers to navigate the application process and to document and maintain eligibility; some states also cut the maximum number of weeks of benefits. In addition, many states maintained outdated eligibility criteria that exclude people such as

¹⁴ CBPP analysis of March 2020 Current Population Survey using the Supplemental Poverty Measure.

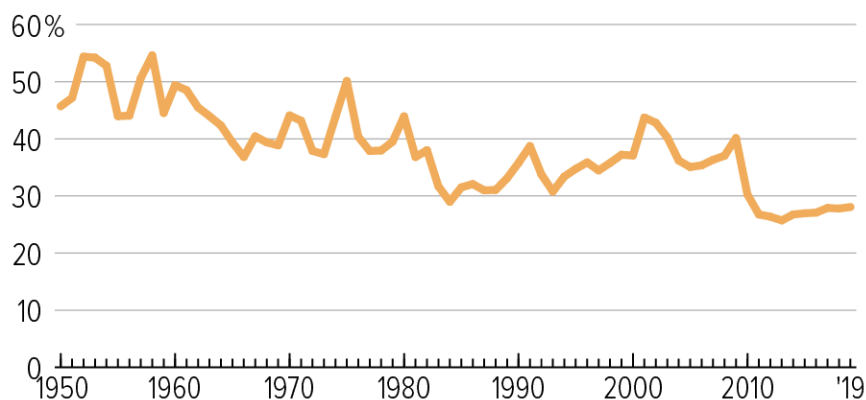
¹⁵ Abt Associates, “Employee and Worksite Perspectives of the Family and Medical Leave Act,” July 2020, https://www.dol.gov/sites/dolgov/files/OASP/evaluation/pdf/WHDD_FMLA2018SurveyResults_FinalReport_Aug2020.pdf.

¹⁶ Joint Center for Housing Studies of Harvard University, “America’s Rental Housing 2020,” Appendix Table W-2, <https://www.jchs.harvard.edu/americas-rental-housing-2020>. “Working” is defined here as having been employed for at least one week during the prior 12 months.

unemployed workers looking for part-time work and those who leave work for compelling family reasons, like caring for an ill family member.

FIGURE 2

Share of Jobless Workers Receiving Regular State Unemployment Benefits at Historic Lows Pre-Crisis



Note: These figures do not include the federal-state Extended Benefits program, which provides extra weeks of benefits in states where the unemployment situation has worsened dramatically, or emergency federal benefits provided on a temporary basis during recessions.

Source: Department of Labor, Employment and Training Administration, data downloaded 12/14/20

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As a result, the share of unemployed workers receiving UI prior to the pandemic ranged from 57 percent in Massachusetts down to 11 percent in Arizona, Florida, and Louisiana; 10 percent in Nebraska, North Carolina, and South Dakota; and 9 percent in Mississippi.¹⁷ Some of the decline in UI reciprocity prior to the current crisis reflected states’ failure to modernize their UI systems to meet the needs of a 21st century economy, but the National Employment Law Project concluded that “it is clear that some states have engaged in conscious strategies to decrease reciprocity.”¹⁸

The bottom line is that on the eve of the pandemic, a large share of low-paid workers — a disproportionate number of whom are women and people of color — didn’t qualify for *any* unemployment benefits if they lost a job or didn’t bother applying because states had made the system so hard to access. (See Figure 2.) For those who did qualify, benefits in many states were very low. Benefits just prior to the current crisis averaged \$387 a week nationwide but less than \$275 in the ten lowest-paying states, and low-paid workers generally received much less than the average. (UI benefit amounts are tied to workers’ previous wages.) At the same time, many workers without

¹⁷ Michael Leachman and Jennifer Sullivan, “Some States Much Better Prepared Than Others for Recession,” Appendix Table 2, CBPP, March 20, 2020, <https://www.cbpp.org/research/state-budget-and-tax/some-states-much-better-prepared-than-others-for-recession>.

¹⁸ George Wentworth, “Closing Doors on the Unemployed: Why Most Jobless Workers Are Not Receiving Unemployment Insurance and What States Can Do About It,” National Employment Law Project, December 19, 2017, <https://www.nelp.org/publication/closing-doors-on-the-unemployed/>.

minor children at home who lost their job or whose work hours dropped below 20 a week faced a three-month time limit on receiving food assistance through SNAP.

During the current crisis, federal policymakers enacted measures to address these deficiencies temporarily. They shored up the unemployment system by expanding eligibility and increasing benefit amounts and durations. They also suspended the SNAP three-month limit to improve access to food assistance regardless of employment status. But absent these kinds of measures, even the temporary loss of a low-paying job can cause immediate financial difficulties for a household.

To be sure, the EITC for families with children and SNAP benefits help millions of households with low earnings make ends meet. And in states that have adopted the Medicaid expansion, many low-paid workers can access comprehensive coverage through Medicaid. But as the data above show, people working in low-paid jobs can face severe economic insecurity.

Building a Recovery That Values All Workers and Helps Those Out of Work

Raising the minimum wage is a key part of better supporting workers; an adequate minimum wage is critical to helping workers in low-paid jobs and their households make ends meet. But that's not enough. The recovery package should include critical investments that would markedly improve economic security for those working in low-paid jobs and those struggling to find jobs, including the following:

Make permanent the American Rescue Plan's EITC expansion for low-paid adults without minor children at home. The Rescue Plan temporarily raises the maximum credit for these adults from about \$540 to about \$1,500, expands eligibility to include younger adults aged 19-24 (excluding students under 24 attending school at least part time) and people aged 65 and over, and raises the income limit to qualify from about \$16,000 to at least \$21,000. Over 17 million low-paid working adults will benefit from these changes. The recovery package should make them permanent.

Reform unemployment insurance. To ensure that workers have access to unemployment benefits when they need them, the recovery package should require states to set the maximum number of available weeks at 26 or higher, set a floor on benefit levels to ensure that they are adequate for low-paid workers, and modernize their eligibility criteria (including permitting good-cause reasons for leaving a job, such as illness or a family emergency, and counting workers' recent work history in determining their eligibility and benefit levels). It also should modernize the permanent Extended Benefits program so that additional weeks of benefits turn on quickly in a recession and do not turn off while a state's unemployment is still high; these steps would improve UI's "automatic stabilizer" properties and support lower-paid workers when jobs are harder to find. Finally, the package should take a first step toward addressing UI financing by increasing the federal taxable wage base, which establishes the minimum state taxable wage base; it has been set at \$7,000 per employee since the early 1980s.

Expand child care assistance to enable parents to work. Child care is expensive: center-based care for a toddler cost \$910 per month on average in 2018, and infant care cost substantially more.¹⁹ For a mother who is paid \$12 an hour for 30 hours of work per week, earning \$1,550 per month, child care for one child would eat up more than half of her income. Yet only a small fraction of those eligible for child care assistance receive it, and families often make do with less stable child care arrangements. Parents often lose their jobs when child care arrangements fall through.

Create a national paid leave program. Paid family and medical leave is important not only during a crisis but also in everyday circumstances, when workers need to take time off from work due to illness or caregiving responsibilities. Paid leave was a critical missing piece of this nation's care infrastructure when the pandemic hit — particularly for women and people of color, who more often work in jobs without these benefits and whose lower earnings make it harder for them to take unpaid leave. (Moreover, women often take on a larger caregiving role in many families.) The recovery package should include a broad-based, comprehensive, progressive paid family and medical leave policy.

Expand housing vouchers and invest in renovating and building affordable housing. As the economy recovers, high housing costs will continue to create economic instability and hardship for millions of low-income renters, increasing their risks of housing instability and homelessness and undercutting their children's chances of succeeding over the long term. Housing vouchers make rent affordable for people in low-paying jobs and are highly effective at reducing homelessness, as noted above. They also serve as an important hedge against housing instability and financial hardship during recessions because the voucher subsidy rises when a household's income falls due to loss of a job or work hours.

Investments in renovating and building affordable housing also have an important role to play, particularly in tight housing markets. Carefully designed investments of this type can make rents more affordable for low-income families, reduce homelessness, improve residents' living conditions and health outcomes, and reduce racial inequities in housing opportunities and housing quality. They also generate jobs and construction activity and can lower greenhouse-gas emissions by making developments more energy efficient. In making such investments, policymakers should place a high priority on renovating the existing public housing stock, creating housing options for people experiencing homelessness, and providing substantial additional resources for affordable housing development through the Indian Housing Block Grant and National Housing Trust Fund.

However, supply interventions alone will not address the affordable housing crisis. Many communities have ample supply of housing but housing remains unaffordable for people with modest incomes. Additionally, supply interventions often do not produce housing with rents that are low enough to be affordable for households with incomes near or below the poverty line — the group that makes up most of the renters confronting severe housing affordability challenges²⁰ —

¹⁹ Simon Workman and Steven Jessen-Howard, "Understanding the True Cost of Child Care for Infants and Toddlers," Center for American Progress, November 15, 2018, <https://www.americanprogress.org/issues/early-childhood/reports/2018/11/15/460970/understanding-true-cost-child-care-infants-toddlers/#:~:text=The%20average%20cost%20to%20provide,cost%20is%20%24800%20per%20month>.

²⁰ Seventy-four percent of renter households that paid more than half their income for housing in 2018 had "extremely low incomes," defined as incomes below the higher of the federal poverty line or 30 percent of the local median income.

unless those households also receive a voucher or similar rental assistance. Voucher expansion is therefore crucial to ensuring that a recovery package reaches those who most need help to afford stable housing.

Invest in workforce development and create subsidized jobs. As the economy recovers, some workers and new entrants to the labor market will continue to face challenges finding jobs for longer periods. Historically, Black workers have experienced very high unemployment rates in the best of times and devastatingly high rates in recessions and slow recoveries. Fully six years after the Great Recession technically ended, for example, unemployment still stood at 9.9 percent for Black workers in the second quarter of 2015, compared to 4.7 percent for white workers. Creating an equitable recovery will require new investments in training for in-demand quality jobs, career navigation for those looking to enter new fields, and subsidized jobs for those unable to find work.²¹ These investments can provide pathways forward to those who would otherwise be left out of the recovery.

Eliminate the SNAP three-month time limit so those out of work can afford food. Adults without a disability who are aged 18-49, not raising children at home, and not employed or in training 20 hours per week can receive only three months of SNAP benefits out of every three years, unless the requirement is waived in a community because of economic conditions. (The requirement is currently waived nationally during the public health emergency.) But many adults, especially those without a college education, face serious labor-market challenges and even in good times may struggle to find new stable employment in just three months. And, evidence shows that many individuals who should meet exemption criteria nonetheless lose food assistance because of the time limit. The recovery package should eliminate the time limit permanently to ensure that when people are out of work, they can afford to eat.

Expanding Health Coverage

The ACA cut the nation’s uninsured rate nearly in half, from 16 to 9 percent.²² This historic achievement led to improvements in health care access, financial security, and health outcomes — including reductions in premature deaths²³ — and narrowed racial gaps in coverage and access to

(CBPP analysis of 2018 American Community Survey and 2018 Housing and Urban Development Department income limit data.)

²¹ For additional details on subsidized jobs, see Caitlin Schnur, Chris Warland, and Melissa Young, “Framework for an Equity-Centered National Subsidized Employment Program,” Heartland Alliance, January 12, 2021, <https://nationalinitiatives.issuelab.org/resource/framework-for-an-equity-centered-national-subsidized-employment-program.html>. For additional details on training and career navigation, see Larry Good and Earl Buford, “Modernizing and Investing in Workforce Development,” Corporation for a Skilled Workforce, March 2021, <https://skilledwork.org/wp-content/uploads/2021/03/Modernizing-and-Investing-in-Workforce-Development.pdf>.

²² Robin A. Cohen *et al.*, “Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2018,” National Center for Health Statistics, May 2019, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf>.

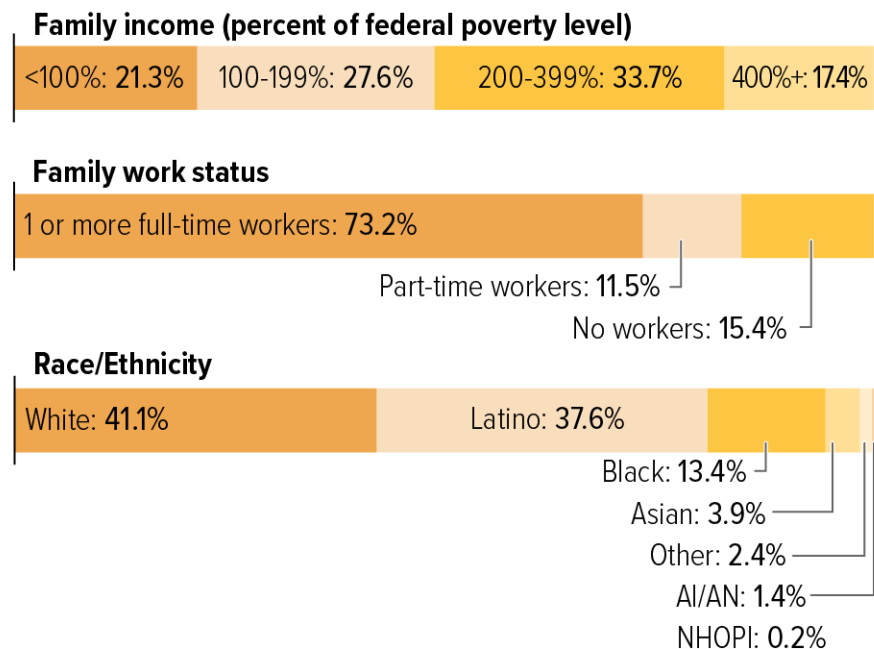
²³ CBPP, “Chart Book: Accomplishments of Affordable Care Act,” March 19, 2019, <https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act>; Jacob Goldin *et al.*, “Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach,” *Quarterly Journal of Economics*, February 2021, <https://academic.oup.com/qje/article/136/1/1/5911132>.

care, especially between Black and white people.²⁴ But the 29 million people who remain uninsured have not shared in these benefits. This group tends to have low incomes, and 56 percent of them are Latino, Black, or other people of color, according to Census data. (See Figure 3.)

Many low-wage jobs either don't offer health coverage or offer coverage that's unaffordable. Strengthening Medicaid and subsidized marketplace coverage should be an important part of a recovery package that strives to make the economy work better for everyone, promote health, and narrow racial and ethnic disparities, including in health care.

FIGURE 3

Roughly Half of Uninsured People Have Low Incomes



Note: Includes nonelderly individuals ages 0 to 64. AI/AN refers to American Indian/Alaska Native. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Latino people may be of any race but are categorized as Latino; other groups are all non-Latino. The 2019 Census Bureau poverty threshold for a family of three was \$20, 578.

Source: Kaiser Family Foundation analysis of 2019 American Community Survey, 1-year estimates.

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By making health care more accessible and affordable for a broader swath of people we could ensure that the recovery improves their health, well-being, and economic security. We must also

²⁴ Jesse C. Baumgartner *et al.*, "How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care," Commonwealth Fund, January 16, 2020, <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access>.

ensure that all people eligible for Medicaid can get covered and make it easier for people to maintain coverage once they have it.

Indeed, expanding Medicaid is critical to achieving an equitable recovery. If the 14 states that have not expanded Medicaid did so, nearly 4 million uninsured low-income adults could gain coverage. People of color would disproportionately benefit: 29 percent of the uninsured people who would gain Medicaid eligibility are Latino and 23 percent are Black, the Kaiser Family Foundation estimates.²⁵ The American Rescue Plan included strong new incentives — on top of those already in place — that hopefully will prod additional states to expand Medicaid.²⁶

The recovery package should also:

Enhance financial assistance in the marketplaces. A major reason why millions of people, especially those with low incomes, remain uninsured is that they cannot afford coverage. Reducing net premiums increases coverage significantly, research shows.²⁷ For example, Massachusetts — which has the nation’s lowest uninsured rate for people with incomes between 138 and 250 percent of the poverty line — provides sizable state subsidies on top of those the ACA offers, greatly reducing premiums for people with income below 300 percent of poverty.

The recovery package should build on the American Rescue Plan’s temporary increases in marketplace premium tax credits by permanently increasing premium credits and cost-sharing assistance to ensure that people with incomes below 200 percent of the poverty line pay \$0 premiums for a plan with reduced deductibles and other cost sharing. It also should boost financial help with premiums, deductibles, and other cost sharing for people with incomes between 200 and 400 percent of poverty. And it should continue the Rescue Plan provision that eliminates the premium tax credit “cliff” of 400 percent of poverty, so that people with incomes above that level who face a high premium burden can get help affording coverage.

Eliminate or lower the ACA “firewall.” About 2.7 million uninsured workers and family members with incomes below 400 percent of poverty are ineligible for subsidized marketplace coverage due to the “firewall,” which makes people who have an offer of employer-sponsored coverage ineligible for marketplace financial assistance if the employer coverage meets minimum federal standards for affordability and comprehensiveness. The standards are insufficient, barring many low-income people from enrolling in subsidized marketplace coverage that would be far more affordable and comprehensive.²⁸ Eliminating the firewall would give workers a choice of employer coverage or subsidized marketplace coverage.

²⁵ Jesse Cross-Call and Matt Broaddus, “States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession,” CBPP, July 14, 2020, <https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and>.

²⁶ Tara Straw *et al.*, “Health Provisions in American Rescue Plan Act Improve Access to Health Coverage During COVID Crisis,” CBPP, March 11, 2021, <https://www.cbpp.org/research/health/health-provisions-in-american-rescue-plan-act-improve-access-to-health-coverage>.

²⁷ Amy Finkelstein *et al.*, “Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts,” *American Economic Review*, Vol. 109, No. 4, 2019, <https://economics.mit.edu/files/15852>

²⁸ Tara Straw, “Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers,” CBPP, December 3, 2019, <https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for>.

Alternatively, policymakers could allow family members to enroll in subsidized coverage if the cost of employer *family* coverage is above the affordability threshold; this is sometimes described as fixing the “family glitch.” They also could lower the affordability threshold (9.83 percent of income in 2021) used to determine whether an employer coverage offer is affordable.

Reduce Medicaid “churn” through continuous eligibility. Many people exit Medicaid because their incomes rise modestly over program limits or they fail to return needed paperwork, only to regain eligibility within months. Often, individuals lose coverage even though they remain eligible. This “churn” disrupts access to medication and other care and is burdensome for states and health plans. About half the states have taken up Medicaid’s continuous eligibility option, which enables them to allow children to remain eligible for 12 months at a time. New York and Montana provide continuous eligibility for adults through a Medicaid demonstration project. The recovery package should require all states to implement continuous eligibility for children and adults, or as an alternative, require it for children and create a state option for adults.

Provide continuity of care for people leaving jail or prison. Many people go without needed health care while incarcerated, leave jail or prison without adequate access to medications, or don’t get needed health care when they are back in the community. These gaps in care contribute to a litany of poor health outcomes — especially for Black and Latino people, who are incarcerated at higher rates — and thus make recidivism more likely. The recovery package should allow states to receive a federal match for Medicaid services provided to people during their last 30 days in prison or jail.

Broaden the availability of home- and community-based services. To ensure that everyone who needs these services can receive ongoing, reliable, quality care, we must expand the caregiving workforce. That, in turn, will require better training and working conditions and higher pay, and the increased costs will be passed on to state Medicaid programs. The recovery package should provide states with additional funding to accommodate them.

Provide adequate, stable Medicaid funding for Puerto Rico and other U.S. territories. Unlike the states, Puerto Rico and the other territories (American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands) receive Medicaid funds through a fixed, inadequate block grant and a 55 percent federal matching rate that is unrelated to need. Temporary increases in the territories’ allotments and matching rates expire at the end of September 2021. The recovery package should include a permanent fix giving the territories stable, adequate funding and putting them on a path to align their Medicaid programs with the program that operates in the states as quickly and completely as possible.

Strengthen Medicaid’s response to future economic downturns. The recovery package should establish a permanent mechanism to raise the federal share of state Medicaid costs when a state’s unemployment rate is above normal levels, which would enable states to receive increased Medicaid funding in a recession without additional congressional action. Proposals with this structure have been introduced in the House, including as part of a House Democratic COVID relief proposal in 2020 (H.R. 6379), and in the Senate, in a bill with 19 sponsors and cosponsors (S. 4108).

The Nation Can Afford These Investments; Failure to Act Would Be Costly

Preferably, policymakers would finance the investments needed to help all children thrive, support workers and those with limited job options, and expand health coverage through higher revenues and responsible health care savings. All else being equal, less debt is better for the economy, though many economists in recent years have concluded that the nation can safely hold more debt than previously thought desirable.²⁹ And, as discussed below, there is plenty of room to raise revenues in a progressive manner: our pursuit in recent decades of ever-lower taxes, especially on wealthy households, has severely weakened our ability to invest in critical priorities. Moreover, raising more revenues in a progressive manner and investing the revenues in ways that improve economic opportunity can push back on racial disparities, as can overhauling regressive or unproductive tax breaks and giving IRS the resources it needs to collect all of the taxes that are owed.³⁰

However, creating a stronger, more sustainable tax structure that raises adequate revenues will likely take time and require more than one piece of legislation. So while we should finance as much of these high-priority investments as possible with revenues and health care cost savings, we should not “go small” on investments. Given the urgent need to build an equitable recovery, the high return on investment of many of these policies, and today’s low interest rates, the nation stands to gain far more by deficit-financing some of these investments than by jettisoning them if the offsets immediately available fall short of the total investment needs. There is a particularly strong argument for using deficit financing, which allows the cost of an investment to be stretched out over a long time horizon, for investments whose benefits similarly accrue over many decades.

Higher Revenues Needed

In 2000, after a strong economic recovery and net tax increases over the previous decade, federal revenues equaled 20 percent of the nation’s gross domestic product (GDP). Yet total U.S. revenues were still well below revenue levels in other wealthy countries with more robust public investments.³¹

Two decades and two large regressive tax cut packages later, and at the same point in the business cycle, that ratio of revenue to GDP had fallen to 16.3 percent in 2019 — far too low to support the kinds of investments needed for a 21st century economy that broadens opportunity, supports workers, and ensures health care for everyone. Next year alone, the difference between revenues at 20 percent of GDP and 16.3 percent is about \$850 billion. Simply restoring a significant fraction of this revenue loss could raise trillions of dollars over the next decade for investments to make the

²⁹ Jason Furman and Lawrence Summers, “A Reconsideration of Fiscal Policy in the Era of Low Interest Rates,” Discussion Draft, November 20, 2020, <https://www.piie.com/system/files/documents/furman-summers2020-12-01paper.pdf>.

³⁰ Chye-Ching Huang and Roderick Taylor, “How the Federal Tax Code Can Better Advance Racial Equity,” CBPP, July 25, 2019, <https://www.cbpp.org/research/federal-tax/how-the-federal-tax-code-can-better-advance-racial-equity>.

³¹ Comparisons with other wealthy countries include total U.S. revenues: federal, state, and local. Organisation for Economic Co-operation and Development (OECD), *Revenue Statistics 2018*, https://doi.org/10.1787/rev_stats-2018-en.

economy stronger and work better for everyone. More will ultimately be needed to address health care and retirement costs as well over the long run.³²

Asking the wealthiest people in the country — a group whose wealth soared in the two decades prior to 2000, rose further during the two decades since 2000, and is now at a record high despite the global pandemic³³ — to pay more would be a good place to start. Very wealthy households do not pay taxes annually on a large share of their income and often can avoid paying taxes on much of the appreciation of their assets throughout their lifetimes, even as middle-income people pay taxes on their earnings.³⁴ And, because of the way in which wealth is shielded from taxation at death, a substantial share of wealth accumulation is *never* taxed.³⁵

When wealthy people do pay tax on the income from wealth, it is often at special, discounted rates. The tax cuts enacted under President George W. Bush created or expanded several tax advantages for income from wealth. For example, dividends are no longer taxed at the same rate as wages, as they had been for much of the previous century. The 2017 Trump tax cuts continued the drive to reduce taxes on very large inheritances, doubling the amount of an estate that is entirely free of estate tax to \$22 million per couple. And some wealthy individuals can use additional asset-protection mechanisms to further shield estates above this exemption level from taxation.

In addition, the 2017 Trump tax cuts slashed the corporate tax rate from 35 to 21 percent, well below the level needed to compete with other nations, the common justification for the change. They set the tax rate on foreign profits of U.S.-based multinationals even lower, which means that companies continue to have sizable incentives to shift profits — and investments — out of the country to reduce their tax bills.

³² Paul Van de Water, “Federal Spending and Revenues Will Need to Grow in Coming Years, Not Shrink,” CBPP, September 6, 2017, <https://www.cbpp.org/research/federal-budget/federal-spending-and-revenues-will-need-to-grow-in-coming-years-not-shrink>

³³ The latest Federal Reserve Distributional Financial Accounts data show that both the levels and shares of wealth for the top 1 percent have risen significantly for decades and are now at record highs, despite the pandemic: <https://www.federalreserve.gov/releases/z1/dataviz/dfa/distribute/table/>. *Forbes* also reported that as of January 2021, the combined net worth of billionaires alone has increased by \$1.1 trillion (38.6 percent) since the start of the pandemic; see Tommy Beer, “Report: American Billionaires Have Added More Than \$1 Trillion In Wealth During Pandemic,” *Forbes*, updated January 26, 2021, <https://www.forbes.com/sites/tommybeer/2021/01/26/report-american-billionaires-have-added-more-than-1-trillion-in-wealth-during-pandemic/?sh=51a5ee1c2564>. For historical trends, see Emmanuel Saez and Gabriel Zucman, “Wealth Inequality in the United States Since 1913: Evidence from Capitalized Income Tax Data,” *Quarterly Journal of Economics*, Vol. 131, No. 2, May 2016, which shows that the wealth shares of the top 1 percent and top 0.1 percent started dramatic climbs in the late 1970s.

³⁴ Currently, high-wealth individuals can accumulate capital gains every year as their investments appreciate, but they don’t owe tax on those gains until (or unless) they “realize” the gain, usually by selling the appreciated asset. This deferral feature makes taxes on capital gains largely voluntary for many high-income people. Moreover, if they pass on those assets, their heirs often do not have to pay any income tax on the gains either. See Chuck Marr, Samantha Jacoby, and Kathleen Bryant, “Substantial Income of Wealthy Households Escapes Annual Taxation or Enjoys Special Tax Breaks,” CBPP, November 13, 2019, <https://www.cbpp.org/research/federal-tax/substantial-income-of-wealthy-households-escapes-annual-taxation-or-enjoys>.

³⁵ *Ibid.* According to Federal Reserve estimates, more than half of the value of the largest estates (i.e., those valued at more than \$100 million) consists of unrealized capital gains that have never been taxed.

This drive toward lower effective tax rates on wealthy people and profitable corporations has led both to greater inequality and to underinvestment in areas that promote broadly shared economic growth, widen opportunity, and improve well-being among those not already well heeled.

Any effort to raise additional revenues should also focus on the roughly half-trillion dollars of taxes that are owed *annually* under current law but go uncollected. The IRS enforcement budget has been cut a quarter since 2010 and the number of revenue agents — auditors who are uniquely qualified to process the complex returns of high-income individuals and corporations — has fallen by 39 percent.³⁶ Audit rates have plummeted. For example, the audit rate on millionaires has fallen by a jaw-dropping 71 percent over the same period, from 8.4 percent to just 2.4 percent.³⁷ Rebuilding the IRS enforcement division should be a key component of any recovery legislation. There is broad consensus that every additional dollar spent on enforcement generates multiple dollars in revenues.

Creating a more adequate and equitable revenue system will likely take a multi-year effort, and this year represents an historic opportunity to start. The package should include robust revenue increases, but we must not shortchange high-payoff investments if revenue increases must be done in several stages. Investments in infrastructure and climate technologies, children, workers, and health care are badly needed now and will address glaring racial disparities, improve health, and allow more children to reach their full potential.

³⁶ Internal Revenue Service, “SOI Tax Stats – IRS Data Books,” 2010-2019, <https://www.irs.gov/statistics/soi-tax-stats-irs-data-book>.

³⁷ *Ibid.*

California Health Benefits Review Program

Analysis of California Senate Bill 245 Abortion Services: Cost Sharing

A Report to the 2021–2022 California State Legislature

March 23, 2021



Key Findings

Analysis of California Senate Bill 245 Abortion Services: Cost Sharing

Summary to the 2021–2022 California State Legislature, March 23, 2021



SUMMARY

The version of California Senate Bill (SB) 245 analyzed by CHBRP would prohibit cost sharing for all abortion services, including follow-up services such as management of side effects and counseling. It also prohibits health plans and policies from imposing any restrictions or delays on abortion services, including prior authorization, and prohibits annual or lifetime limits on any covered abortion services.

In 2022, 100% of the 21.9 million Californians enrolled in state-regulated health insurance would have insurance subject to SB 245.

Benefit Coverage: At baseline, CHBRP estimates there are 23,492 enrollees who would have induced abortions and use associated services. Of these, 9,652 enrollees (41%) have cost sharing. Postmandate, 100% of enrollees with coverage for abortion would have \$0 cost sharing for abortion services, including associated medical services.

Medical Effectiveness: There is insufficient evidence that utilization management policies affect abortion outcomes. There is limited evidence that cost-sharing policies reduce access to, and use of, abortion services and insufficient evidence that cost sharing for abortion services affects maternal health outcomes.

Cost and Health Impacts¹: In 2022, CHBRP estimates SB 245 would result in an increase of 9,748 women utilizing abortion services with zero cost sharing. This estimate includes the population of women who shift from having cost-sharing payments for abortion services at baseline and an estimated additional 97 women who would be new users of abortion services due to the elimination of cost sharing. This would result in a decrease of \$1,501,000 (0.0011%) in annual expenditures (includes likely reduction in health care costs

associated with continued pregnancies due to increased utilization of abortion services, as well as applicable reductions in benefit-related expenses for enrollees).

SB 245 may reduce the negative health outcomes associated with being unable to access an abortion for the additional 97 women who would be new users of abortion services. Furthermore, the average out-of-pocket cost for any abortion service is estimated to be \$543, which has been shown to be a financial barrier. Therefore, SB 245 may also provide a financial benefit for enrollees that experience an elimination of cost sharing for covered abortion services.

CONTEXT

Abortion is the termination of pregnancy by either medication or procedure. There are two types of abortion methods — medication abortions and procedural (surgical) abortions. Both require associated services such as pre-abortion evaluation services and follow-up care.

Abortion is considered a basic health care service in California and, therefore, is required to be covered by commercial health insurance plans and policies, the California Public Employees' Retirement System (CalPERS), and Medi-Cal. Medically necessary, follow-up services to abortions that constitute basic health care services must also be covered. However, the state does not mandate which types of abortion methods (i.e., procedural or medication) must be covered nor does it mandate cost-sharing requirements specific to these services.

In the United States, the average out-of-pocket cost paid for a medication abortion ranges from \$300 to \$1,500 and for a procedural abortion from \$295 to \$1,600, depending on insurance coverage and geographic location.² Studies show that saving money or securing funds to pay for an abortion is a financial barrier to obtaining abortion services. Other identified barriers to use of abortion services include the cost of travel

¹ Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

² Refer to CHBRP's full report for full citations and references.

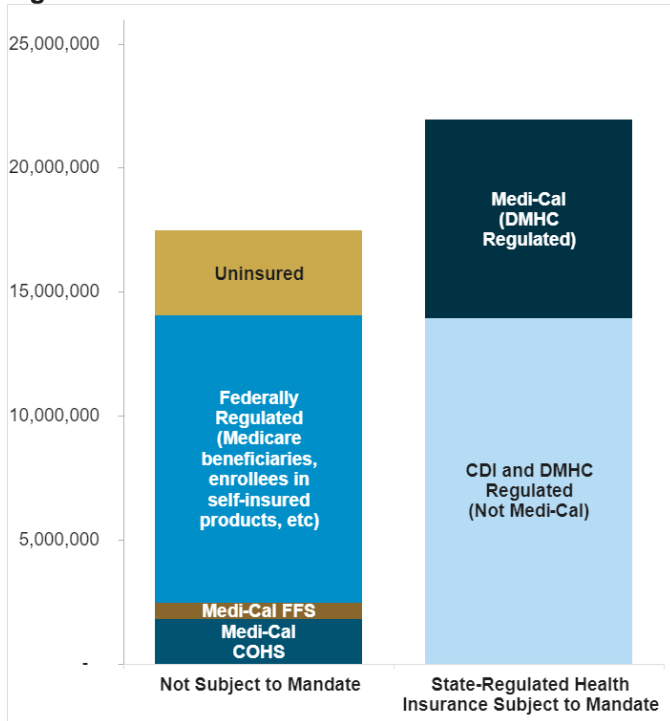
necessary to obtain services, lost wages, and expenses for childcare.

BILL SUMMARY

As introduced, SB 245 would prohibit cost sharing for all abortion services, including follow-up services such as management of side effects and counseling. It also prohibits state-regulated health plans and policies (including CalPERS and Medi-Cal) from imposing any restrictions or delays on abortion services, including prior authorization, and prohibits annual or lifetime limits on any covered abortion services.

Figure A notes how many Californians have health insurance that would be subject to SB 245.

Figure A. Health Insurance in California and SB 245



Source: California Health Benefits Review Program, 2021.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates at baseline there are 23,492 users of any abortion services, including medication and procedural abortions and associated services, enrolled in plans regulated by the California Department of

Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI). Of this population, 9,652 users of any abortion services have cost sharing. Postmandate, 100% of users of abortion services with cost sharing at baseline will have zero cost sharing.

SB 245 prohibits prior authorization and other restrictions or delays from being imposed by health plans/insurers for covered abortion services and follow-up services. These provisions may clarify existing law, however, they still appear to be duplicative of existing law. As such, this portion of SB 245 will have no effect for enrollees in DMHC-regulated plans and CDI-regulated policies.

Utilization

CHBRP estimates that, postmandate, a 1% increase in utilization would occur resulting in an additional 97 women obtaining abortions with zero cost sharing.

Expenditures

At baseline, average out-of-pocket costs for enrollees who use any abortion services and have cost sharing is \$543. The average cost share is \$306 for a medication abortion, \$887 for a procedural abortion, and \$182 for associated services.³ These do not reflect average total costs per enrollee for services, which would depend on the amount and type of services used. Postmandate, enrollees with coverage with cost sharing for abortion services at baseline would have \$0 cost sharing for abortion services, including associated medical care.

SB 245 would decrease total net annual expenditures by \$1,501,000, or 0.0011%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a \$5,527,000 decrease in enrollee cost sharing for covered benefits adjusted by a \$4,026,000 increase in total health insurance premiums paid by employers and enrollees.

Total premiums for private employers purchasing group health insurance would increase by \$1,808,000, or 0.0033%. Total premiums for purchasers of individual market health insurance would increase by \$1,361,000, or 0.0086%. Changes in premiums as a result of SB 245 would vary by market segment. The greatest change in premiums as a result of SB 245 is for DMHC-regulated individual market plans (0.0085% increase) and for CDI-regulated individual market policies (0.0104% increase).

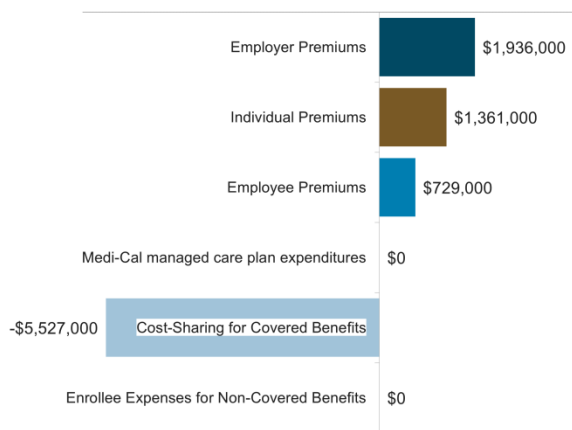
³ The cost of medication and procedural abortion includes any associated services performed on the same day of the abortion. Associated services includes both pre-abortion and follow-up services.

Among publicly funded DMHC-regulated health plans, there is no impact on Medi-Cal premiums because no enrollees have cost sharing for induced abortion services or related associated care. Among CalPERS health maintenance organization (HMO) plans, there is an estimated increase of \$128,000, or 0.0022%, in premiums.

The decreases in enrollee expenditures for covered benefits in commercial plans range from \$0.0242 per member per month (PMPM) among enrollees in DMHC-regulated large-group plans to \$0.0594 PMPM among enrollees in CDI-regulated individual policies. Among publicly funded plans, there is no impact for Medi-Cal enrollees; however, CalPERS enrollees will have a decrease in enrollee expenditures of \$0.0249 PMPM.

CHBRP assumes that women who have induced abortions, if they had continued their pregnancies, would have had the same proportion of live births and miscarriages as the overall population of pregnant women. CHBRP estimates there are an additional 97 women who would choose to have an induced abortion as a result of the elimination of cost sharing postmandate. The per-unit cost of continuing a pregnancy averages \$25,574, accounting for labor and delivery charges and medical costs associated with miscarriages. CHBRP does not include prenatal care in these average costs. The discontinuation of these 97 pregnancies postmandate leads to an estimated cost offset of \$2,455,000.

Figure B. Expenditure Impacts of SB 245



Source: California Health Benefits Review Program, 2021.

Note: Employer premiums include private employers and CalPERS HMO employers.

Medi-Cal

Medi-Cal covers abortions as a physician service without cost sharing. Medi-Cal policy prohibits requiring medical

justification and/or prior authorization for outpatient abortion services. Inpatient hospitalizations for procedural abortions do require prior authorization; however, this mandate follows the same criteria as any other medical procedure requiring hospitalization. As such, no impact on this population by SB 245 is projected.

CalPERS

For CalPERS HMO enrollees, there is an estimated increase of \$128,000, or 0.0022%, in premiums due to the elimination of enrollee cost sharing under SB 245.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, no measurable impact is projected on the number of uninsured persons due to the enactment of SB 245.

Medical Effectiveness

CHBRP developed a logic model to determine the potential impacts of cost sharing policies on utilization of abortions services and their related health outcomes as follows. The model is based on the idea that the elimination of cost sharing and utilization management policies, as proposed under SB 245, would reduce the barriers that cost and delays related to cost and utilization management can present in obtaining an abortion. As such, enactment of SB 245 would lead to increased access to timely abortion services, and therefore an increase in abortions completed when chosen. Consequently, SB 245 would decrease unintended pregnancies, which are associated with poor pregnancy and maternal health outcomes.⁴ In alignment with this logic model, CHBRP looked at the evidence of the impact of cost sharing and utilization management policies on abortion outcomes, including: abortion access, utilization of abortion services, abortion complications, prenatal care, maternal health outcomes, maternal mental health outcomes, birth outcomes, infant morbidity and mortality, child health status, and breastfeeding after being unable to obtain abortion.

CHBRP found there is:

⁴ Because many women who seek abortions do so for unintended pregnancies, it stands to reason that outcomes associated with unintended pregnancy can apply to women who sought abortion but were unable to obtain an abortion due to a cost or other barrier

- Insufficient evidence⁵ that utilization management policies affect abortion outcomes.
- Limited evidence⁶ that cost-sharing policies reduce access to, and use of, abortion services and insufficient evidence that cost sharing for abortion services affects maternal health outcomes.
- Limited evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding and an increase in postpartum depression and low birth weight or preterm births.
- Insufficient evidence that unintended pregnancies impact maternal health outcomes.
- Limited evidence that not obtaining a chosen abortion may have socioeconomic consequences for their children and that there is no impact on child health outcomes.
- Inconclusive evidence⁷ of the impact on child development of children born to women who were denied an abortion.

Public Health

In the first year postmandate, CHBRP projects that the removal of cost sharing for abortion services, as proposed under SB 245, would enable an additional 97 women, for whom the baseline cost-sharing requirements would have otherwise prevented them from accessing these services, to obtain an abortion. For those women, SB 245 may reduce the negative health outcomes associated with being unable to access an abortion. CHBRP estimates the average out-of-pocket cost for any abortion service is \$543, which has been shown to be a financial barrier. Therefore, SB 245 may also provide a financial benefit for the approximately 9,650 commercially-insured women who had cost sharing for covered abortions at baseline. These

⁵ Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

⁶ Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

⁷ Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

estimates are supported by limited evidence that cost-sharing policies reduce access to, and use of, abortion services.

CHBRP did not identify any studies that assessed utilization management among those with insurance coverage for abortion; therefore, there is insufficient evidence that utilization management policies affect abortion outcomes.

Although there is evidence of disparities in the United States related to racial/ethnic disparities in the rates of abortions, CHBRP found insufficient evidence of reduction in racial/ethnic disparities due to eliminating cost sharing and utilization management among women with commercial insurance. Please note that the absence of evidence is not “evidence of no effect.” It is possible that an impact — desirable or undesirable — could result, but current evidence is insufficient to inform an estimate.

CHBRP also found insufficient evidence of reduction in income-related disparities due to eliminating cost sharing among women with commercial insurance. Despite the lack of evidence that eliminating cost sharing results in increased utilization of abortions and associated services, SB 245 may have an impact for a subset of women with commercial insurance who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

CHBRP found insufficient evidence of reduction in age related disparities due to eliminating cost sharing among women with commercial insurance. However, SB 245 may have an impact for adolescents who are willing to use their parent’s commercial insurance coverage or have their own commercial insurance and who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

Long-Term Impacts

CHBRP estimates annual utilization of induced abortion services after the initial 12 months from the enactment of SB 245 would likely stay similar to utilization estimates during the first 12 months postmandate. Utilization changes may occur if new abortion medications or procedures change the landscape for enrollees; however, CHBRP is unable to predict these types of changes. Similarly, health care utilization due to improved reproductive health services may change in the long term.

CHBRP estimates of cost after the initial 12 months from the enactment of SB 245 are likely to remain similar in the subsequent years. Any savings resulting from a

decrease in the outcomes from continuing a pregnancy would also lead to reductions in any subsequent health care needed from those outcomes; however, that cannot be quantified.

The long-term impact of SB 245 on potential disparities related to abortions and associated services among women with commercial insurance is unknown. However, SB 245 may have an impact on social determinants of health (SDoH) by eliminating the cost barrier associated with obtaining an abortion and improving the long-term mental health outcomes and aspirational goals of women who obtained abortion services.

Essential Health Benefits and the Affordable Care Act

SB 245 would not require coverage for a new state benefit mandate and instead modifies cost-sharing terms and conditions of an already covered benefit. Therefore, SB 245 appears not to exceed the definition of EHBs in California.

A Report to the California State Legislature

Analysis of California Senate Bill 245 Abortion Services: Cost Sharing

March 23, 2021

California Health Benefits Review Program
MC 3116; Berkeley, CA 94720-3116
www.chbrp.org

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Table 1. SB 245 Impacts on Benefit Coverage, Utilization, and Cost, 2022

	Baseline (2022)	Postmandate Year 1 (2022)	Increase/Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,945,000	21,945,000	0	0.00%
Total enrollees with health insurance subject to SB245	21,945,000	21,945,000	0	0.00%
Total percentage of enrollees with coverage subject to SB245 (b)	100%	100%	0%	0.00%
Utilization and Cost				
Utilization of abortion services with cost sharing				
Number of users with cost sharing using ANY abortion services (c)	9,652	0	-9,652	-100.00%
Number of users of medication abortion (d)	3,759	0	-3,759	-100.00%
Number of users of procedural abortion (d)	3,516	0	-3,516	-100.00%
Number of users of associated services (e)	5,366	0	-5,366	-100.00%
Utilization of abortion services without cost sharing (f)				
Number of users <u>without</u> cost sharing using ANY abortion services (c)	13,840	23,589	9,748	70.43%
Number of users of medication abortion (d)	7,414	11,210	3,797	51.21%
Number of users of procedural abortion (d)	5,063	8,614	3,551	70.13%
Number of users of associated services (e)	4,429	9,849	5,420	122.37%
Average costs for abortion services per user				
Average costs of ANY abortion service per user	\$1,601	\$1,601	\$0	0.00%
Average cost of medication abortion per user (d)	\$741	\$741	\$0	0.00%
Average cost of procedural abortion per user (d)	\$2,763	\$2,763	\$0	0.00%
Average cost of associated services per user (e)	\$574	\$574	\$0	0.00%
Average out of pocket costs for users with cost sharing				
Average out of pocket costs for users with cost sharing for ANY abortion services	\$543	\$0	-\$543	-100.00%
Average cost share for medication abortion (d)	\$306	\$0	-\$306	-100.00%
Average cost share for procedural abortion (d)	\$887	\$0	-\$887	-100.00%
Average cost share for associated services (e)	\$182	\$0	-\$182	-100.00%

Continued pregnancies resulting from users facing cost-sharing barriers				
Number of continued pregnancies due to cost-sharing barrier	97	0	-97	-100.00%
Average cost of continued pregnancy per user (g)	\$25,574	\$25,574	\$0	0.00%
Expenditures				
<i>Premium (expenditures) by Payer</i>				
Private Employers for group insurance	\$55,032,803,000	\$55,034,611,000	\$1,808,000	0.0033%
CalPERS HMO employer expenditures (h) (i)	\$5,765,017,000	\$5,765,145,000	\$128,000	0.0022%
Medi-Cal Managed Care Plan expenditures	\$24,150,529,000	\$24,150,529,000	\$0	0.0000%
<i>Enrollee premiums (expenditures)</i>				
Enrollees for individually purchased insurance	\$15,847,507,000	\$15,848,868,000	\$1,361,000	0.0086%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (i)	\$20,753,446,000	\$20,754,175,000	\$729,000	0.0035%
<i>Enrollee out-of-pocket expenses</i>				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	\$13,168,032,000	\$13,162,505,000	\$5,527,000	-0.0420%
Expenses for noncovered benefits (j)	\$0	\$0	\$0	0.00%
	\$134,717,334,000		-	
Total Expenditures	0	\$134,715,833,000	\$1,501,000	-0.0011%

Source: California Health Benefits Review Program, 2021.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) SB 245 does not affect coverage for induced abortions. Rather, it impacts cost sharing for plans covering abortion services. This percentage reflects the percentage of DMHC-regulated plans and CDI-regulated policies that are subject to SB 245, and not the percentage of enrollees with coverage or cost sharing for abortion services.

(c) A single enrollee may receive medication abortion services, procedural abortion services, and associated services. Therefore, the number of enrollees using any abortion services is not a summation of the three categories.

(d) Cost of medication and procedural abortion includes any associated services performed on the same day of the abortion.

(e) Associated services includes both pre-abortion and follow-up services.

(f) Postmandate utilization of abortion services without cost sharing aggregates users who had no cost sharing at baseline, users who had cost sharing at baseline who have no cost sharing postmandate, and users who decide to use abortion services due to the elimination of cost sharing. The third category is also represented in the "continued pregnancy" offset section of Table 1, as postmandate, these users choose to no longer continue their pregnancy.

(g) These costs only include labor and delivery for a live birth or medical care for a miscarriage. They do not include prenatal care.

(h) Of the increase in CalPERS employer expenditures, about 54.1%, or \$69,000, would be state expenditures for CalPERS members who are state employees or their dependents.

(i) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(j) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HMO = Health Maintenance Organizations

POLICY CONTEXT

The California Senate Committee on Health has requested that the California Health Benefits Review Program (CHBRP)⁸ conduct an evidence-based assessment of the medical, financial, and public health impacts of SB 245 Abortion Services: Cost Sharing.

Bill-Specific Analysis of SB 245, Abortion Services: Cost Sharing

Bill Language

For plans and policies, including Medi-Cal Managed Care plans, that provide coverage for abortion services, SB 245 would prohibit cost sharing for all abortion services, including follow-up services such as management of side effects and counseling.

SB 245 also prohibits health plans and policies from imposing any restrictions or delays on abortion services, including prior authorization, and prohibits annual or lifetime limits on any covered abortion services.

SB 245 defines abortion services as “any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.”

The full text of SB 245 can be found in Appendix A.

Relevant Populations

If enacted, SB 245 would apply to the health insurance of approximately 21.9 million enrollees (55.7% of all Californians). This represents 100% of Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enacted, the law would apply to the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, including Medi-Cal Managed Care plans regulated by DMHC.

Although Medi-Cal Managed Care plans are subject to the Health and Safety Code, cost sharing for all Medi-Cal services is determined through the Welfare and Institutions Code (Section 14134). Therefore, Medi-Cal Managed Care plans are not impacted by the cost-sharing–related provisions of SB 245. Furthermore, the Medi-Cal program already covers abortions as a physician service without cost sharing.

Analytic Approach and Key Assumptions

CHBRP uses the following terms throughout the report:

- “Induced abortion” refers to a medical treatment that causes the termination of a pregnancy except for the purpose of producing a live birth. Induced abortions may be performed using medication or by procedure. See the *Background* section for additional information on these techniques.
- “Associated services” refers to any pre-abortion evaluation services and any follow-up care related to abortion services. Pre-abortion evaluation services are classified as abortion services and therefore CHBRP includes them as part of the analysis. Follow-up services are included per

⁸ CHBRP’s authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

the explicit mandate under SB 245. Counseling for abortion services may include options counseling as a pre-abortion service, or behavioral health counseling as a follow-up service.

- “Pregnant women.” CHBRP uses the term “pregnant women,” but recognizes that some individuals may identify as male or nonbinary and may also have female reproductive organs.

CHBRP does not include emergency contraception, such as Plan B, in the analysis. Emergency contraception is not considered an abortifacient, or a drug that can cause an abortion.

CHBRP assumes that abortion services are typically covered under the medical benefit for any induced abortion. However, medication abortions may be covered under the pharmacy benefit by some health plans/insurers.

Because SB 245 defines abortion services as those intended to induce the termination of pregnancy, CHBRP excludes selective reduction, spontaneous miscarriage, ectopic pregnancies, and pregnancy losses after the first trimester/stillbirth. This approach is consistent with definitions used by public health departments (NYC Department of Health, 2021):

- Selective reduction: In multifetal pregnancies, the purpose of a selective reduction is to improve the viability of a fetus and produce a live birth (Rao, 2015).
- Miscarriage (spontaneous abortion): In the United States, miscarriage is defined as fetal loss prior to 20 weeks gestation (CDC, 2020; Harvard Medical School, 2021). Although a dilation and curettage or another procedure may be necessary to complete the process, the loss is considered spontaneous in nature and not induced by a medical procedure or medication.
- Ectopic pregnancies: The fertilized egg is unable to survive in an extrauterine pregnancy, and the growing tissue may cause life-threatening bleeding, if left untreated. Treatment is typically given through an injection of methotrexate or laparoscopic surgery.
- Stillbirth: In the United States, stillbirth is defined as fetal loss after 20 weeks gestation (CDC, 2020). Although a dilation and evacuation or another procedure may be necessary to complete the process, the loss is considered spontaneous in nature and not induced by a medical procedure or medication.

Cost Sharing and Utilization Management

This section provides an overview of the cost sharing and utilization management structures used for health insurance benefits, including prescription drugs.

Cost Sharing

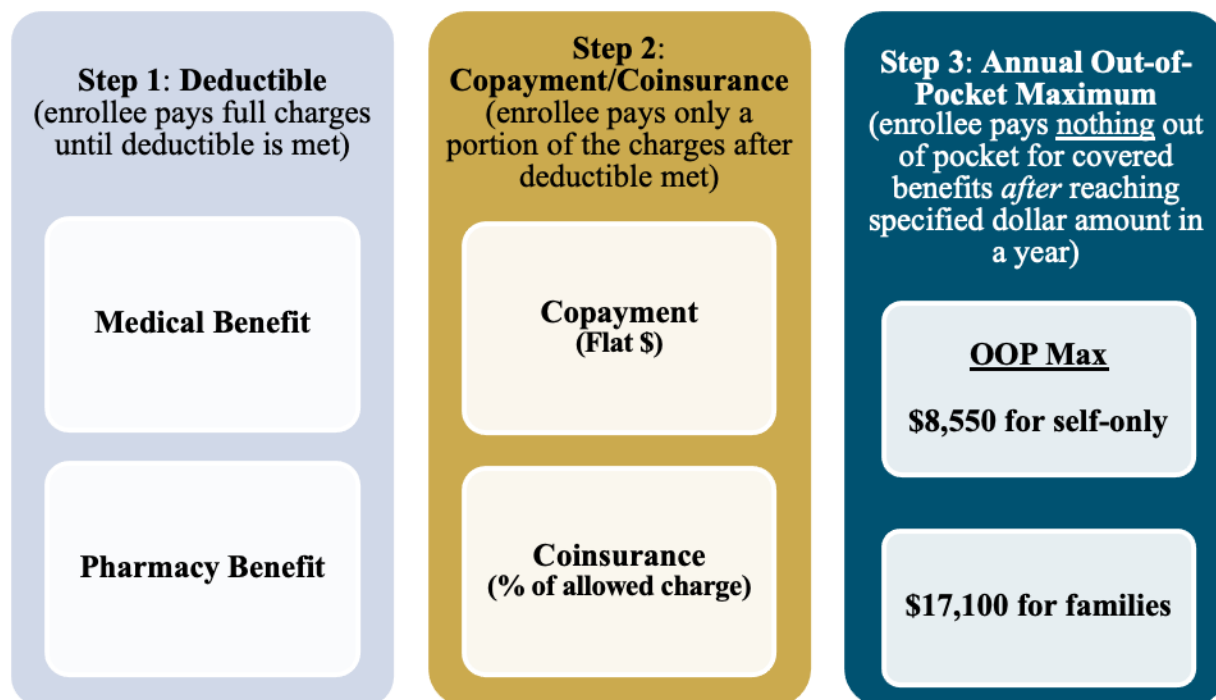
Payment for use of covered benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee using the covered test, treatment, or service. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses⁹). There are a variety of cost-sharing mechanisms that can be applicable to covered benefits (Figure 1). Deductibles and copayments/coinsurance are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. Some health insurance benefit designs incorporate higher enrollee cost sharing in order to lower

⁹ Premiums are paid by most enrollees, regardless of their use any tests, treatments, or services. Some enrollees may not pay premiums because their employers cover the full premium, they receive premium subsidies through the Covered California, or receive benefits through Medi-Cal.

premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits.¹⁰

Annual out-of-pocket maximums for covered benefits limit annual enrollee cost-sharing (medical and pharmacy benefits). After an enrollee has reached this limit through payment of coinsurance, copayments, and/or deductibles, insurance pays 100% of the covered services. The enrollee remains responsible for the full cost of any tests, treatments, or services that are not covered benefits.

Figure 1. Overview of the Cost-Sharing Mechanisms Used in Health Insurance



Source: California Health Benefits Review Program, 2021.

Notes: 1. The annual cost sharing amounts in this figure are the maximum amounts allowed in 2021 for nongrandfathered plans/policies; some nongrandfathered plans/policies may have lower annual cost-sharing limits. 2. Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2).

Key: OOP Max = annual out-of-pocket maximum.

Utilization Management

Utilization management techniques are used by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Examples include benefit coverage requirements related to prior authorization, step therapy, quantity limits, and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men). Utilization management that

¹⁰ Plans and policies sold within Covered California are required by federal law to meet specified actuarial values. The actuarial value is required to fall within specified ranges and dictates the average percent of health care costs a plan or policy covers. If a required reduction in cost sharing impacts the actuarial value, some number of these plans or policies might have to alter other cost-sharing components of the plan and/or premiums in order to keep the overall benefit design within the required actuarial value limits.

may be used in conjunction with abortion care includes prior authorization. A brief description of this technique is below.

Prior authorization

Prior authorization — also known as precertification, prior approval, or prospective review — is used to enforce clinical guidelines from professional societies and organizations, and the U.S. Food and Drug Administration (FDA) indication for use of specific medications. The process typically requires providers to establish eligibility and submit documentation demonstrating medical need to the plan/insurer for approval of coverage before either medical services are provided or a prescription is filled in order to qualify for payment. Health plans/insurers may also impose prior authorization requirements on nonpreferred medications in an effort to promote the use of preferred medications that they can procure at lower prices.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

Coverage and Costs

Under the Reproductive Privacy Act, California law prohibits the State from denying or interfering with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when medically necessary. The state defines viability as the point in a pregnancy when, in the good faith medical judgment of a physician, there is a reasonable likelihood that a fetus will survive outside the uterus without "extraordinary medical measures."

Abortion is considered a basic health care service in California¹¹ and, therefore, is required to be covered by commercial health insurance plans and policies and CalPERS.¹² Medically necessary follow-up services to abortions that constitute basic health care services must also be covered. However, the state does not mandate which types of abortion methods (i.e., procedural or medication) must be covered, nor does it mandate cost-sharing requirements specific to these services.

California's Medi-Cal program is 1 of 16 state Medicaid programs that use their own funds to cover abortion services and follow-up services for beneficiaries (Salganicoff et al., 2021). The Medi-Cal program covers abortions as a physician service without cost sharing for all enrollees.

California law prohibits family planning grants distributed by the Department of Health Care Services from funding abortions or associated services, including postabortion examinations.¹³

Utilization Management

Medi-Cal Managed Care plans, providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services are prohibited from requiring medical justification and/or prior authorization for outpatient abortion services.¹⁴ It should be noted that under Medi-Cal policy,

¹¹ DMHC letter to health plans dated August 22, 2014.

¹² HSC 1367.006; INS 10112.27.

¹³ WIC 14509.

¹⁴ Department of Health Care Services All Plan Letter 15-020.

inpatient hospitalizations for procedural (surgical) abortions do require prior authorization. However, this mandate follows the same criteria as any other medical procedure requiring hospitalization; the purpose of the review is to ensure the number of days of hospital care is appropriate for the diagnosis specified or the operative procedure contemplated in the authorization request.¹⁵ Hospitalizations due to induced abortions are rare (ACOG, 2018). As such, the provisions of SB 245 related to prior authorization will have no effect on Medi-Cal Managed Care beneficiaries.

CHBRP conducted a survey of the largest (by enrollment) providers of health insurance in California to determine current coverage of abortion services and existence of utilization management for commercial enrollees. Responses to this survey represent 92% of commercial enrollees with health insurance that can be subject to state benefit mandates. In their responses, health insurance providers stated they do not require utilization management, including prior authorization, for abortion services, with the exception of one health plan that stated prior authorization and medical necessity review is required for inpatient admissions. As previously discussed, such requirements are typical for medical procedures and are related to the provision of hospital care and are not specific to abortion services. As such, CHBRP anticipates the provisions of SB 245 related to prior authorization and other restrictions or delays will have no impact on commercial enrollees.

Patient Confidentiality

Health plans/insurers are required to honor enrollee requests for confidential communications relating to receipt of sensitive services. Health care providers are authorized by law to make arrangements with a patient for payment of out-of-pocket expenses and communicate that arrangement with the health plan/insurer.¹⁶ As abortion services are sensitive in nature, enrollees may request confidentiality from health plans/insurers so that these procedures are not shown in the explanation of benefits (EOB). Health plans/insurers use EOBs in part to prevent fraud. They are sent to policyholders and typically show the actions taken by any individual covered under the plan/policy and all related costs. Although SB 245 addresses cost sharing, the provisions do not impact existing law related to patient confidentiality for sensitive services. Thus, patient confidentiality is not addressed in this report.

Similar requirements in other states

Three states have passed laws that prohibit commercial health insurance plans from imposing cost sharing for abortion coverage, as of February 2021. Illinois prohibits private health insurance plans from imposing any deductibles, coinsurance, waiting periods, or other cost-sharing limitations that are greater than what is required for other pregnancy-related benefits covered by the policy.¹⁷ Oregon requires private health insurance plans to cover all reproductive health services, including abortion services, with no cost sharing.¹⁸ New York prohibits copayments, coinsurance, or annual deductibles on medically necessary in-network abortion services, with limited exceptions for high deductible health plans.¹⁹

Massachusetts²⁰ and New Jersey²¹ have recently introduced legislation similar to SB 245.

¹⁵ 22 CCR 51327.

¹⁶ CIV 56.107; INS 791.29.

¹⁷ Illinois Senate Bill 25 of 2019.

¹⁸ Oregon House Bill 3391 of 2017.

¹⁹ New York Codes, Rules and Regulations 11 CRR-NY 52.16.

²⁰ Massachusetts Senate Bill 605 of 2021.

²¹ New Jersey Senate Bill 3030 of 2020.

Federal Policy Landscape

Hyde Amendment

Since 1976, Congress has included a provision in the annual appropriations legislation for the Departments of Labor, Health and Human Services, and Education prohibiting the use of federal funds for most abortions. This provision, the Hyde Amendment, only provides exceptions to this prohibition in cases of rape, incest, or if a woman suffers from a life-threatening physical injury or illness that would place her in danger of death unless an abortion is performed.

Medicaid is a jointly funded program by the federal and state governments. States may choose to pay for abortion services for additional circumstances; however, they must use nonfederal funds to pay for the service. Sixteen states currently have policies that allow for Medicaid funds to be used to pay for abortions that exceed Hyde limitations, including Alaska, California, Connecticut, Hawaii, Illinois, Oregon, Maine, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Washington, and Vermont (Salganicoff et al., 2021).

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how SB 245 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).^{22,23}

Any changes at the federal level may impact the analysis or implementation of this bill, were it to pass into law. However, CHBRP analyzes bills in the current environment given current law and regulations.

Essential Health Benefits

SB 245 would not require coverage for a new state benefit mandate and instead modifies cost-sharing and utilization management terms and conditions of an already covered service. Therefore, SB 245 appears not to exceed the definition of EHBs in California.

Annual and Lifetime Limits

The ACA prohibits health plans and policies from imposing annual or lifetime limits on EHBs. Annual and lifetime limits are dollar limits on what health plans and policies will spend for an enrollee on covered benefits for 1 year or the entire time of enrollment, respectively. Health plans and policies may still require these limits for any health care services not considered EHBs. Grandfathered individual health insurance policies are exempt from this rule.

Women's Health and Preventive Services

Under the ACA, all non-grandfathered small-group and individual health plans/policies sold on the health insurance marketplace must include certain preventive health care benefits for women without cost sharing, regardless of whether the annual deductible has been met. Services that must be covered for pregnant women, or women who may become pregnant, include contraception, screenings for various

²² The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.

²³ Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

conditions, and counseling for breastfeeding and tobacco use.²⁴ The U.S. Health Resources and Services Administration does not include abortion services in its list of women’s preventive services that require coverage without cost sharing.

²⁴ More information about these services are included in CHBRP’s Resource: Federal Preventive Services Mandates and California Mandates. Available at https://chbrp.org/other_publications/index.php#revize_document_center_rz44.

BACKGROUND ON ABORTION SERVICES

Abortion is the termination of pregnancy by either medication or procedure (Steinauer, 2021). This section defines the different types of abortion services and the disparities in the incidence of abortions associated with cost sharing and utilization management.

Abortion Services

There are two types of abortion services — medication abortions and procedural abortions, the latter of which is sometimes referred to as surgical abortion. Both require associated services such as pre-abortion evaluation services and follow-up care. The method chosen for an abortion is dependent on gestational age, medical condition (comorbidities that favor either medication or procedural abortion), patient preference (socioeconomic or personal choice associated with the side effects of medication or procedural abortions), clinician experience, and availability of the necessary equipment or medications (Steinauer, 2021). Emergency contraception, such as Plan B, are not abortifacients and will not be discussed in this analysis.

Associated Services: Pre-Abortion Evaluation

Provider evaluation (office visit or telemedicine [ACOG, 2020c]) and other clinical services are part of the pre-abortion evaluation for pregnant women²⁵ seeking abortions. These services and tests are offered to women when indicated based on the women's preferences and medical history. During the initial evaluation, a medical history, physical exam, laboratory and radiology tests, and counseling on abortion methods, including risk, benefits, alternatives, are conducted as relevant to the individual. These laboratory or radiology tests may include pregnancy confirmation and/or dating (urine or serum human chorionic gonadotropin measurement or pelvic ultrasound), hematocrit and hemoglobin levels²⁶, and Rh(D) status²⁷. Discussion about contraception may occur at the initial visit and can typically be started the day of the abortion procedure (Steinauer, 2021).

It is necessary to know the gestational age of the pregnancy to assist providers and pregnant women in choosing the safest and most effective type of abortion. Gestational age may be determined by menstrual dating (if patients have regular menses and are confident of the date of their last period) or pelvic ultrasound examination (if patients are uncertain of dates, have irregular menses, their uterine size is inconsistent with menstrual dating, or uterine size cannot be accurately measured) (Steinauer, 2021).

Note that some associated services may be billed as prenatal services under certain circumstances, such as when women are unsure about whether they will continue the pregnancy or if they decide to have an abortion after initial prenatal services. See the *Benefit Coverage, Utilization, and Cost Impacts* section for further discussion.

²⁵ CHBRP uses the term pregnant women, but recognizes that some individuals may identify as male or nonbinary, and also have female reproductive organs.

²⁶ Hemoglobin levels are checked to ensure that women do not have anemia or hemoglobin below 9.5 g/dl ((normal levels for women are 12 to 15.5 g/dl (Mayo Clinic, 2019a).

²⁷ Approximately 15% of pregnant women are Rh(D)-negative and will require an intramuscular injection of RhoGAM whether the pregnancy is carried to term or terminated. During a pre-abortion office visit, a clinician will give the injection to prevent the women's body from developing Rh antibodies. If women do not receive RhoGAM during their first pregnancy, there is risk to subsequent pregnancies. If the future fetus is Rh(D)-positive, the antibodies from the mother could cross the placenta and damage the fetus's red blood cells causing life-threatening anemia (Mayo Clinic, 2020).

Medication Abortions

There are two FDA-approved medications for use to terminate a pregnancy within the first 70 days of gestation, or first trimester: mifepristone and misoprostol. According to the American College of Obstetricians and Gynecologists (ACOG), the most common medication protocol involves prescribing both medications in sequence: mifepristone is administered first and blocks progesterone to prevent the pregnancy from progressing; misoprostol is administered 24 to 48 hours later and induces cramping and bleeding to empty the uterus, similar to a miscarriage (ACOG, 2020b). In rare instances, if mifepristone is not available, misoprostol alone may be prescribed as an approved alternative to the two-drug regimen (Raymond et al., 2019). There are various ways misoprostol alone may be prescribed for medication abortions. Providers typically prescribe at least one dose with up to five additional doses and different routes (Table 2) (Raymond et al., 2019). In California, both physicians and advanced practice clinicians can prescribe and dispense medication abortion pills.

Second trimester medication abortions are uncommon and usually occur in the hospital setting under the supervision of a provider (ACOG, 2013, 2018). Medication is administered to cause the body to go into labor to pass the pregnancy tissues through the vagina. Methods used for second trimester medication abortions are similar to the first trimester medication abortion regimen and include one or more of the following: mifepristone, misoprostol, osmotic cervical dilators, Foley catheters, and oxytocin. However, evidence suggests the majority of second trimester abortions (95%) performed are dilation and evacuation (D&E) (ACOG, 2013).

Table 2. FDA-Approved Medications Utilized in Two-Drug Regimen for Medication Abortions

FDA-Approved Medications	Intended Use	Route	Time of Administration	Gestational Age	Side Effects	Aftercare
Mifepristone (Mifeprex)	Counters the effect of progesterone	Oral pill	Dispensed in office or prescribed via telemedicine and obtained at clinic; taken in clinic or at home	Within 70 days of gestation (10 weeks)	Nausea, vomiting, vaginal bleeding, pelvic pain	Pain and/or nausea medication
Misoprostol (Cytotec)	Prostaglandin-like drug; causes uterus to contract	Buccal (between cheek and gum) or Vaginally	24–48 hours after mifepristone buccally; or 6 to 72 hours after mifepristone vaginally	Within 70 days of gestation (10 weeks)	Diarrhea, nausea, vomiting	Pain and/or nausea medication

Source: California Health Benefits Review Program, 2021 based on (ACOG, 2020b; Grossman et al., 2011; KFF, 2020).

Women are advised to contact their provider or emergency services if the following occur after administration of misoprostol: heavy bleeding, significant abdominal pain, or fever for more than 4 hours (ACOG, 2020b; WHO, 2018). A follow-up visit may be scheduled to address these adverse side effects or complications, or women may be advised to seek emergency care if necessary. In about 3% to 5% of cases medications are unsuccessful (Gatter et al., 2015), and women may be treated with additional doses of misoprostol. However, depending on the women's preference and/or clinical circumstances, some women may need an additional procedure, such as uterine aspiration or D&E (ACOG, 2020b). See the complications discussion below.

Procedural (Surgical) Abortions

Procedural abortions are medical procedures that occur in a clinic or hospital setting to terminate a pregnancy. They are minor operative procedures that use suction or forceps to remove all of the pregnancy tissue and uterine contents (ACOG, 2018). There are two methods for procedural abortions that may be used in the first trimester of pregnancy: vacuum suction aspiration (suction curettage) and dilation and curettage (D&C). Procedural abortions completed in the second trimester are D&E (Table 3) (ACOG, 2018).

Table 3. Comparison of Procedural Abortion Services

Type of Procedural Abortion	Description of Procedure	Indication	Gestational Age	Recovery	Aftercare
Vacuum suction Aspiration	Suction device inserted through the cervix to remove contents of uterus under local anesthesia	Procedural abortion or failed medication abortion	First trimester (up to 12 weeks)	Observed 1 hour after procedure; cramping 1 to 2 days, bleeding up to 2 weeks	Antibiotics, oral pain medication
Dilation and curettage (D&C)	Cervix dilated and curette inserted to scrape uterine wall; suction device used to remove remaining tissue under light sedation and local or general anesthesia	Procedural abortion or failed vacuum aspiration	First to second trimester (up to 16 weeks)	Observed for several hours after procedure; light cramping and bleeding up to 2 weeks	Antibiotics, oral pain medications
Dilation and evacuation (D&E)	Cervix dilated and removal of the fetal tissue through the vagina using a suction device and/or forceps under light sedation or anesthesia	Abortion in second trimester	Second trimester (After 12 weeks)	Observed for several hours after procedure; light cramping and bleeding up to 2 weeks	Antibiotics, oral pain medications

Source: California Health Benefits Review Program, 2021 based on ACOG, 2018; American Pregnancy Association, 2017; and Jones and Lopez, 2013.

Associated Services: Post-Abortion Aftercare

Follow-up care for medication abortions include a routine clinic visit, telemedicine visit, or phone call with a provider 1 to 4 weeks after the abortion (ACOG, 2020b; Grossman et al., 2004; Steinauer et al., 2021; Upadhyay et al., 2017). At a follow-up visit, an ultrasound may be conducted to confirm completion of the abortion. For women who complete a follow-up phone/telemedicine visit, and symptoms are indicative of a completed abortion, no ultrasound is necessary. A home pregnancy test may be administered 4 weeks after the abortion. If pregnancy symptoms persist for more than a week or menses has not restarted 6 to 8 weeks post-procedure, women should contact their physician (Grossman et al., 2004). If the medication abortion was incomplete, misoprostol may be prescribed, or a procedural abortion may be scheduled (Steinauer et al., 2021).

Follow-up care for procedural abortions does not routinely include an additional office visit unless there are complications or adverse outcomes (Steinauer et al., 2021; Upadhyay et al., 2017). The aftercare associated with procedural abortions include antibiotics, pain medications, and educating patients on the symptoms to monitor for including heavy bleeding, cramping, or fever. If a woman chooses, plans for

contraception can be discussed and begin immediately after the abortion, and behavioral health counseling services may be offered (Steinauer et al., 2021).

Rates of Abortions by Gestational Age

In 2018, 92.2% of all abortions were provided at 13 weeks or less (Kortsmit et al. 2020). The most common abortion method at 13 weeks or less were procedural abortions (52.1%) followed by early medication abortions at 9 weeks or less (38.6%), and medication abortions greater than 9 weeks (1.4%). After 13 weeks, procedural abortions only are done (7.8% of all abortions). Medication abortions and aspiration abortions are both safe and effective methods to end a pregnancy (ACOG, 2020a; Steinauer, 2021).

Abortion-Related Complications

Complications related to abortion services are rare. Although research has shown that abortion past the first trimester is safer than carrying a pregnancy to term with respect to risk of death, studies have shown that abortion complication risk increases with duration of pregnancy (Paul et al., 2009; Zane et al., 2015). The earlier the gestational age, the lower the risk of complications. One study reported that the risk of death associated with abortion rises from 0.3 for every 100,000 abortions at or before 8 weeks to 6.7 per 100,000 abortions at 18 weeks or later (Zane et al., 2015). An analysis conducted with California Medical Cal data found the rate of complications associated with abortions, from all sources, including emergency departments and abortion facilities, is estimated to be about 2% (5.2% for medication abortions, 1.3% for first-trimester aspiration abortions, and 1.5% for second-trimester or later procedures)(Upadhyay et al., 2015b) The most common complications reported were incomplete or repeat abortions, which were treated with uterine aspiration (Upadhyay et al., 2015b). Major complications, including failed abortion, hemorrhage, infection, and uterine perforation were seen in less than 0.23% of all abortions in the study (Upadhyay et al., 2015b). Other potential complications include injury from the procedure (vaginal or cervical lacerations, uterine, bowel, or bladder injury) (Sajadi-Ernazarova and Martinez, 2020).

Additional associated services may be required in the event of complications (Sajadi-Ernazarova and Martinez, 2020). These services may include physical assessment (vital signs, abdominal exam, pelvic exam, rectal exam), lab tests (complete blood count, metabolic panel, blood type, blood cultures, coagulation studies, blood or urine human chorionic gonadotropin test), imaging studies (x-ray, ultrasound, computed tomography scan), additional procedures (procedural abortion in the case of failed medical abortion, abdominal surgery, stitches, blood transfusions), or medications (antibiotics, medications to stop bleeding) (Sajadi-Ernazarova and Martinez, 2020).

Payment for Abortion Services

In the United States, research shows that for states without restrictive laws on abortion services, the average out-of-pocket cost paid for a medication abortion ranges from \$300 to \$1,500 and for a procedural abortion from \$295 to \$1,600, depending on insurance coverage (Jones et al., 2018). In California, median abortion costs based on a 2020 survey of 151 clinics are \$926 for a medication abortion, \$994 for a first trimester procedural abortion and \$1,218 for a second trimester procedural abortion.²⁸ Studies suggest most women with private insurance pay out of pocket for abortion services (Jones et al., 2010, 2013b; Roberts et al., 2014; Van Bebber et al., 2006). In a national survey administered to abortion patients, at least 69% paid out of pocket for abortion care although only 36% reported a lack of health insurance (Jones et al., 2013b). For women with private insurance, reasons for paying out of pocket included “insurance doesn’t pay for abortion” (48.4%), “not sure if insurance covers abortion” (26.2%), “don’t want to use my insurance” (13.1%), and “clinic doesn’t accept my insurance” (10.7%). A total of 18% of patients who had private insurance through a spouse or family member

²⁸ Advancing New Standards in Reproductive Health (ANDIRH). Abortion Facility Database, University of California, San Francisco. 2021.

reported that they did not utilize insurance because they did not want others to know they had obtained an abortion (Jones et al., 2013b).

When women do not use their insurance coverage for abortion services or cannot afford the out-of-pocket costs associated with abortion services, they may seek abortions at women's health clinics, such as Planned Parenthood, or seek other resources to help pay for abortion services, such as the National Network of Abortion Funds. However, some women may not have access to women's health clinics due to travel and the barriers associated with travel such as cost of travel, lost wages, or expenses for childcare (Jones et al., 2013b; Kiley et al., 2010; Upadhyay et al., 2014). In addition, abortion funds may not provide sufficient resources to cover the full cost of a procedure (Roberts et al., 2014). As such, some women may delay an abortion procedure while they save for its cost (Finer et al., 2006; Roberts et al., 2014). Women may pursue self-managed abortions, which occur when pregnant women terminate their pregnancy independent of the medical care setting (KFF, 2020). The most common method for completing a self-managed abortion is by ordering abortion medication pills (mifepristone–misoprostol combination packs or misoprostol only) online without a prescription. The cost of these medication packs range from \$110 to \$360 (Murtagh et al., 2018). SB 245 does not apply to self-managed abortions because these medications are not covered by insurance in this circumstance.

Disparities²⁹ and Social Determinants of Health³⁰ in Abortion Incidence, Access, and Cost Sharing

Per statute, CHBRP includes discussion of disparities and social determinants of health (SDoH) as it relates to the cost sharing and utilization management associated with abortion care. Disparities are noticeable and preventable differences between groups of people. CHBRP found no data regarding disparities by race/ethnicity and age for abortion services in California and, thus, relies on reports at the national level.

Abortion Incidence

In 2017, an estimated 862,320 abortions were completed in the United States. Within California, 132,680 abortions were completed (Jones et al., 2019). About half of all the abortions completed in California are covered by Medi-Cal (Johns et al., 2017). CHBRP did not find specific incidence rates by demographics for California because there are no published data with these statistics.³¹

Age

In 2018, in the United States, 619,591 abortions were reported to the CDC for women 15 to 44 years of age. Women aged 20 to 29 years accounted for more than half of all abortions (57.7%) (Kortsmit et al., 2020) (Table 4). See the *Public Health Impacts* section for further discussion of disparities related to age, and cost sharing and utilization management for abortion services.

²⁹ Several competing definitions of “health disparities” exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population.

³⁰ CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from: Healthy People 2020, 2019, CDC, 2014). See CHBRP's SDoH white paper for further information: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

³¹ California, Maryland, and New Hampshire do not participate in the CDC's voluntary abortion surveillance program, which gathers data to document the number and characteristics of women who obtain abortions and the number of abortion-related deaths in the United States.

Table 4. Percent of U.S. Women 15–44 Years of Age Who Obtained Abortions in 2018

Age, Years	<15	15–19	20–24	25–29	30–34	35–39	40–44
Percent of women who obtained abortions	0.2%	8.8%	28.3%	29.4%	18.8%	10.7%	3.5%

Source: California Health Benefits Review Program, 2021 based on Kortsmitt et al., 2020.

Race or Ethnicity

Abortion rates among women of color in the United States are two to three times higher than among White women (Dehlendorf et al., 2013). In 2018, the CDC reported the abortion rate³² for Black women to be 21.2 abortions per 1,000 Black women, Hispanic women to be 10.9, and other non-Hispanic women to be 11.9 as compared to White women at 6.3 (Kortsmitt et al., 2020). These rates reflect systemic barriers that lead to inequalities for women of color relative to White women. The systemic barriers that affect women of color include “decreased access to health care, higher levels of stress, exposure to racial discrimination, and poorer living and working conditions” (Braveman et al., 2011; Dehlendorf et al., 2013; Dominguez et al., 2008; Williams and Mohammed, 2009). All of these systemic barriers impact a women’s ability to access contraceptives and prevent unintended pregnancies and may perpetuate higher rates of abortions among women of color (Dehlendorf et al., 2013). Although women of color obtain abortion services at higher rates than White women, disparities exist in access to abortion services at earlier gestational ages for women of color (Jones and Finer, 2012), and delayed abortion services are associated with greater risk than abortions performed earlier (Bartlett et al., 2004; Dehlendorf et al., 2013). SB 245 only addresses disparities associated with cost sharing for abortion services.

Social Determinants of Health

Social determinants of health (SDoH) include factors outside of the traditional medical care system that influence health status and health outcomes (e.g., income, education, geography, etc.). In this section, CHBRP describes income and geography related to costs and cost sharing associated with abortion services.

Income

The financial burden related to abortion care disproportionately affects low-income women due to higher abortion rates among this population and increased barriers to paying for abortion services (Dehlendorf et al., 2013). Research shows that saving money or securing funds to pay for an abortion is a financial barrier to obtaining abortion services (Finer et al., 2006; Foster et al., 2008). In 2014, data³³ from the Guttmacher Institute showed that 19% of women who obtained abortions had private insurance, and among these privately insured women, more than two-thirds reported income below 200% of the Federal Poverty Level. “For poor and low-income women, even meeting a relatively low deductible may be prohibitive” (Jones et al., 2013b). Pregnant women report additional financial barriers to obtaining an abortion, including transportation costs, lost wages, childcare expenses, and cost of bills or rent, food, or utilities (Jones et al., 2013b; Kiley et al., 2010; Upadhyay et al., 2014). These additional financial barriers are not addressed by SB 245 but are important considerations for low-income women seeking abortion

³² The CDC defines the abortion rate as “Number of abortions obtained by women in a given racial/ethnic group per 1,000 women in that same racial/ethnic group. For the total abortion rate only, abortions for women of unknown race/ethnicity were distributed according to the distribution of abortions among women of known race/ethnicity” (CDC, 2020).

³³ These data were extracted from the 2014 Abortion Patient Survey. The dataset is nationally representative of all individuals obtaining abortions, and not intended to be representative of all people obtaining abortions in California.

care. Research indicates that financial barriers, such as out-of-pocket costs associated with abortion services, for women of low-income status delays their abortion care or prevents them from obtaining abortions at the desired gestational age (Dehlendorf et al., 2013; Roberts et al., 2014). California Medi-Cal plans already provide abortion services with no cost sharing for all enrollees.

Geography

Location of the abortion clinic or provider can have an impact on how far women must travel to obtain abortion services and result in additional costs related to abortion service, separate from the medical services costs, because they must pay for transportation, hotel, or childcare and might experience lost wages from missed days of work (Jones et al., 2013a; Kiley et al., 2010; Upadhyay et al., 2014). In 2008, women reported traveling 30 miles one way for abortion services, and 6% of women reported traveling more than 100 miles for abortion services (Jones and Jerman, 2013). Another study conducted in California reported that 12% of women must travel over 50 miles for abortion services (Johns et al., 2017). According to the Guttmacher Institute, in 2017, although 40% of California counties did not have a clinic that could provide abortions, only 3% of California women resided in those counties (Jones et al., 2019). However, the size of each county must be considered because many counties in California are very large, and women may have to travel long distances even within each county. For women in California who do not live in a county that provides abortion services, they may have to travel outside of their community to receive abortion services and may incur additional costs related to travel for abortion services. SB 245 does not address the location of clinics or providers that offer abortion services nor does it provide coverage for any of these costs.

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, SB 245 prohibits plans and policies from applying a deductible, coinsurance, and other cost-sharing requirements on abortion services. The medical effectiveness review summarizes findings from evidence³⁴ on the impact of cost sharing and utilization management for abortion services on access to care, utilization of health care services, and health outcomes.

Research Approach and Methods

Studies of effects of cost sharing and/or utilization management for abortion on health outcomes and utilization were sought through searches of relevant databases of peer-reviewed literature listed in Appendix B. The search was limited to abstracts of studies published in English.

Studies of the impact of cost sharing on abortion services were identified through searches of PubMed, Embase, and Business Source Complete. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Guttmacher Institute and Kaiser Family Foundation.

The search was limited to abstracts of studies published in English.

Because of the limited studies available, the search included studies published from 2010 to present. Of the 109 articles found in the literature review by CHBRP, 9 were reviewed as potentially relevant for inclusion in this report on SB 245, plus an additional 8 were included from CHBRP's 2016 analysis of SB 999, the Content Expert, and snowball searches for a total of 17 studies included in the medical effectiveness review for this report. Only articles that addressed the research questions below were included in this report. The other articles were eliminated because they did not focus on abortion services, were of poor quality, or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.³⁵ Unpublished studies were not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

- What are the effects of utilization management policies (as discussed in the *Policy Context* section) for abortion on utilization and related health outcomes?
- What are the effects of cost sharing for abortion on utilization and related health outcomes?

³⁴ Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence on page 11 of the Medical Effectiveness Analysis and Research Approach document (posted at http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php), in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

³⁵ Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, visit http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

Methodological Considerations

Most of the research related to abortion services is not classified as high quality as defined by CHBRP methodology (see Appendix B for description), which limits the potential strength of the conclusions. There are not randomized control trials on abortion because it is not ethical to randomize women who are seeking abortion services into an intervention or placebo group. Most studies on abortion services analyzed for this report use self-reported survey data, and most studies investigating financial barriers to abortion access have been done with an uninsured population. One study compares groups of women in states that fund abortion through Medicaid to women in states that do not fund abortion without studying the individual women who had Medicaid-paid abortions; that is, they used population level data rather than individual data to make conclusions about individual-level outcomes (ecological fallacy).

CHBRP developed a logic model to determine the potential impacts of cost sharing policies on utilization of abortions services and their related health outcomes as follows. The model is based on the idea that the elimination of cost sharing and utilization management policies, as proposed under SB 245, would reduce the barriers that cost and delays related to cost and utilization management can present in obtaining an abortion. As such, enactment of SB 245 would lead to increased access to timely abortion services, and therefore an increase in abortions completed when chosen. Consequently, SB 245 would decrease unintended pregnancies, which are associated with poor pregnancy and maternal health outcomes. Using this logic model, CHBRP examined literature that studied the impacts of cost sharing and utilization policies on access to abortion services to help answer the key questions proposed earlier in this section.

Most of the studies included in this review are based on data from the Turnaway study at the University of California, San Francisco,³⁶ a prospective cohort study of 956 women who sought abortions at abortion facilities in the United States. Women were recruited from 2008 to 2010, from 30 abortion facilities in 21 states throughout the United States. They completed telephone interviews 1 week after seeking an abortion, and then semiannually for 5 years. Women were categorized into two groups, those who received abortions because they were under the gestational age limit for abortion, and those who were turned away from abortion because they were just beyond the gestational age limit for abortion. This study documented women's reports of side effects, and physical and mental health outcomes experienced after abortion, or if they were turned away after seeking abortion, ongoing pregnancy and birth.

In addition, CHBRP considered the literature on the health outcomes related to unintended pregnancies, previously examined in CHBRP's analysis of SB 999 on contraceptive coverage (CHBRP, 2016).

Outcomes Assessed

In alignment with the logic model discussed above, this analysis looked at the evidence of the impact of cost sharing and utilization management policies on abortion outcomes, including: abortion access, utilization of abortion services, abortion complications, prenatal care, maternal health outcomes, maternal mental health outcomes, birth outcomes, infant morbidity and mortality, child health status, and breastfeeding after being unable to obtain abortion.

Study Findings

The following section summarizes CHBRP's findings regarding the strength of evidence on the impact of cost sharing and utilization management for abortion services, as related to the bill language. Thus, it

³⁶ Advancing New Standards in Reproductive Health (ANDIRH). The Turnaway Study. 2013. University of California, San Francisco. Available at: <https://www.ansirh.org/research/ongoing/turnaway-study>. Accessed March 2021.

does not review the medical effectiveness of abortion or related abortion services, for which the medical effectiveness has been well documented.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

More information is available in Appendix B.

Findings on the Impact of Utilization Management Policies on Abortion Outcomes

CHBRP did not find any studies that examine the impact of utilization management policies such as prior authorization on abortion outcomes.

Summary of findings regarding utilization management policies on abortion outcomes: CHBRP did not identify any studies that assessed utilization management among those with insurance coverage for abortion; therefore, there is insufficient evidence that utilization management policies affect abortion outcomes (Figure 2).

Figure 2. Utilization Management Policies on Abortion Outcomes

NOT EFFECTIVE		INSUFFICIENT EVIDENCE				EFFECTIVE
Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing

Findings on the Impact of Cost-Sharing Policies on Abortion Access and Utilization

CHBRP did not find any studies that directly examine the impact of cost sharing on abortion access and utilization. However, it is well established in the literature that persons who face higher cost sharing use fewer services than persons with lower cost sharing (CHBRP, 2020; Effros et al., 2009). Therefore, it stands to reason that, for patients whose insurance coverage has out-of-pocket costs that are close to or

equal to the uninsured cost of an abortion, due to high deductibles, that research findings around cost of abortion for the uninsured would apply to the high deductible insured population as well. Therefore, CHBRP reviewed articles that addressed cost as a barrier to abortion access and utilization. Much of this research has been done in populations without insurance coverage for abortion. CHBRP also reviewed more general research on those attempting to obtain abortions and their outcomes.

Delayed abortion due to cost as a barrier to abortion

An analysis examining payment for abortion based on data from the Turnaway study, a 5-year prospective cohort study previously described, reported cost as a reason for delay in obtaining an abortion (725 subjects) (Roberts et al., 2014). This study reported that more than half of the sample (54%) reported that raising money for an abortion delayed obtaining care. Another survey study in multiple U.S. states (874 subjects) found that on initial attempt to access abortion services, 67% cited cost for the abortion or travel to the abortion as a barrier. For the 283 pregnant women who were unable to obtain an abortion when sought and still attempting to obtain one 4 weeks later, 80% identified cost as a barrier (Upadhyay et al., 2021). Both studies included women with and without insurance coverage for abortion or Medicaid.

Self-managed abortion

CHBRP identified two studies that found women who performed self-managed abortion, that is an abortion done without physician supervision, cited cost as a common reason (Aiken et al., 2020; Ralph et al., 2020). Aiken et al. (2020) used data from U.S. residents requesting early medication abortion from the online abortion telemedicine service Women on Web (WoW). WoW is a nonprofit organization that typically provides abortion medications to women living in countries where safe abortion is not available. This study found that, although women in states with prohibitive abortion laws reported cost as a reason for self-managed abortion significantly more often than women in abortion supportive states, women in both groups frequently cited cost as a reason for self-managed abortion (71.1% versus 62.9%). Ralph et al. (7,022 subjects) found that women attempting a self-managed abortion, defined in this study as doing something “on their own to try to end a pregnancy without medical assistance,” tended to be poor, measured as living below 100% of the federal poverty level (FPL) compared with those at 200% FPL or greater (OR: 3.43) (Ralph et al., 2020).

Maternal mental health outcomes related to cost as a barrier to abortion

CHBRP found one study that compared maternal mental health outcomes in states with Medicaid coverage for abortion to states that do not provide this coverage, so women have to pay out of pocket for abortion services. The study found that women in states without Medicaid coverage for abortion tend to have higher rates of postpartum depression compared to women in states with Medicaid coverage for abortion (Medoff et al., 2014). Analyzing Pregnancy Risk Assessment Monitoring System data in 22 states, the researchers found that, based on symptom questions for postpartum depression, states that prohibit Medicaid funding of abortions have statistically significantly higher rates of women who stated they often or always felt depressed, down, or hopeless (9.3%) or had these symptoms and/or little interest or pleasure in doing things (13.9%) than in those states that fund Medicaid abortions (8.2% and 11.6%, respectively). The study found that states with other restrictive abortion policies (e.g., parental involvement laws, mandatory counseling laws, waiting period laws), compared to states without these restrictive abortion laws, had similar rates of postpartum depression (Medoff et al., 2014). As discussed in the methodology, this research design examines effects at a population level and not individual level. However, it illustrates the potential impacts of cost barriers to abortion.

Summary of findings regarding cost-sharing policies on abortion access and utilization: There is limited evidence that cost-sharing policies reduce access to, and use of, abortion services based on 4 survey studies that assessed out-of-pocket costs on abortion access and utilization (Figure 3). There is insufficient evidence that out-of-pocket costs for abortion affects maternal mental health outcomes based on one ecological study of survey data that compared health outcomes of women in states without Medicaid coverage for abortion compared to states with Medicaid coverage for abortion (Figure 4).

Figure 3. Cost-Sharing Policies as a Barrier to Abortion



Figure 4. Cost-Sharing Policies on Maternal Mental Health Outcomes



Findings on Maternal and Child Health Outcomes Associated With Continued Pregnancy After Not Obtaining Abortion

As discussed in the CHBRP report for SB 999 on contraception prescriptions and the Turnaway study, both unintended pregnancies or pregnancies continued after women were unable to obtain an abortion, and the resultant births are associated with a range of adverse prenatal and postpartum outcomes (CHBRP, 2016), maternal outcomes, and associated child health and development outcomes. CHBRP determined the findings from SB 999 on unintended pregnancies after lack of contraception are relevant to SB 245 as indirect findings on the impact of barriers to abortion. Because many women who seek abortions do so for unintended pregnancies, it stands to reason that outcomes associated with unintended pregnancy can apply to women who sought abortion but were unable to obtain an abortion due to a cost or other barrier. Findings from SB 999 are presented as the outcomes associated with unintended pregnancy. The Turnaway study directly examined the impact of women who desired abortions and were unable to obtain them, thus their pregnancies continued. Findings from the Turnaway study are presented as outcomes associated with continued pregnancy after being unable to obtain an abortion due to gestational age limits. It stands to reason that women who are not able to obtain an abortion for cost-related reasons would have similar outcomes as those turned away for being just past the gestational age limit.

Prenatal, perinatal, and postnatal outcomes associated with unintended pregnancy

For those who choose abortion, SB 245 aims to increase access by decreasing cost as a barrier. As CHBRP was unable to find articles that directly studied cost sharing on prenatal, perinatal, and postnatal outcomes after being unable to obtain a desired abortion, studies that assessed these outcomes for unintended pregnancies were reviewed. Many, but not all, women who choose abortion had unintended (mistimed or undesired) pregnancies. The following studies present evidence on health outcomes for unintended pregnancies without specifically addressing if abortion was sought.

The CHBRP report for SB 999 on contraceptive coverage included four studies that reported on prenatal and postpartum outcomes for unintended pregnancies. One review (Gipson et al., 2008) reported that

women with unintended pregnancies are more likely to delay initiating prenatal care and have fewer prenatal care visits compared to women with intended pregnancies. Another systematic review (15 studies) (Shah et al., 2011) found that the odds of low birth weight and preterm birth were higher among unintended pregnancies compared to intended pregnancies. Additionally, research shows that children born from unintended pregnancies are less likely to be breastfed and if they are breastfed, are more likely to be breastfed for a shorter duration (Cheng et al, 2009; Gipson et al., 2008).

As discussed in the CHBRP report for SB 999, several studies have found that women with unintended pregnancies had an increased risk of postpartum depression as compared to women with intended pregnancies (Cheng et al., 2009; Mercier et al., 2013; Nakka et al., 2006).

Maternal health outcomes after being unable to obtain an abortion

Analysis of survey data from the Turnaway study comparing women who had abortions to women who gave birth after being turned away from an abortion found that although women reported similar rates of side effects and health issues, such as cramping and pain, women who gave birth reported potentially life-threatening complications (6.3%), such as eclampsia and postpartum hemorrhage, whereas those having either first (0.4%) or second (1.1%) trimester abortions did not (Gerds et al., 2016).

Another analysis surveyed women at baseline and 5 years later to compare the self-reported health of women who had an abortion compared to women who sought an abortion but were turned away due to gestational limits then subsequently gave birth (Ralph et al., 2019; 874 subjects). At 5-year follow-up, women who gave birth reported significantly worse health, more chronic headaches or migraines, and more joint pain. Both groups reported similar levels of other types of chronic pain and obesity compared to women who had an abortion.

An analysis from the Turnaway study (956 subjects) (Biggs et al., 2017), found women assessed 1 week after seeking and being denied an abortion more commonly reported anxiety symptoms compared with women who received abortions. However, at 1-year follow-up, these symptoms declined, and both groups showed similar levels of anxiety.

Child outcomes after being unable to obtain an abortion

An analysis from the Turnaway study (348 subjects) (Foster et al., 2019) compared existing children of pregnant women denied an abortion due to gestational age. This study found that existing children of pregnant women denied abortions had significantly lower mean child development scores (4% fewer milestones achieved) and were significantly more likely to live below the Federal Poverty Level than the children of women who received a wanted abortion (OR: 3.74). There were no significant differences in child health outcomes.

Another analysis from the Turnaway study (328 subjects) (Foster et al., 2018) compared children born to women denied an abortion for that pregnancy to children born subsequently to women who previously received an abortion. Researchers reported that poor maternal bonding was significantly more common for children of women denied an abortion compared with subsequent children of women who previously received an abortion (9% versus 3%), children of women denied an abortion lived in households with significantly lower incomes than did subsequent children (101% versus 132% of the Federal Poverty Level), and were significantly more likely to live in households without enough money to pay for basic living expenses (72% versus 55%) This study reported no difference in child health outcomes between groups, and no clear pattern of delayed child development between groups.

Summary of findings regarding unintended pregnancy and/or continued pregnancy after being unable to obtain an abortion on maternal health and child outcomes:

There is limited evidence based on contraception studies as indirect findings on the impact of barriers to abortion that suggest that unintended pregnancy has negative maternal and child health outcomes. There is limited evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding and an increase in postpartum depression and low birth weight or preterm births.

There is insufficient evidence that being unable to obtain an abortion has the adverse maternal health outcomes of life-threatening birth complications, chronic joint or headache pain, and worse self-reported health. There is limited evidence based on two analyses within the Turnaway survey study that children in families where women were denied an abortion have lower household income. There is limited evidence based on these same two analyses that children in families where women were denied an abortion do not have worse health outcomes. There is inconclusive evidence based on these two analyses that child development is impacted in families where an abortion is denied.

Summary of Findings

CHBRP found there is:

- Insufficient evidence that utilization management policies affect abortion outcomes.
- Limited evidence that cost-sharing policies affect abortion access and utilization and insufficient evidence that cost sharing for abortion affects maternal health outcomes.
- Limited evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding and an increase in postpartum depression and low birth weight or preterm births.
- Insufficient evidence that unintended pregnancies impact maternal health outcomes.
- Limited evidence that not obtaining a chosen abortion may have socioeconomic consequences for their children and that there is no impact on child health outcomes.
- Inconclusive evidence of the impact on child development of children born to women who were denied an abortion.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, SB 245 would require DMHC-regulated health plans and CDI-regulated health policies that currently offer coverage for induced abortion services to eliminate all cost sharing (i.e., copays, coinsurance, or deductible payments) and prior authorization requirements for abortions and associated services. The removal of enrollee cost-sharing obligations is commonly known as “first dollar coverage,” meaning that an enrollee would not have any out-of-pocket expenses for abortion services if covered by their insurance. SB 245 does not include reductions in other costs commonly associated with accessing abortion services, including transportation to the clinic, any necessary lodging expenses, or reimbursement for time taken off work.

In addition to commercial enrollees, more than 50% of enrollees associated with the California Public Enrollees’ Retirement System (CalPERS) and more than 70% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.³⁷ As noted in the *Policy Context* section, SB 245 would not impact Medi-Cal beneficiaries’ benefit coverage, because these enrollees currently do not have cost sharing or prior authorization requirements for abortion services.

This section reports the potential incremental impacts of SB 245 on estimated baseline benefit coverage, utilization, and overall cost. SB 245 does not affect coverage for induced abortion, but rather impacts cost sharing for existing coverage. In approaching this issue, CHBRP is unable to determine the specifics of cost sharing for each enrollee among DMHC-regulated plans and CDI-regulated policies. However, in CHBRP’s survey of the largest providers of health insurance in California, health plans and policies reported that enrollees who currently have coverage for abortion services also have cost sharing. To estimate the impact of eliminating cost sharing, CHBRP applied an average estimated rate of cost sharing based on existing medical claims data for abortion services (see Appendix C for full details). Additionally, the total number of enrollees who use associated services include women who used pre- and post-abortion care for their induced abortions, as well as those who used pre-abortion care and then did not have the induced abortion. Finally, CHBRP accounted for the fact that an increase in induced abortions resulting from the enactment of SB 245 would decrease the total number of continued pregnancies in the overall population. Although these outcomes potentially could occur outside of the 12 months after enactment,³⁸ CHBRP is unable to determine the precise timeframe and therefore includes this outcome and its resulting cost offset in the analysis of SB 245 so as to present a more accurate picture of an average year of costs.

CHBRP’s analysis includes the following assumptions:

- As discussed in the *Background on Abortions and Medical Effectiveness* sections, enrollees who have induced abortions often do not choose to use their insurance coverage for the abortion, due to numerous factors, including a preference for privacy or a lack of knowledge that their plan or policy covers abortion services (Drey et al., 2006; Jones et al., 2013a, 2019; Jones and Jerman, 2013; Upadhyay, et al., 2014). CHBRP assumes that these reasons would remain if SB 245 were enacted, and therefore, most women who, at baseline, choose to forego using their private insurance for other reasons would continue to do so.
- Some women who faced cost-sharing barriers and did not obtain an abortion at baseline would successfully obtain an induced abortion postmandate due to the removal of cost sharing. CHBRP assumes the increase in use of abortion services would be similar to other intensive medical services when cost sharing is reduced to zero. There are no data in the literature on price elasticity for abortion services. CHBRP therefore assumes that utilization of abortion services will

³⁷ For more detail, see CHBRP’s *Estimates of Sources of Health Insurance in California for 2021*, a resource available at http://chbrp.org/other_publications/index.php.

³⁸ CHBRP postmandate analyses focus on the first 12 months after enactment of a benefit mandate and defines long-term impacts as those occurring beyond the first 12 months after implementation.

increase by 1% among enrollees in commercial plans and policies who had cost sharing at baseline (see Appendix C for a full explanation).

- To determine cost offsets from increased utilization of induced abortions, CHBRP assumes that medical costs from continued pregnancies are the same at baseline and postmandate. See *Appendix C* for a full description of the breakdown of offset costs.

For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

In response to the COVID-19 pandemic, CHBRP assumes utilization of health care services in 2022 will be roughly equivalent to utilization in 2019,³⁹ with adjustments made to account for changes in enrollment and population. CHBRP does not make additional assumptions to adjust for changes in utilization due to COVID-19 because recent 2020 claims data indicates utilization in aggregate has mostly returned to pre-pandemic levels. However, CHBRP acknowledges utilization has not rebounded for some services and for some groups of enrollees (i.e., visits for younger children had not returned to pre-pandemic baseline as of October 2020) (Mehrotra et al., 2020). Additionally, there are additional unknown factors that may impact utilization as a result of COVID-19, such as the potential impacts of deferred care and long-term impacts from COVID-19 infections.

Baseline and Postmandate Benefit Coverage

SB 245 would apply to 100% of the 21,945,000 enrollees in commercial, CalPERS, and Medi-Cal DMHC-regulated plans and CDI-regulated policies would be subject to SB 245 (Table 1).

CHBRP estimates at baseline there are 23,492 enrollees who have induced abortions and use associated services in DMHC-regulated plans and CDI-regulated policies (Table 1). Of these, 9,652 enrollees (41%) have cost sharing, which represents the enrollees in privately funded DMHC-regulated plans and CDI-regulated policies, along with CalPERS HMOs. Postmandate, 100% of enrollees with coverage for abortion would have \$0 cost sharing for abortion services, including associated medical care.

Baseline and Postmandate Utilization

Using relevant codes from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), CHBRP extracted data from Milliman's 2019 Consolidated Health Cost Guidelines™ Sources Database Plus (CHSD+) to develop baseline estimates of utilization of induced abortion (both medication abortion and procedural abortion), and associated services (See Appendix C for full list of codes). CHBRP calculated utilization rates for enrollees whose claims for induced abortion services included cost sharing (Table 1).

At baseline, a total of 23,492 enrollees had any use of abortion services, including associated services. As detailed in the *Background* section, it is sometimes medically necessary for a woman to have both a medication and a procedural abortion. Additionally, nearly all women who used associated services did so in relation to an induced abortion that occurred, but there is some proportion of women who have pre-abortion services and then do not have an abortion procedure. Many women who have a medication or procedural abortion require no associated services beyond the day of the procedure. Therefore, due to the overlapping populations of enrollees, the utilization estimates of number of services do not add to the number of total enrollees who used abortion services.

Additionally, CHBRP is aware that the number of enrollees who have induced abortions using their DMHC- or CDI-regulated coverage does not sum up to the overall number of induced abortions in

³⁹ CHBRP uses Milliman's 2019 Consolidated Health Cost Guidelines Sources Database Plus (CHSD+) to estimate utilization in 2022.

California, as detailed in the *Background* section. Combining the CHBRP Cost and Coverage Model’s estimate of enrollees who use their insurance coverage for an induced abortion with the total estimated number of induced abortions in California, CHBRP finds that an estimated 18% of enrollees who have induced abortions use their insurance coverage at baseline.

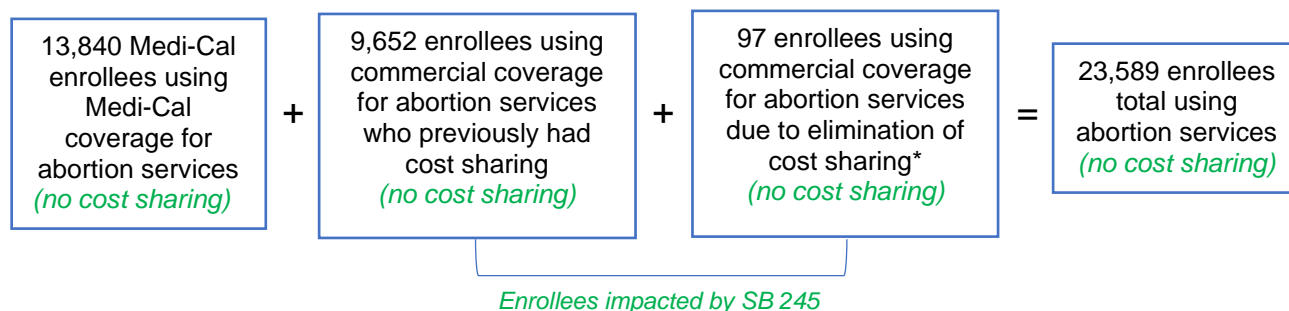
Of the total 23,492 enrollees in DMHC-regulated plans or CDI-regulated policies who used abortion services under their insurance coverage at baseline, 13,840 enrollees had no cost sharing and 9,652 had any cost sharing (Figure 5). CHBRP estimates that at baseline, 7,414 enrollees have medication abortions with no cost sharing, and 3,759 enrollees have a medication abortion with cost sharing (Table 1). Among enrollees having a procedural abortion, 5,063 have no cost sharing and 3,516 have cost sharing. Finally, among enrollees who use associated services at baseline, 4,429 have no cost sharing and 5,366 have cost sharing.

Figure 5. Baseline Utilization Calculations



Postmandate, there would be an overall increase in utilization due to the elimination of cost sharing for abortion services. To estimate changes in utilization postmandate, CHBRP applied an estimate of price elasticity of demand (see the full explanation in Appendix C). This estimated 1% increase in utilization combined with the reduction of cost sharing to zero for all enrollees results in a total of 23,589 enrollees who have any induced abortion or associated services (Figure 6).

Figure 6. Postmandate Utilization Calculations.



**This population represents the estimated 1% increase postmandate from baseline who no longer continuing pregnancies due to enactment of SB 245.*

Postmandate, by service, this results in an estimated 11,210 enrollees who have medication abortions, 8,614 who have procedural abortions, and 9,849 who have associated services (Table 1).

Baseline and Postmandate Cost

At baseline, according to the Milliman claims database, medication abortion has an average total cost of \$741, and procedural abortion has an average total cost of \$2,763 (Table 1); these totals include any costs from associated services performed on the same day of the abortion. Associated services have an

average total cost of \$574. Baseline cost sharing for medication abortion is, on average, \$306 for enrollees with cost sharing. For procedural abortion, cost sharing averages \$887, and associated services have, on average, \$182 in additional cost sharing (Table 1). These do not reflect average total costs per enrollee, which would depend on the amount and type of services used. Enrollees may need to obtain multiple services for various reasons, including medical necessity. For example, as described in the *Background* section, if a medication abortion is incomplete, a woman may need to obtain a procedural abortion. Postmandate, average cost sharing for medication abortion, procedural abortion, and associated services will become \$0 (Table 1).

Because SB 245 only impacts cost sharing for induced abortions, CHBRP estimates that the number of abortions newly paid for by DMHC-regulated plans and CDI-regulated policies will not be of a large enough magnitude to affect total per-unit costs for either medication or procedural abortion, or for the related associated services. Therefore, CHBRP estimates that the average total per-unit costs will remain the same postmandate.

Baseline and Postmandate Expenditures

Table 6 and Table 7 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies according to the CHBRP Cost and Coverage Model. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

SB 245 would decrease total net annual expenditures by \$1,501,000, or 0.0011%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a \$5,527,000 decrease in enrollee cost sharing for covered benefits (see *Enrollee Expenses* section below) adjusted by a \$4,026,000 increase in total health insurance premiums paid by employers and enrollees.

Premiums

CHBRP estimates that the mandate would increase premiums by about \$4,026,000 due to increased costs assumed by insurance carriers. Total premiums for private employers purchasing group health insurance would increase by \$1,808,000, or 0.0033%. Total premiums for purchasers of individual market health insurance would increase by \$1,361,000, or 0.0086%. Changes in premiums as a result of SB 245 would vary by market segment. Note that such changes are related to the number of enrollees with health insurance that would be subject to SB 245 (Table 1, Table 6, and Table 7). The greatest change in premiums as a result of SB 245 is for commercial individual plans in the DMHC-regulated market (0.0085% increase) and for the individual plans in the CDI-regulated market (0.0104% increase).

Among publicly funded DMHC-regulated health plans, there is no impact on Medi-Cal premiums because no enrollees have cost sharing for induced abortion services or related associated care. Among CalPERS HMO plans, there is an estimated increase of 0.0022% in premiums.

Enrollee Expenses

SB 245–related changes in cost sharing for covered benefits and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees with health insurance that would be subject to SB 245 expected to use induced abortion services during the year after enactment (Table 1, Table 6, and Table 7).

It is possible that some enrollees incurred expenses related to induced abortion services for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and therefore cannot offer a calculation of impact. CHBRP also cannot estimate impacts on enrollees who choose to use abortion services outside of their insurance coverage, and who therefore pay the total cost out-of-pocket.

The decreases in enrollee expenditures for covered benefits in commercial plans range from \$0.0242 PMPM among enrollees in DMHC-regulated large-group plans to \$0.0594 PMPM among enrollees in CDI-regulated individual policies. Among publicly funded plans, there is no impact for Medi-Cal enrollees, however CalPERS enrollees will have a decrease in enrollee expenditures of \$0.0249 PMPM (Table 7). These decreases in cost sharing for covered benefits PMPM would result in an overall reduction in total costs of \$5,527,000 postmandate.

Average enrollee expenses per user

With the elimination of cost sharing, CHBRP estimates that 9,748 enrollees in DMHC-regulated large group plans and CDI-regulated large-group policies who use abortion services would experience an average decrease in costs of \$429 postmandate (Table 5). Among enrollees in small-group DMHC-regulated plans or CDI-regulated policies, cost-sharing decreases will average \$721 per user. Enrollees who use abortion services who have individual DMHC-regulated plans or CDI-regulated policies will have an average reduction in cost sharing by \$825. Finally, CalPERS enrollees will have an average decrease of \$426 in cost sharing per user. Medi-Cal enrollees will not see a reduction in cost sharing postmandate, because they already have \$0 cost sharing at baseline.

Table 5. Average Enrollee Cost-Sharing Reductions Postmandate

	Large Group	Small Group	Individual	CalPERS HMO	Medi-Cal HMO *
Average reduction in cost sharing	-\$429	-\$721	-\$825	-\$426	\$0

Source: California Health Benefits Review Program, 2021.

Notes: Average enrollee out-of-pocket expenses include expenses for both covered and noncovered benefits. Out-of-pocket expenses only reflect those related to abortion services and not pregnancy offsets.

* Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

It should be noted Table 5 that shows the per-user annual impact in the form of cost-sharing savings for users facing cost sharing at baseline. These numbers reflect population averages and will vary significantly for individual members. Sources of variation include the specific services utilized by the enrollee and the cost sharing and utilization management protocols applicable to their specific DMHC-regulated plan or CDI-regulated policy.

Potential Cost Offsets or Savings in the First 12 Months After Enactment

CHBRP assumes that women who have induced abortions, if they had continued their pregnancies, would have had similar medical outcomes for the pregnancies as the general population of pregnant women. Although these outcomes would have potentially occurred outside of the 12 months after the first year of enactment of SB 245, CHBRP includes them in Table 1 and the analysis so as to present a more accurate picture of an average year of costs. See Appendix C for a full discussion of the methods used in these cost offset estimates.

According to the CHBRP Cost and Coverage Model, there are an estimated 97 women who would choose to have an induced abortion with the elimination of cost sharing postmandate. These pregnancy outcomes at baseline result in an average of \$25,574 per pregnancy, accounting for labor and delivery charges and medical costs associated with stillbirths or miscarriages. CHBRP does not include prenatal care in these average costs. The discontinuation of these 97 pregnancies postmandate leads to an estimated cost offset of \$2,455,000 from the enactment of SB 245 (Table 1).

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost-related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (Table 1, Table 6, and Table 7), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 245.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 245.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

Because enrollees in Medi-Cal already have abortion services coverage without cost sharing, there is no expected cost shifting to occur from public programs into the privately insured market nor would these public programs incur a cost as a result of SB 245. CHBRP is also aware that clinics and foundations exist that can assist women financially to access abortion services through either sliding scale fees based on income or direct funds to cover out-of-pocket costs; however, CHBRP is unable to quantify how many enrollees may use these services.

Table 6. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee Counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to SB245	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Premium Costs										
Average portion of premium paid by employer	\$426.28	\$374.49	\$0.00	\$540.40	\$226.61	\$478.87	\$530.80	\$421.81	\$0.00	\$84,948,349,000
Average portion of premium paid by enrollee	\$141.02	\$180.89	\$624.47	\$96.86	\$0.00	\$0.00	\$186.55	\$212.07	\$545.57	\$36,600,954,000
Total Premium	\$567.30	\$555.38	\$624.47	\$637.27	\$226.61	\$478.87	\$717.35	\$633.88	\$545.57	\$121,549,303,000
Enrollee Expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	\$43.61	\$121.70	\$173.51	\$50.75	\$0.00	\$0.00	\$134.75	\$197.13	\$184.11	\$13,168,032,000
Expenses for noncovered benefits (e)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0
Total Expenditures	\$610.91	\$677.07	\$797.97	\$688.02	\$226.61	\$478.87	\$852.10	\$831.01	\$729.68	\$134,717,335,000

Source: California Health Benefits Review Program, 2021.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 7. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee Counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to SB245	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Premium Costs										
Average portion of premium paid by employer	\$0.0101	\$0.0269	\$0.0000	\$0.0121	\$0.0000	\$0.0000	\$0.0218	\$0.0356	\$0.0000	\$1,937,000
Average portion of premium paid by enrollee	\$0.0033	\$0.0130	\$0.0529	\$0.0022	\$0.0000	\$0.0000	\$0.0077	\$0.0179	\$0.0567	\$2,089,000
Total Premium	\$0.0134	\$0.0400	\$0.0529	\$0.0142	\$0.0000	\$0.0000	\$0.0294	\$0.0535	\$0.0567	\$4,026,000
Enrollee Expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	-\$0.0242	-\$0.0456	-\$0.0574	-\$0.0249	\$0.0000	\$0.0000	-\$0.0379	-\$0.0566	-\$0.0594	-\$5,527,000
Expenses for noncovered benefits (e)	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0
Total Expenditures	-\$0.0108	-\$0.0056	-\$0.0045	-\$0.0107	\$0.0000	\$0.0000	-\$0.0085	-\$0.0031	-\$0.0028	-\$1,501,000
Postmandate Percent Change										
Percent change insured premiums	0.0024%	0.0072%	0.0085%	0.0022%	0.0000%	0.0000%	0.0041%	0.0084%	0.0104%	0.0033%
Percent Change total expenditures	-0.0018%	-0.0008%	-0.0006%	-0.0016%	0.0000%	0.0000%	0.0010%	0.0004%	0.0004%	-0.0011%

Source: California Health Benefits Review Program, 2021.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care

PUBLIC HEALTH IMPACTS

As discussed in the *Policy Context* section, SB 245 would prohibit plans and policies from imposing cost sharing for all covered abortion and follow-up services, including management of side effects and counseling. Additionally, SB 245 prohibits health plans and policies from imposing any restrictions or delays on abortion services, including prior authorization, and prohibits annual or lifetime limits on any covered abortion services.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact⁴⁰ of SB 245 on eliminating cost sharing and utilization management for abortions and associated services for women with coverage through DMHC-regulated plans or CDI-regulated policies.

Estimated Public Health Outcomes

The analysis discussed in the *Medical Effectiveness* section used indirect evidence to estimate the impact of cost or cost sharing on abortion outcomes including abortion access, utilization of abortion services, abortion complications, prenatal care, maternal health outcomes, maternal mental health outcomes, birth outcomes, infant morbidity and mortality, child health status, and breastfeeding after being unable to obtain an abortion. CHBRP found there is:

- Limited evidence that cost-sharing policies affect abortion access and utilization and insufficient evidence that cost sharing for abortion affects maternal health outcomes.
- Limited evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding and an increase in postpartum depression and low birth weight or preterm births.
- Insufficient evidence that unintended pregnancies impact maternal health outcomes.
- Limited evidence that not obtaining a chosen abortion may have socioeconomic consequences for their children and that there is no impact on child health outcomes.
- Inconclusive evidence of the impact on child development of children born to women who were denied an abortion.

CHBRP did not identify any studies that assessed utilization management among those with insurance coverage for abortion; therefore, there is insufficient evidence that utilization management policies affect abortion outcomes.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP estimates that marginal postmandate impact of SB 245 would be an additional estimated 9,748 women receiving abortion services with zero cost sharing. This includes the population of women who shift from having cost-sharing payments for abortion services at baseline and an estimated additional 97 women who would be new users of abortion services due to the elimination of cost sharing.

Barriers to Abortion Services

There are significant barriers that may prevent or delay women from obtaining abortions. These barriers include financial barriers (out-of-pocket costs, costs for travel and time off work) (Finer et al., 2006; Foster et al., 2018), distance and time to clinics or providers that perform abortion services (transportation,

⁴⁰ CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.

childcare, accommodations, work schedule), limited clinic options (limited options close to home especially for procedures for second trimester abortions, unavailable appointment times), navigating the system (logistics in securing an appointment, lack of information about resources or referrals, multiple visits needed for the procedure, delay of care), and desire to maintain privacy (seek out new doctor, avoid using insurance) (Jerman et al., 2017; Jones et al., 2013b; Kiley et al., 2010; Upadhyay et al., 2014). SB 245 specifically addresses the financial barrier related to out-of-pocket costs associated with abortion services and would eliminate cost sharing and utilization management for abortions already covered by commercial insurance.

Psychological Outcomes

There are short-term psychological harms associated with not being able to access abortion services. Research demonstrates that rates of self-esteem and life satisfaction are lowest the week after being denied an abortion (Biggs et al., 2017). However, between 6 months to 1 year, the impact of being denied an abortion decreases.

An analysis from the Turnaway study (Biggs et al., 2014) found women assessed 1 week after seeking and being denied an abortion more commonly reported lower self-esteem and lower life satisfaction compared with women who received abortions. However, at 1-year follow-up, these symptoms declined, and both groups showed similar levels of self-esteem and life satisfaction scores (Biggs et al., 2014). Another study (McCarthy et al., 2020) found women denied a wanted abortion were less optimistic about their long-term futures than women who received a wanted abortion. Women denied an abortion had lower odds of setting an aspiring 5-year life plan and goals than women who had an abortion. However, at 5 year follow-up, there were no differences by group in achieving 5-year life plans or goals among those who had them (McCarthy et al., 2020).

As previously discussed, SB 245 may increase access to abortion services for women with commercial insurance by reducing the financial burden associated with cost sharing. However, there are other barriers to seeking abortion services such as distance from clinic, limited clinic options, or navigating the system that may prevent women from obtaining abortion services. Women may also seek abortion services without the use of insurance due to concerns of confidentiality or stigma associated with abortions.

In the first year postmandate, CHBRP projects that the removal of cost sharing for abortion services, as proposed under SB 245, would enable an additional 97 women, for whom the baseline cost-sharing requirements would have otherwise prevented them from accessing these services, to obtain an abortion. For those women, SB 245 may reduce the negative health outcomes associated with being unable to access an abortion. CHBRP estimates the average out-of-pocket cost for any abortion service is \$543, which has been shown to be a financial barrier that most people are not prepared to experience. Therefore, SB 245 may also provide a financial benefit for the approximately 9,650 commercially-insured women who had cost sharing for covered abortions at baseline. These estimates are supported by limited evidence that cost-sharing policies reduce access to, and use of, abortion services.

CHBRP did not identify any studies that assessed utilization management among those with insurance coverage for abortion; therefore, there is insufficient evidence that utilization management policies affect abortion outcomes.

Impact on Disparities⁴¹

Insurance benefit mandates that bring more state-regulated plans and policies to parity may change an existing disparity. As described in the *Background* section, disparities in access to/utilization of abortion and associated services exist by race/ethnicity, age, and income. Within the first 12 months postmandate, CHBRP estimates SB 245 would not change disparities related to race/ethnicity, age, and income.

Impact on Racial or Ethnic Disparities

CHBRP found no studies that discuss the impact of cost sharing on racial/ethnic disparities related to abortion services. However, research indicates that women of color report higher rates of abortion in the United States than White women. This is an underlying public health issue related to the need for increasing access to contraceptive use, reducing unintended pregnancies, and improving women's health outcomes for women of color (Dehlendorf et al., 2013).

People of color — Latinos, Black, Asians, and others — represent a larger portion of Medi-Cal enrollees in DMHC-regulated plans (around 80%) and a smaller portion of commercial enrollees (55%). However, although these racial/ethnic groups are overrepresented in the Medi-Cal population relative to their share of California's population, there are more people of color among commercial enrollees (around 8 million) than there are among Medi-Cal beneficiaries enrolled in DMHC-regulated plans (around 5 million). There may be a subset of women of color within the commercially insured population that have not utilized abortions and associated services because they could not afford the out-of-pocket costs. However, there is insufficient evidence to determine whether racial/ethnic disparities exist among commercially insured women seeking abortions and associated services and whether SB 245 would impact racial/ethnic disparities related to eliminating cost sharing and utilization management for women of color within the insured population.

Although there is evidence of disparities in the United States related to racial/ethnic disparities in the rates of abortions, CHBRP found insufficient evidence of reduction in racial/ethnic disparities due to eliminating cost sharing and utilization management among women with commercial insurance. Please note that the absence of evidence is not “evidence of no effect.” It is possible that an impact — desirable or undesirable — could result, but current evidence is insufficient to inform an estimate.

Impact on Income

Research shows that low-income women utilize abortion services at higher rates than higher-income women (Jones et al., 2010, 2013b). These women are disproportionality impacted by the financial burden related to abortion care and associated services. SB 245 would bring parity for abortion services between Medi-Cal beneficiaries enrolled in DMHC-regulated plans and enrollees in CDI-regulated policies and DMHC-regulated plans by removing cost sharing for covered abortions for those with commercial insurance.

In the United States, the majority of women with commercial insurance pay out of pocket for abortion services (Jones et al., 2010). As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, the estimated average out-of-pocket cost sharing for any abortion service is \$543. The average cost is \$306 for medication abortions, \$887 for procedural abortions, and \$182 for associated services (Table 1). Incurring one large health care-associated payment can be especially burdensome, and most adults are not prepared to experience a financial disruption of \$400 or greater (Chen et al., 2021; Federal Reserve, 2020). Additionally, many women report delaying abortion services in order to save money or find financial assistance from outside sources (partners, family members, abortion funds) to pay for abortions

⁴¹ For details about CHBRP's methodological approach to analyzing disparities, see the Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts document here: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

and associated services (Finer et al., 2006; Foster et al., 2008). SB 245 may have an impact for women with commercial insurance by eliminating the large financial burden related to high out-of-pocket costs so that they may utilize abortion services.

Regardless of income or insurance status, there is a group of pregnant women who do not use commercial insurance for abortion services even when they have access to coverage, which may be related to concerns about stigma, confidentiality (such as to prevent a spouse or parent insurance policyholder from seeing a bill), or lack of knowledge about insurance coverage (Jones et al., 2013b; Roberts et al., 2014).

There is evidence of disparities in the United States related to income among women who seek abortions and associated services; however, CHBRP found insufficient evidence of reduction in income-related disparities due to eliminating cost sharing among women with commercial insurance. Despite the lack of evidence that eliminating cost sharing results in increased utilization of abortions and associated services, SB 245 may have an impact for a subset of women with commercial insurance who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

Impact on Age

In the United States, both pregnancy and abortion rates among women aged 15 to 17 years old have declined. In 2017, the California adolescent pregnancy rate was 13 pregnancies per 1,000 women 15 to 17 years of age, and the abortion rate was 5 abortions per 1,000 women 15 to 17 years of age (Maddow-Zimet and Kost, 2021). California provides publicly funded family planning services through the Family Planning, Access, Care, and Treatment (PACT) program, and evidence shows that Family PACT has helped reduce unintended pregnancies among adolescents. Adolescents seeking abortion services may face barriers to access disproportionately compared to adult women seeking abortion services (Dragoman and Davis, 2008). Adolescents experience barriers to abortion such as distance to abortion clinics and cost, and tend to access services later, which delays their abortion care and can lead to gestational limits for abortion (Davis and Beasley, 2009). They may not know how to access the appropriate resources or have the financial means to pay out of pocket for the abortion services. In California, adolescents can obtain abortions without consent or notification of their parents (Ralph and Brindis, 2008). Adolescents who seek abortions may choose to not use their parent's insurance in order to maintain privacy and keep the abortion confidential. They may seek services through women's health clinics, abortion funds, or self-managed abortion options that require cash payment. Adolescent parenthood is associated with negative outcomes such as educational underachievement, poverty, welfare dependence, domestic violence, and poor social relationships (Fergusson et al, 2007). SB 245 would eliminate cost sharing related to abortion services for adolescents who are willing to use their parent's commercial insurance coverage or have their own commercial insurance.

Although there is evidence of disparities in the United States related to age among women who seek abortions and associated services, CHBRP found insufficient evidence of reduction in age related disparities due to eliminating cost sharing among women with commercial insurance. Despite the lack of evidence that eliminating cost sharing results in increased utilization of abortions and associated services, SB 245 may have an impact for adolescents who are willing to use their parent's commercial insurance coverage or have their own commercial insurance and who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of SB 245, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

CHBRP estimates annual utilization of induced abortion services after the initial 12 months from the enactment of SB 245 would likely stay similar to utilization estimates during the first 12 months postmandate. Utilization changes may occur if new abortion medications or procedures change the landscape for enrollees, however CHBRP is unable to predict these types of changes. Similarly, health care utilization due to improved reproductive health services may change in the long term.

Cost Impacts

CHBRP estimates cost after the initial 12 months from the enactment of SB 245 are likely to remain similar in the subsequent years. Any savings resulting from a decrease in the outcomes from continuing a pregnancy would also lead to reductions in any subsequent health care needed from those outcomes; however, that cannot be quantified.

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts on social determinants of health.

As previously discussed, one study from the Turnaway project assessed women's mental health outcomes 5 years after receiving or being denied an abortion (Biggs et al., 2017). The study concluded that women who received an abortion reported similar or better mental health outcomes compared to the women who did not receive an abortion (Biggs et al., 2017). Additional studies from the Turnaway project found that women who receive abortions are more likely to report aspirational 1-year plans (Upadhyay et al., 2015a) and aspirational 5-year plans (McCarthy et al., 2020) as compared to women who were denied abortion services. The 5-year aspirational plans were focused on employment, finances, education, relationship status, child-related plans, living situation, and emotions. Among women who set aspirational 5-year plans, the women who were denied abortions were just as likely to achieve their plans as women who obtained abortions (McCarthy et al., 2020). These studies suggest there may be a positive impact on the long-term mental health outcomes and aspirational life-planning goals for women who obtain wanted abortions as compared to women who are unable to obtain wanted abortions.

Impacts on Disparities and the Social Determinants of Health⁴²

In the case of SB 245, CHBRP estimates utilization of abortion services would remain similar to utilization rates during the first 12 months postmandate. The long-term impact of SB 245 on potential disparities related to abortions and associated services among women with commercial insurance is unknown. However, SB 245 may have an impact on SDoH by eliminating the cost barrier associated with obtaining an abortion and improving the long-term mental health outcomes and aspirational goals of women who obtained abortion services.

⁴² For more information about SDoH, see CHBRP's publication Incorporating Relevant Social Determinants of Health Into CHBRP Benefit Mandate Analyses at http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

APPENDIX A TEXT OF BILL ANALYZED

On January 22, 2021, the California Senate Committee on Health requested that CHBRP analyze SB 245.

SENATE BILL

NO. 245

**Introduced by Senator Gonzalez
(Principal coauthor: Senator Leyva)
(Principal coauthor: Assembly Member Kamlager)
(Coauthor: Senator Durazo)
(Coauthors: Assembly Members Bauer-Kahan, Boerner Horvath, Burke, Calderon,
Cervantes, Friedman, and Cristina Garcia)**

January 22, 2021

An act to add Section 1367.251 to the Health and Safety Code, and to add Section 10123.1961 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 245, as introduced, Gonzalez. Health care coverage: abortion services: cost sharing.

Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. The act defines "abortion" as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

Existing law also establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care Services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate

health insurers. Existing law requires group and individual health care service plan contracts and disability insurance policies to cover contraceptives, without cost sharing, as specified.

This bill would prohibit a health care service plan or an individual or group policy of disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2022, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, as specified, and additionally would prohibit cost sharing from being imposed on a Medi-Cal beneficiary for those services. The bill would apply the same benefits with respect to an enrollee's or insured's covered spouse and covered nonspouse dependents. The bill would not require an individual or group health care service plan contract or disability insurance policy to cover an experimental or investigational treatment.

Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.251 is added to the Health and Safety Code, to read:

1367.251. (a) (1) A health care service plan, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2022, shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, including followup services including, but not limited to, management of side effects and counseling. Cost sharing shall not be imposed on a Medi-Cal beneficiary.

(2) Except as otherwise authorized by this section, a health care service plan shall not impose any restriction or delay, including prior authorization and annual or lifetime limit, on the coverage for abortion services.

(3) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(4) For purposes of paragraphs (2) and (3) and subdivision (b), "health care service plan" includes Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, risk-bearing

organizations pursuant to this chapter and any other participating provider acting pursuant to a subcontract with a managed care plan.

(b) This section does not deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a health care service plan provides coverage for abortion services.

(c) This section does not require an individual or group health care service plan contract to cover an experimental or investigational treatment.

(d) For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

SEC. 2. Section 10123.1961 is added to the Insurance Code, to read:

10123.1961. (a) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2022, shall not impose a deductible, coinsurance, copayment, or other cost-sharing requirement on coverage for all abortion services, including followup services including, but not limited to, management of side effects and counseling.

(2) Except as otherwise authorized by this section, an insurer shall not impose any restrictions or delays, including prior authorization and annual or lifetime limit, on the coverage for abortion services.

(3) Coverage with respect to an insured under this subdivision shall be the same for an insured's covered spouse and covered nonspouse dependents.

(b) This section does not deny or restrict in any way the department's authority to ensure an insurer's compliance with this chapter when the insurer provides coverage for abortion services.

(c) This section does not require an individual or group disability insurance policy to cover an experimental or investigational treatment.

(d) For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B LITERATURE REVIEW METHODS

This appendix describes methods used in the literature review conducted for this report. A discussion of CHBRP's system for medical effectiveness grading evidence, as well as lists of MeSH Terms, publication types, and keywords, follows.

Studies of the effects of cost sharing and utilization management on abortion outcomes including access to care, health services utilization, and health outcomes were identified through searches of PubMed, Embase, and Business Source Complete. Websites maintained by the following organizations were also searched: The Guttmacher Institute and Kaiser Family Foundation. The search was limited to abstracts of studies published in English and studies in the United States. The search was limited to studies published from 2000 to present. The literature on the medical effectiveness of cost sharing policies on abortion did not include any randomized controlled trials. The majority of the papers returned were case reports or survey data.

Reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

Medical Effectiveness Review

The medical effectiveness literature review returned abstracts for 106 articles, of which 38 were reviewed for inclusion in this report. A total of 16 studies were included in the medical effectiveness review for SB 245.

Medical Effectiveness Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's *Medical Effectiveness Analysis Research Approach*.⁴³ To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- *Clear and convincing evidence;*
- *Preponderance of evidence;*
- *Limited evidence;*
- *Inconclusive evidence;* and

⁴³ Available at: http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

- *Insufficient evidence.*

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

A grade of *limited evidence* indicates that the studies had limited generalizability to the population of interest and/or the studies had a fatal flaw in research design or implementation.

A grade of *inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Search Terms (* indicates truncation of word stem)

Abortion	Health Expenditures
Abortion, Induced	Income
Abortion, Spontaneous	Induced Abortion
Abortion, Therapeutic	Insurance Coverage
Age Factors	Medicaid
Coinsurance	Poverty
Cost Sharing	Prior Authorization
Deductible*	Race Factors
Deductibles and Coinsurance	Racism
Economic Factors	Social Class
Economic Status	Social Factors
Economics	Socioeconomic Factors
Educational Status	Socioeconomics
Ethnicity	United States
Ethnology	

APPENDIX C COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.⁴⁴ Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.⁴⁵

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Current coverage of abortion services and existence of cost sharing for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 92% of commercial, enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS, DHCS, and the four largest (by enrollment) DMHC-regulated plans enrolling Medi-Cal beneficiaries were queried regarding related benefit coverage.

Analysis-Specific Caveats and Assumptions

Identification of Induced Abortions and Associated Services

CHBRP examined Milliman's proprietary 2019 Consolidated Health Cost Guidelines™ Sources Database Plus (CHSD+) for enrollees with an induced abortion diagnosis or abortion-related procedure codes in California's commercial and Medi-Cal markets. The 2019 CHSD+ contains proprietary historical claims experience from several of Milliman's Health Cost Guideline (HCG) data contributors. The database contains annual enrollment and paid medical and pharmacy claims for over 72 million commercially insured individuals covered by the benefit plans of large employers, health plans, and governmental and public organizations nationwide. Medicaid members were also included in the database.

The analysis of California's 2019 CHSD+ claims data for induced abortion services required categorizing claims to estimate annual utilization rates and costs per service. Abortions were classified as either a medication abortion or procedural abortion based on Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, and all abortion associated services were identified using diagnosis codes. Any associated service rendered on the same day as a medication or procedural abortion were included in the cost of the abortion. Other pre-abortion or follow up services not performed on same day are included under associated services. Patients who used pre-abortion services for elective abortions, but ultimately did not pursue an abortion are included in associated service user count.

Content expert input and guidance from recent research formed the basis for CHBRP's methodology on how to group claims codes into abortion treatment categories.⁴⁶ In this analysis, only in-network claims were considered.

CHBRP completed the following steps to identify enrollees who used abortion services:

⁴⁴ CHBRP's authorizing statute, available at https://chbrp.org/about_chbrp/index.php, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.

⁴⁵ See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2021 Cost Analyses: Data Sources, Caveats, and Assumptions*.

⁴⁶ Personal communication with Dr. Ushma Upadhyay, February 2021.

- First, users receiving a medication or procedural abortion were identified. Claims were subset to only include members with the following HCPCS codes: S0199, S0190, S0191, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260, S2265, S2266, or S2267.
- Potential users were then limited to those with one of the following ICD-10 diagnosis codes:
 - Elective abortions: Z332, Z640, Z3009, Z30430, or O0480.
 - Therapeutic abortions: O351XX0, O359XX0, O358XX0, O350XX0, or Q897.
 - Any potential user without one of these diagnoses were not included in the analysis.
- For enrollees identified as having an elective abortion, claims occurring no more than 14 days before the abortion date with any of the following ICD 10 diagnosis codes were labeled as an associated service to reflect any pre-abortion services.
 - Diagnosis codes: Z332, Z640, Z3009, or Z30430.
- For enrollees identified as having an elective or therapeutic abortion, claims occurring subsequent to their abortion with any of the following ICD 10 diagnosis codes were labeled as an associated service to reflect any follow-up services performed as result of the abortion.
 - Diagnosis codes: Z332, Z640, Z3009, Z30430, O351XX0, O359XX0, O358XX0, Q897, O045, O046, O047, O0480, O0481, O0482, O0483, O0484, O0485, O0486, O0487, O0488, O0489, O070, O071, O072, O0730, O0731, O0732, O0733, O0734, O0735, O0736, O0737, O0738, O0739, or O074.
 - MSDRG codes: 769, 776.
- Separately, all enrollees with either ICD-10 diagnosis code Z332 or Z640 were identified. Those not previously identified as having had either a medication or procedural abortion were categorized as having only received an abortion associated service. An enrollee may have received an associated service but did not go on to receive an induced abortion.

Baseline Utilization — Induced Abortions

- Percent (%) of people with cost sharing – CHBRP is unable to determine the particular distribution of cost sharing among DMHC-regulated plans and CDI-regulated policies, and therefore assumed the empirical cost sharing shown in the Milliman CHSD+ reflects those in DMHC-regulated large group nongrandfathered plans. CHBRP applied the average empirical cost sharing shown in the Consolidated Health Cost Guidelines™ Sources Database Plus (CHSD+) to DMHC-regulated large group nongrandfathered plans. For enrollees in other plan types, cost sharing was estimated by applying a relative value of the plans' average actuarial value to the DMHC-regulated large-group nongrandfathered plans' actuarial value. CHBRP assumed all abortion services users in commercial plans have cost sharing to estimate the upper range of the impact from the elimination of cost sharing.⁴⁷ In addition, an average for all abortion-related associated services are included in the SB 245 Cost and Coverage Model as seen in the Milliman health claims dataset (see *Background on Abortions* for a discussion on associated services). The responses to the survey of the largest (by enrollment) health insurance providers suggested

⁴⁷ This approach may slightly overestimate the impact of SB 245, because some enrollees in commercial plans may have already met their annual deductible or otherwise have no cost sharing for their abortion services. CHBRP is unable to determine how many enrollees would be in that situation annually.

that enrollees in commercial plans who have coverage for abortion services at baseline have cost sharing for abortion services that is the same as major medical services. All commercial and CalPERS enrollees were assumed to be subject to cost sharing while no Medi-Cal enrollees were assumed to be subject to cost sharing.

- Percent (%) of enrollees using services – The proportion of enrollees using services was assumed to be similar to the proportion of commercial or Medi-Cal members in California identified in the 2019 CHSD+ database found to have received an induced abortion or associated service by age category.
- Utilization data from the 2019 CHSD+ was trended forward three years to reflect the 2022 baseline. The utilization trend was based on data from the Milliman Health Cost Guidelines (HCG) outpatient and professional trends. Procedural induced abortions were trended by 1% per year and medication induced abortions and all associated services were trended by 1.5% per year.

Postmandate Utilization — Induced Abortions

- Percent (%) of people with cost sharing – If passed, SB 245 would eliminate all cost sharing for all plans that cover induced abortions. CHBRP assumed no cost sharing in the postmandate period.
- Percent (%) of enrollees using services – For enrollees subject to cost sharing at baseline, CHBRP used Milliman HCGs adjusted for elasticity of demand for abortion services to estimate an induced utilization factor of 1%. This reflects additional abortions performed with elimination of cost sharing. This factor was only applied to people who are subject to cost sharing at baseline.

Baseline Cost — Induced Abortions

- Using the methodology outlined in the Identification of Induced Abortions and Associated Services section, the California average cost per identified user was calculated for commercial and Medi-Cal enrollees using trended 2019 CHSD+ cost data.
- Cost data from the 2019 CHSD+ was trended forward three years to reflect the 2022 baseline. The cost trend was based on data from the Milliman HCGs outpatient and professional trends. Procedurally induced abortions were trended by 7% per year and medication induced abortions and all associated services were trended by 4.5% per year.

Postmandate Cost – Induced Abortions

- Postmandate costs of induced abortions and associated services are assumed to be the same as in the baseline scenario.

Pregnancy Offsets

- In the baseline scenario, we assume that 1% of enrollees subject to cost sharing decide to not seek an induced abortion due to the cost sharing barrier. Instead, these enrollees would continue with their pregnancy, resulting in a live birth, a miscarriage, or a stillbirth.
- Live births include vaginal and C-section deliveries, which include the professional and facility costs. The cost and frequency of this pregnancy outcome are determined using the following MSDRG codes:

- Births: 765, 766, 767, 768, 774, 775, 783, 784, 785, 786, 787, 788, 796, 797, 798, 805, 806
- Miscarriages and stillbirth cost and frequency are determined using data from the 2019 CHSD+ matching the following ICD-10 diagnosis codes:
 - Miscarriages: O021, O030, O031, O032, O0330, O0331, O0332, O0333, O0334, O0335, O0336, O0337, O0338, O0339, O034, O035, O036, O037, O0380, O0381, O0382, O0383, O0384, O0385, O0386, O0387, O0388, O0389, or O039.
 - Stillbirths: Z377, Z371, P95, Z374, or Z373.
- To determine the cost of pregnancies for women who avoided an induced abortion due to cost sharing, the costs of live births and miscarriages were blended based on their respective prevalence. For women who know they are pregnant, we assumed 15% of pregnancies end in miscarriage and 85% end in a live birth (Mayo Clinic, 2019b), similar to the general population of pregnant women. CHBRP is aware that this represents a higher-end estimate of miscarriages, as many miscarriages occur prior to when an induced abortion would take place. This assumption slightly reduces the average medical cost offsets since a live birth has higher associated costs than a miscarriage.
- Cost and utilization data were trended forward three years from 2019 to the 2022 baseline scenario using outpatient and professional trends from the HCGs. Total allowed costs for live births are trended at 7% per year and total allowed costs for miscarriages and stillbirths are trended at 8% per year.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

- Considers the bargaining history of organized labor; and
- Compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that in general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS currently have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of SB 245 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second year impacts and determined the second year's impacts of SB 245 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

APPENDIX D INFORMATION SUBMITTED BY OUTSIDE PARTIES

In accordance with the California Health Benefits Review Program (CHBRP) policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

The following information was submitted by Senator Levya's office, ACCESS Reproductive Justice, Black Women for Wellness Action Project, NARAL Pro-Choice California, National Health Law Program, and Planned Parenthood Affiliates of California in February 2021.

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Submitted information is available upon request. For information on the processes for submitting information to CHBRP for review and consideration please visit: www.chbrp.org/requests.html.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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*Karen Shore, PhD, and An-Chi Tsou, PhD, are Independent Contractors who work with CHBRP to support legislative analyses and other special projects on a contractual basis.

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Elizabeth Magnan, MD, PhD, of the University of California, Davis, and Margaret Fix, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Penny Coppernoll-Blach, MLIS, of the University of California, San Diego, conducted the literature search. Julia Huerta, MPH, Elizabeth Magnan, MD, PhD, Dominique Ritley, MPH, all of the University of California, Davis, prepared the public health impact analysis. Shana Charles, PhD, MPP, of the University of California, Los Angeles, and California State University, Fullerton, prepared the cost impact analysis. Amy Kwong, FSA, MAAA, MPH, and Addison Luria Roberson, provided actuarial analysis. Ushma Upadhyay, PhD, MPH, of the University of California, San Francisco, provided technical assistance with the literature search and expert input on the analytic approach. An-Chi Tsou, PhD, CHBRP contractor, prepared the Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and members of the CHBRP Faculty Task Force, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley, Joy Melnikow, MD, MPH, of the University of California, Davis, and Nadereh Pourat, PhD, of the University of California, Los Angeles, and Adara Citron, MPH, of CHBRP staff, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org

MAR, 23, 2021

COBRA Assistance in the American Rescue Plan Act: A Guide for States

Dan Meuse, SHVS

The American Rescue Plan Act (ARPA) was signed into law on March 11, 2021 as a signature effort to assist in the recovery from the COVID-19 pandemic and the related economic downturn. Included as part of the sweeping legislation is a program to fully subsidize COBRA coverage for six months starting in April of 2021. The COBRA Assistance program will operate alongside a number of other programs designed to improve affordability of insurance coverage, and states will need to review what actions they should take to implement ARPA provisions and assist their consumers. This expert perspective provides a short overview of COBRA and mini-COBRA, the major elements of the ARPA COBRA Assistance program, and considerations for state policymakers related to the program.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) included a provision that allowed a person who loses employer-sponsored coverage to remain in that coverage if they elect to pay the full premium amount, plus an administrative fee of two percent. As a result, for many, the cost of continuing their coverage through COBRA is prohibitively expensive. Indeed, the Kaiser Family Foundation estimates that the total annual cost of employer-sponsored health coverage offered by firms of 20 or more employees in 2019 was \$7,012 for single coverage and \$20,599 for family coverage.^[1]

Archives

SELECT MONTH

A person qualifies for COBRA coverage if their employment is terminated for any reason other than gross misconduct, or if their hours are reduced. Family members of an employee also qualify for COBRA coverage along with the employee or in the event of the death of the employee, divorce, or if the employee gains eligibility for Medicare. The employee must be enrolled in the employer health plan at the time of the qualifying event.

Employees and other beneficiaries must be provided notice of COBRA rights for continuation of coverage and the plan must be notified of a qualifying event to trigger a COBRA election notice. A person generally has 60 days to enroll in COBRA coverage after the qualifying event. Generally, COBRA coverage can be maintained for 18 months, unless the COBRA coverage is due to the employee's qualification for Medicare, which provides a 36-month COBRA window.^[ii]

COBRA generally applies to employers with 20 or more employees. Most states^[iii] have a state continuation of coverage program for employees that are not protected by COBRA, often called mini-COBRA. While each state structures its mini-COBRA system a little differently, generally, the programs function in the same way as COBRA.

The American Rescue Plan Act and COBRA Assistance

ARPA creates a new 100 percent subsidy for COBRA coverage premiums from April 1, 2021, through September 30, 2021. Additionally, ARPA opens up the ability to enroll in COBRA coverage even if a person declined coverage earlier or if their enrollment window closed. Finally, ARPA extends the subsidy to continuation coverage under state mini-COBRA requirements.

Subsidy structure and operation. The COBRA assistance program is designed to be generally invisible to the enrollee. The language from ARPA reads: "In the case of any premium... for COBRA continuation coverage with respect to any assistance eligible individual described in paragraph (3), such individual shall be treated for purposes of any COBRA continuation provision as having paid in full the amount of such premium."^[iv] Enrollees that are eligible are deemed to have paid their premium. The assistance is accessed by plan sponsors or insurance companies as a refundable tax credit against payroll taxes.^[v] This allows 501(c)(3) organizations to access the assistance credits. The Department of Labor will provide guidance on identifying

assistance-eligible individuals.

New COBRA election opportunity. ARPA also allows individuals who would have been eligible to enroll in COBRA coverage but did not enroll, as well as those who enrolled in COBRA but then unenrolled, to join (or re-join) COBRA coverage. However, no one can join coverage if their COBRA coverage window (either 18 or 36 months from their qualifying event) has passed. Also, coverage cannot extend beyond the original 18 or 36 month window.^[vi] Plan administrators or insurance companies will be required to provide notice to those eligible for the new election opportunity by May 30, 2021.^[vii]

State continuation of coverage programs (mini-COBRA). The COBRA Assistance program of ARPA is explicitly available for state continuation of coverage programs, also called mini-COBRA.^[viii] These programs are generally available to employees of small employers (fewer than 20 employees) or other entities not subject to COBRA. Mini-COBRA programs, however, are not uniform across states, and include different election windows, notice requirements, and coverage eligibility categories.

Limitations. COBRA coverage allows for plan enrollment for anyone whose employment is terminated except for the reason of gross misconduct. The ARPA COBRA Assistance program limits assistance to those eligible for COBRA, unless the eligibility was due to the voluntary termination of employment by the employee.^[ix] Also, COBRA is only available if the employer is still offering a health plan. ARPA allows for enrollment in the employer plan if it changed, but if the employer is closed, and no health plan is offered, there is no opportunity for COBRA enrollment. COBRA assistance does not apply to Health Reimbursement Accounts (HRAs) which some employers use to allow their employees to purchase their own coverage.

State Considerations for the COBRA Assistance Program

There are a number of elements of the COBRA Assistance program that warrant attention by state policymakers—even if COBRA is generally not a state-regulated program.

Limited time for COBRA Assistance. The COBRA Assistance program provides six months (April – September, 2021) of coverage subsidy. On October 1, there could be a bolus of newly uninsured and as it stands now, there is no Special Enrollment

Period (SEP) for persons who choose to end COBRA coverage because of unaffordability. It is possible that legislation could be passed to extend the COBRA Assistance program, or that marketplaces could take action to allow a SEP due to loss of government COBRA subsidies.[x] However, persons that move into Marketplace coverage at that point would have to enroll in a new plan with a new deductible and maximum out-of-pocket limit for the final months of 2021.

Increased assistance for Marketplace coverage. ARPA also significantly increases the financial assistance available to consumers on the Marketplace. Not only are there additional subsidies to cap the cost of health insurance at 8.5 percent of income, the amount of income lower-income individuals are expected to pay towards premiums is also lowered.[xi] That means families up to 150 percent of the federal poverty level will have access to \$0 premium plans and other income levels will see significant premium reductions. ARPA also provides \$0 premiums for the so-called “high value silver” plans, with significantly reduced cost-sharing for anyone that is deemed eligible for unemployment compensation in 2021.[xii] These options provide a low or no-cost alternative to COBRA without the assistance cliff in October. As a result, states will need to develop communications support to help consumers navigate the complex decision process for options.

State mini-COBRA eligibility changes. The COBRA Assistance availability for state continuation of coverage programs, along with the new eligibility window, may require states to take regulatory or legislative action to allow individuals to re-gain access to mini-COBRA benefits so they can access the assistance. Given that the COBRA assistance begins in April and ends September 30 regardless of when and individual enrolls, states will need to take quick action to allow enrollment in mini-COBRA for eligible individuals.

The COBRA Assistance program creates a short-term, affordable health insurance option for many Americans impacted by the pandemic economic slowdown. As states work through the variety of opportunities to increase coverage through the American Rescue Plan, understanding the value and limitations of the COBRA Assistance program will be key to designing effective state policy and communicating with consumers about the options available to them.

[i] <https://www.kff.org/private-insurance/issue-brief/key-issues-related-to-cobra-subsidies/>

[ii] COBRA is overseen by the Department of Labor. Further information on COBRA can be found at:

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf>

[iii] <https://www.kff.org/private-insurance/state-indicator/expanded-cobra-continuation-coverage-for-small-firm-employees/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

[iv] Public Law 117-2. Section 9501(a)(1)(A)

[v] Public Law 117-2. Section 9501(b)(1)(A)

[vi] Public Law 117-2. Section 9501(a)(4)

[vii] Public Law 117-2. Section 9501(a)(5)(C)

[viii] Public Law 117-2. Section 9501(a)(9)(B)

[ix] Public Law 117-2. Section 9501(a)(3)(A)

[x] Note: In 2020, healthcare.gov created a SEP if an *employer* completely ceases to subsidize someone's COBRA premiums.

[xi] Public Law 117-2. Section 9661

[xii] Public Law 117-2. Section 9663

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The American Rescue Plan: Communicating Affordability Provisions

GMMB

March 23, 3:30 – 4:30pm ET

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at www.shvs.org.

COVID-19 Resources for States

State Health and Value Strategies has created an accessible one-stop source of COVID-19 information for states at www.shvs.org/covid19/. The webpage is designed to support states seeking to make coverage and essential services available to all of their residents, especially high-risk and vulnerable people, during the COVID-19 pandemic.

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Today's Agenda

- Communications Considerations
- Messaging
- Outreach Strategies and Tactics
- Insights from States
- Q&A



Communications Considerations

Fulfilling an Affordability Promise

- The American Rescue Plan is the biggest step towards making health insurance affordable since the passage of the Affordable Care Act
- Our job: make sure residents know there are more ways than ever to save on health insurance
 - More financial help
 - \$0 premium plans
 - Free COBRA plans



Keep in Mind Where Consumers Are

New Survey Finds 1 in 5 Potential Marketplace and Medicaid Enrollees Used Consumer Assistance, But Many Others Report Trying and Failing to Obtain Help

Published: Aug 07, 2020



The Commonwealth Fund

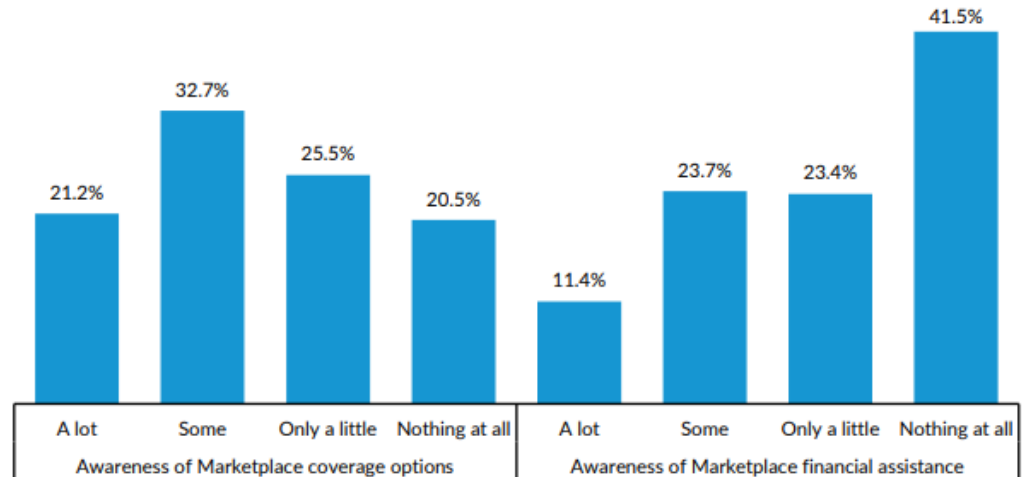
Issue Briefs
August 19, 2020

Adults Who Look for but Do Not Buy Plans in the Individual Market or Marketplaces Cite Affordability

KFF Tracking Poll: More Than a Third of Americans Say They've Struggled to Pay Living Expenses Since December; 6 in 10 Families Hit by COVID Have Lost A Job or Income

Published: March 03, 2021

Awareness of Marketplace Health Plans and Financial Assistance among Uninsured Adults Ages 18 to 64, September 2020



January 2021

URBAN INSTITUTE

Key Questions to Drive Communications

- What action do consumers need to take?
- How long will they have to act?
- When to share information and are there phases to promotion?
- Is the enrollment network informed and prepared?
- What channels to tap to spread the word?
- When to consider broad vs. targeted promotion?

Audiences

- Consumers
 - **Purchased an off-marketplace plan**
 - **Uninsured**
 - Currently enrolled *with* a tax credit
 - Currently enrolled *without* a tax credit
 - Current COBRA enrollees
- Policymakers
- Carriers
- Navigators/assistors/brokers
- Employers





Messaging

Overall Message Frame

New COVID relief legislation passed by Congress provides more financial help, to more people, to help them afford health insurance. Even if you already purchased a plan for 2021, you could qualify for a higher tax credit or even a \$0 premium plan. Whether you're already enrolled in a Marketplace plan, have bought a plan on your own, or need health insurance, you could save more than ever before through [MARKETPLACE]. Visit [MARKETPLACE WEBSITE] by [DEADLINE] to see how much you can save and get free help choosing the plan that's right for you.

Drilling Down on Affordability Provisions

- Free plans for people receiving unemployment insurance (UI).
- More financial help at every income level to buy a Marketplace plan.
- Free COBRA insurance through September.



Free Plans for People Receiving UI

- If you receive unemployment insurance benefits for at least one week in 2021, you may be eligible to enroll in a free private health insurance plan with no to low deductible through [MARKETPLACE].

More Financial Help at Every Income Level

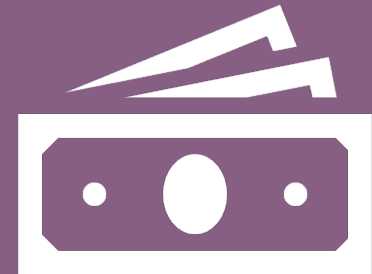
- [STATE RESIDENTS] can now save more on health insurance, no matter how much you earn. Even if you already enrolled in a 2021 plan, you may qualify for additional financial help or a \$0 premium plan through [MARKETPLACE]. And for the first time, someone earning above \$51,500 a year or a family of four earning above \$106,000 a year can now qualify for a tax credit through [MARKETPLACE]. You may also pay less for a more generous plan as a result.

More Financial Help at Every Income Level

For example, a family of four earning \$90,000 can now save nearly \$2,500 more per year on their health plan.

And a 60-year-old couple earning \$75,000 a year can save more than \$16,000 a year.

A 45-year-old earning \$45,000 can save nearly \$100 more per month on their premium.



Free COBRA Insurance

- If you lost your job or had a reduction in hours, you can get free COBRA health benefits from April 1 through September 2021. It's still a good idea to compare plans at [MARKETPLACE] to see if you can get a \$0 premium plan and/or a lower deductible so you can get more care before having to pay anything out of pocket.

Additional Messages

- **Medicaid coverage available**
 - Reinforce year-round enrollment
 - Coverage is available (even temporarily) to help those with job loss/changes in income or family situation
- **Tax credit reconciliation relief**
 - Underscore you are not required to pay back any of your 2020 tax credit
 - Be prepared to push out information from IRS, including how to receive refund if already filed/paid



Outreach Strategies and Tactics

Outreach Strategies

- Earned media
- Social media
- Paid advertising
- Targeted email marketing
- Navigator/assister/broker outreach
- Agency coordination and outreach
- Community outreach
- Tax preparers and VITA sites



Leverage existing SEP
marketing plans
where possible!

Communications Tactics

- Website FAQs
- Q&A, call scripts for navigators/call centers
- Tax credit calculators
- Info sessions
- Social graphics with savings examples

Health Insurance Marketplace Calculator

Financial Help for Health Insurance Coverage through Marketplaces

Enter Information About Your Household

1. Select a State ?
2. Enter income as
3. Enter your yearly household income (dollars) ?
4. Is coverage available from your or your spouse's job? ?
5. Number of people in family ?
6. Number of adults (21 to 64) enrolling in Marketplace coverage ?
7. Number of children (20 and younger) enrolling in Marketplace coverage



Insights from States



Audrey Morse Gasteier
Chief of Policy & Strategy



Marci Natale
Director, Division of Communications



Recap

- Get clear on consumer actions and deadlines pending operational schedules
- Prepare the enrollment network
- Leverage current SEP marketing plans
- Prioritize consumers who must come in to save
- Lean into new help and savings examples

Questions

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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Postpartum Coverage Extension in the American Rescue Plan Act of 2021

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Mar 18, 2021



Inside the \$1.9 trillion [American Rescue Plan Act](https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-HD0A062309C1143928EF82EC5845217C3) (<https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-HD0A062309C1143928EF82EC5845217C3>) of 2021 is a less noticed provision that makes a major change to Medicaid coverage for low-income pregnant and postpartum women, addressing a long-standing gap for people who have had their maternity care covered by Medicaid, especially those in states that have not expanded Medicaid as permitted by the ACA. While the Act adds new [incentives for](https://www.kff.org/coronavirus-covid-19/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/) (<https://www.kff.org/coronavirus-covid-19/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/>) states to take up the ACA Medicaid expansion, it also now gives all states the new option to [extend](https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/) (<https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/>) the postpartum coverage period under Medicaid from 60 days following pregnancy to a full year. This post explains the new policy and raises some questions that policymakers are likely to grapple with as the implementation unfolds.

What does the new policy do?

- **The American Rescue Plan Act of 2021 gives states a new option to extend Medicaid postpartum coverage from 60 days to 12 months.** Currently, Medicaid covers [almost](https://www.cdc.gov/nchs/products/databriefs/db387.htm#section_3) (https://www.cdc.gov/nchs/products/databriefs/db387.htm#section_3) half of births nationally, with eligibility levels [ranging](https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/) (<https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/>) from 138% to 380% of poverty across states. States must cover pregnant women with incomes up to 138% of the federal poverty level (FPL) through 60 days postpartum (the end of the month of the 60th postpartum day). The American Rescue Plan Act allows states to extend the postpartum period to a year by filing a State Plan Amendment (SPA) to their Medicaid program.

Under the new law, the postpartum coverage duration can also be lengthened

- **under the CHIP program.** Currently, six states [cover](https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/) (https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/) some low-income pregnant women through their CHIP programs. If a state takes up the new option to extend the postpartum period, this will apply to their CHIP coverage in addition to Medicaid.
- **States that elect the new option must provide full Medicaid benefits during pregnancy and the extended postpartum period.** Currently, states are permitted to cover a more narrow set of pregnancy-related benefits to those who qualify under the pregnancy pathway, although most align their benefits with other Medicaid eligibility groups. States that elect this new option however would have to provide full Medicaid benefits.
- **The new option can take effect starting April 1, 2022 and would be available to states for five years.** While the new option takes effect next year, currently postpartum women covered by Medicaid can remain on the program beyond 60 days because of a [Maintenance of Effort](https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/) (https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/) requirement enacted in 2020 that lasts through the COVID [public health emergency](https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-07Jan2021.aspx) (https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-07Jan2021.aspx).

Questions going forward

- **Which states will take up this option?** While we do not know which states will take up the option, [several](https://www.nashp.org/view-each-states-efforts-to-extend-medicare-coverage-to-postpartum-women/) (https://www.nashp.org/view-each-states-efforts-to-extend-medicare-coverage-to-postpartum-women/) have shown interest in extending the postpartum coverage period beyond 60 days. Some states have applied and have [waivers](https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table7) (https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table7) pending at CMS to extend postpartum coverage. This includes expansion states like Illinois and New Jersey as well as non-expansion states like Georgia (which applied for extension through 180 days postpartum). These states could now file a SPA instead of waiting for approval of their waivers. Some states may decide to change earlier proposals. For example, Missouri has [submitted](https://www.medicare.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82361) (https://www.medicare.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82361) a waiver application to CMS that would extend postpartum coverage to a year just for substance

use and mental health services. That proposal would not qualify for the new SPA option because it would not cover full benefits.

- What will be the impact on women's coverage in non-expansion states?** Non-expansion states that take up the option could see a decrease in the share of low-income mothers who are uninsured. Medicaid income eligibility levels for parents (<https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&selectedDistributions=january-2019&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) are much lower than for pregnant people (**Figure 1**). Currently, in non-expansion states, some new mothers fall into the coverage gap (<https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>) where their incomes are too high for Medicaid parent eligibility yet too low for Marketplace subsidies (which are available only at the poverty level or above), putting them at risk for becoming uninsured.

Figure 1

Medicaid Eligibility Is Much More Restrictive for Parents than Pregnant Women, Particularly in States that Have Not Expanded Medicaid

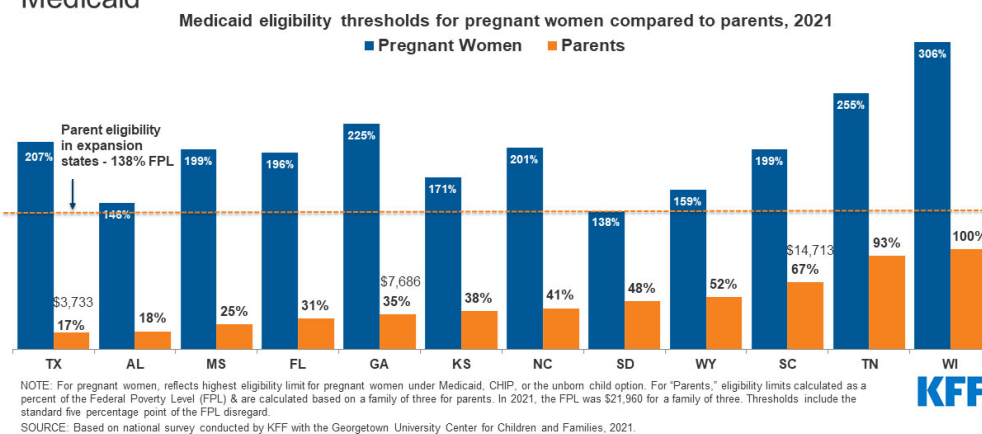


Figure 1: Medicaid Eligibility Is Much More Restrictive for Parents than Pregnant Women, Particularly in States that Have Not Expanded Medicaid

- Will this option be adopted by expansion states?** In states that have expanded Medicaid under the ACA, most postpartum women have a pathway to coverage – either Medicaid or subsidized private insurance through the ACA Marketplaces, but a longer postpartum period could allow for greater continuity with Medicaid providers. Studies (<https://www.healthaffairs.org/doi/10.1377/hblog20190913.387157/full/>) have documented that new moms who have Medicaid funded childbirths experiencing significant churning in coverage.

- **What will be the impact on federal and state budgets?** The Congressional Budget Office (CBO) estimates (<https://www.cbo.gov/publication/57056>) that by 2024, about a quarter of postpartum beneficiaries will live in states that elect the new option. CBO estimates that extended Medicaid coverage will result in almost \$6.1 billion in federal spending over the first ten years. States that adopt this extension would also incur costs as the extended coverage would remain at the same federal matching level, which ranges (<https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>) from 56.2% to 84.51%. These estimates take into account potential shifts in private insurance enrollment, including lower ACA subsidy costs. It is not clear if the estimates account for factors such as greater access to preventive services like contraception, which could avert unintended pregnancies that would otherwise be covered by Medicaid.
- **What will be the impact on health outcomes?** Part of the motivation for postpartum extension is the nation's high rate of preventable pregnancy-related mortality and morbidity, particularly the stark disparities (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-maternal-infant-health-overview/>) among Black and Native American women. There is also growing recognition that the postpartum period extends far beyond 60 days. Many of the conditions that account for a significant share of pregnancy-related mortality and morbidity, such as cardiovascular diseases, hypertension, and depression often require care over a longer-term. Providing Medicaid access to low-income mothers for a longer period also promotes continuity and access to preventive services such as contraception and intrapartum care.

The role of coverage as a key element of reproductive health care access is well understood. However, maternal health is also heavily connected to a complex set of issues, particularly poverty and systemic racism that pervade the health care system (<https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth>).

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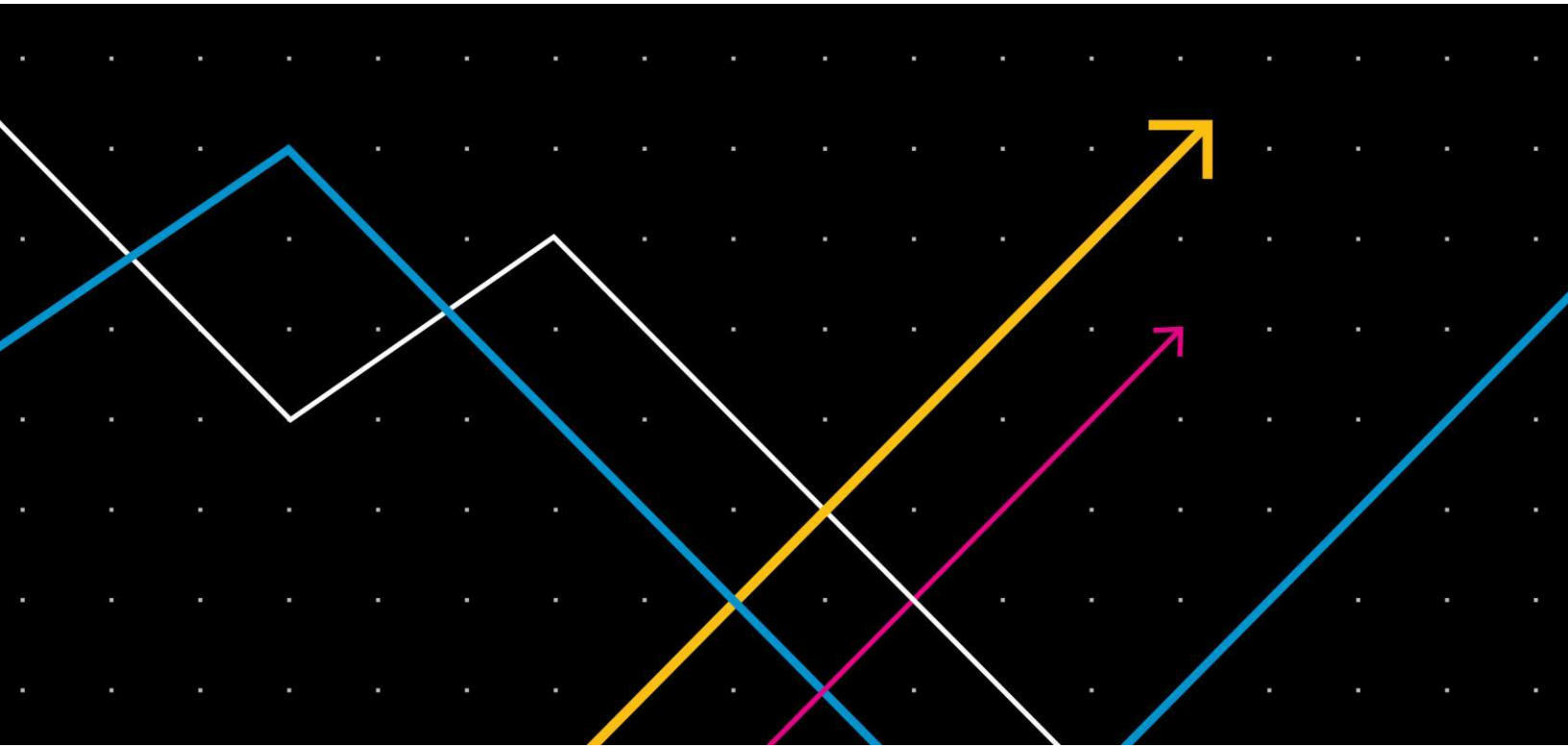
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RESEARCH REPORT

Comparing Public Option and Capped Provider Payment Rate Proposals

Linda J. Blumberg

March 2021



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Comparing Public Option and Capped Provider Payment Rate Proposals

In recent years, policymakers and analysts have discussed and debated two initiatives for lowering consumers' health insurance premiums and government costs in subsidized insurance markets. One initiative, a public option, would create a government-designed and administered (directly or via contract) health insurance plan or set of insurance plans that would be introduced in one or more insurance markets. The federal government would set rates paid to providers (e.g., doctors, hospitals, pharmaceutical manufacturers) participating with a public option. A second initiative, capping provider payment rates, would require providers participating in designated insurance markets to accept payment rates at or below a government-designated level. Thus, these capped rates would apply to providers participating in any private insurance plan offering coverage in the specified markets. The two options overlap on some key objectives but differ on others, and their implementation issues, distributional effects on consumers, and potential to reduce government spending vary as well.

This analysis explores the conceptual similarities and differences between a public option and capped provider payment rates, as well as potential differences in their distributional consequences. The two policies' differential distributional effects would have implications for consumers' and federal government spending.

Implementing either of these policies would involve the government using its leverage to set or limit provider payment rates. However, where those payment rates are ultimately set (or capped) and how they grow over time will require the government to predict (1) how insurers and providers will likely respond to a particular payment schedule, (2) how providers are likely to use their more limited bargaining power in response, and (3) how insurers will respond to greater potential competition. Though these policies are not explicitly based on negotiation, both would involve political negotiation and strategic planning based on expected industry responses. For example, insurers can compete with a public option or leave the market. Greater insurer competition could lower prices for all consumers, even those remaining enrolled in private plan options. Fewer private options could decrease consumer

satisfaction for at least some enrollees, depending on how they value the public option versus other private plans available. Capping provider payment rates would likely have different implications for private insurer pricing than would a competing public option, and the former could increase insurer participation in some markets. Capping payment rates could alienate providers and decrease their participation in affected plans if rates are set too low. Alternatively, payment rates set too high will eradicate potential savings for the government and consumers. Overall, though the federal government could exert substantial pricing power, the ultimate outcomes would reflect both insurers' and health care providers' bargaining powers.

The financial implications of a public option or capped payment rates could also differ markedly over time. Rate negotiations could occur every year, or a defined growth rate could be used over a specified period before renegotiations take place. How growth rates are determined can have implications for cost and provider/insurer participation at least as significant as the implications for where initial rates/caps are set.

Past experience does not allow us to estimate insurers' and providers' responses to a given set of public option payment rates. Therefore, we make clear assumptions about the effects of both approaches on private insurer pricing. Our analysis assumes private insurers continue competing once a public option is in place. However, we recognize this will not always be the case and will vary depending on these plans' abilities to maintain sufficient market share. We also assume sufficient numbers of providers will participate in the affected markets, even at somewhat reduced payment rates. We provide further detail in the section on modeling assumptions below. We delineate our specific assumptions so others can adjust them if they feel different assumptions would more likely reflect particular circumstances.

This analysis focuses on the private nongroup insurance market, in which a public option or capped provider payment rates are most likely to be considered and implemented in the coming years. Yet the reforms examined here could be extended to the employer-based insurance market, too. In earlier microsimulation work, we assumed both a public option and capped provider payment rates would have the same effects on federal government spending if implemented using the same payment rate proposals (Blumberg et al. 2020; Blumberg, Holahan, Buettgens, et al. 2019). We made this necessary assumption because of the microsimulation model's data limitations.¹ In this analysis, we explore whether that is true. Importantly, our analysis excludes other reforms often considered along with a public option or capped payment rates, namely increases in the generosity of premium tax credits and expansion of eligibility for both tax credits and cost-sharing subsidies. Instead, we provide insight into these two policy options in isolation.

We apply the following logic when analyzing these two policy options:

- In general, markets with greater insurer and provider competition today have lower nongroup insurance premiums. Therefore, the potential savings under either reform studied are lower if competition in the area is already strong.
- When introducing a public insurance option into a market, competition for private insurance plans increases, and insurers respond as if the market were more competitive. The public option is an additional insurer, likely paying providers rates below those paid by the highest-priced insurers today and perhaps below others' rates as well. Providers recognize some commercial insurers can be driven out of a market unless their payment rates, and thus premiums, can be reduced somewhat; it is in providers' interest that these insurers remain in the market.
- Insurers with the highest nongroup premiums today tend to pay providers the highest rates. This may owe to a lack of competition among insurers, providers, or both, or it may owe to broader provider networks necessitating higher payments to gain greater provider participation. When provider payment rates are capped close to Medicare rates, premiums for higher-priced plans decrease the most, reducing the variation across plans. This may owe to providers accepting lower rates because of the reform or higher-priced insurers being forced to reduce the breadth of their networks.
- These reforms change the distribution of premiums in a market and therefore likely change the market's benchmark premium. Because nongroup premium tax credits are tied to the benchmark premium, these changes have significant implications for federal government spending and households' abilities to afford existing private insurance plans.
- The reforms lead to lower payments for hospitals and physicians and would be accompanied by cost controls applied to prescription drug manufacturers as well.

We first discuss the policy objectives associated with a public option and capped provider payment rates. Next, we describe how we approach modeling these reforms and their potential consequences.

Policy Objectives

Public option. Advocates for a public option do not always share the same objectives for such a policy. For some, support for this reform arises from a desire to create a broad-based provider network similar to that associated with the traditional Medicare program. This contrasts with the narrower-network insurance plans that increasingly dominate the Affordable Care Act's nongroup Marketplaces (Wengle et al. 2020). This objective is not necessarily associated with a desire to contain consumer spending or government spending on financial assistance for people purchasing nongroup insurance, though some advocates for a public option hope and expect such a policy will significantly contain costs.

Advocates who emphasize the public option as a mechanism to **reduce health care spending** focus on the federal government's ability to determine the provider payment levels under public option plans. (A public option can be thought of as a set of plans, but model the reform as a single plan in the following analysis.) Setting provider payment rates significantly below those typically paid by private insurers would provide a lower-cost health insurance option to consumers than is currently available and could reduce federal subsidy costs to the extent the public option alters the premium tax credit benchmark. Some also anticipate the public option could operate at lower administrative costs than private insurers.

Capped provider payment rates. Capping provider payment rates is, in comparison, explicitly designed to **contain costs** by limiting the amounts insurers can pay health care providers in specified markets. Insurers able to build provider networks by paying providers less than the caps would be allowed to do so. The reform would set caps in such a way that reduces insurer premiums for some or even all insurance plans in an affected market. Lower premiums would make more plan options affordable or attractive for more consumers. And if the approach lowers the benchmark premium, the federal government could save on premium tax credits as well. As noted in our discussion of a public option's objectives and discussed further below, these capped payment rates could be set in myriad ways. The Medicare Advantage program is a current-law example of the effectiveness of capping provider payment rates for private insurers.

Implementation Issues

A public option and capped provider payment rates share some implementation issues and differ on others. Here, we first delineate three implementation issues that apply to both a public option and capped payment rates, followed by two that differ across the two approaches.

The payment rates chosen. The government must designate the rates paid to providers under a public option and the caps above which providers cannot be paid under capped payment rates. The initial payment rates used will undoubtedly be the outcome of political negotiation and will be based significantly on expectations of how insurers and providers may respond to particular payment schedules. Frequently, however, discussions of these approaches presuppose providers would be paid at Medicare rates or some percentage above them. Using median commercial insurance payment rates or some percentage thereof is another option. Alternatively, entirely new provider payment schedules could be developed.

Though no provider fee schedule is ideal in all circumstances, Medicare rates are known and already in wide use nationally throughout the Medicare program. Thus, implementing a reform based on them would be faster than developing a new approach or relying on commercial prices. Medicare payment rates are also based on relative value units based on resource use.² They are not necessarily correlated with commercial rates, however, and switching to them could lead to some redistribution across providers and/or medical services. Commercial prices are likely to have some political appeal, particularly with health care providers. However, no data on these prices currently exist, and, therefore, an enormous data collection effort would be required. In addition, the limited data available that have been analyzed by researchers indicate extreme variation in payment rates by both provider and service across the US. In addition, commercial payment rates can depend on particular provider competition in an area, as opposed to a schedule determined analytically based on resource use for particular procedures and services. For example, an area with a single anesthesiology group generally pays those providers much higher payment rates than an area with multiple competing anesthesiology groups, even at the median. Therefore, the relative payments across services result from many dynamics unrelated to value. Conversely, Medicare sets payments relative to their value to each other.

Regardless of the approach to developing the payment rate schedule for either reform, policymakers must decide

- how the target payment rates should vary across providers and specialties;
- the period over which target payment rates should be achieved;

- and, once the target payment rates are achieved, how they should grow over time.

These design decisions will substantially affect the extent to which health care providers' finances and, by extension, health care delivery will be disrupted by reform (e.g., change in supply of some services and procedures, impacts on quality of care provided). The larger the decreases in provider payment rates are relative to current law and the faster they are implemented, the greater the potential for disruptions in care provision, at least in the near term. However, smaller changes in provider payment rates and slower implementation lead to lower savings for the government and consumers.

Provider participation. The provider payment rates chosen affect provider participation in the affected plans. The lower the payments are set in a public option or the lower payment rate caps are set, the less likely health care providers will participate in those plans. However, these risks are small because nongroup insurance markets constitute a small share of the typical provider's caseload. However, the objectives of broad provider networks and cost containment intrinsically compete against each other;³ achieving broad networks likely requires higher provider payment rates than policymakers or advocates seeking significant cost containment would choose, particularly for physicians.

Policymakers could develop requirements tying provider participation in the public option or in capped rate nongroup markets to their participation in other public insurance programs, such as Medicare and Medicaid. However, this is unlikely to be politically popular among providers or to survive a political negotiation required for either reform. Additionally, policing participation and compliance with physicians would be challenging for the federal government.

Markets where reforms would be implemented. Designers of a public option or capped rates would have to decide the specific insurance markets in which the reforms would be implemented. Most commonly, public option and capped rate proposals have focused on nongroup insurance markets, but some have suggested implementation in both the nongroup and employer markets.⁴ The larger the number of insured people affected, the greater the potential for consumer and government savings. But the potential for health care delivery system disruptions is greater as well when more insured people are affected. Among people under age 65 (i.e., below Medicare age), enrollment in employer-sponsored insurance is roughly 8.5 times greater than enrollment in compliant nongroup insurance. Therefore, both savings and health system impacts are substantially larger if employer-based insurance markets are included in a reform.

In addition, some have suggested only a subset of markets should be included in these reforms. This might include areas that do not meet minimum competitiveness levels in their insurer and/or

provider markets, which tends to increase provider payment rates and therefore premiums. Relatedly, the reforms' implementation could vary by rural versus urban status, or otherwise focus on geographic areas with high premiums and/or provider payment rates. However, limiting a public option or capped payment rates to certain geographic areas is complex and could be overly disruptive; circumstances like insurer or provider competitiveness in a market can change over time, and it is unclear how these policies would adapt to changes in competition in the local market. Also, limiting such reforms to certain areas would have significant implications for the savings achieved nationally (Holahan and Simpson 2021a, 2021b, and 2021c).

Creation of an insurance product or set of products. Unlike capped payment rates, which modify the payment rates for providers in existing private insurance plans, a public option requires the government or a government contractor to create an insurance product or products, risk bearing entities that contract with various provider types. Even if the public option relied on a Medicare-like payment schedule, the structure of the set of plans would differ from Medicare's structure. Assuming the public option would only be available in the nongroup insurance market, the plans would presumably be structured consistent with the rules for a qualified health plan.

The public option would require administrators to develop and contract with a nationwide network of physicians, hospitals, and other providers and create a system for filing and paying claims. In addition, the public option requires a system for utilization review and oversight, marketing, and other roles insurers play. These tasks are feasible, but they require time, resources, and a team to be implemented. In contrast, capping provider payment rates does not require creating a new insurance entity or systems. Insurers would continue to contract with providers independently, but they would have the additional negotiating leverage of the payment rate caps; the plans for which the caps would be used are already established.

Impact on private insurers' participation. Depending on the chosen provider payment rates and the reform's success building broad-based provider networks, a public option could decrease insurer participation in some insurance markets. Private insurers may struggle to compete for enrollees if (1) insurers cannot negotiate provider payment rates as favorable as those under a public option or (2) a public option can develop a broader provider network than those of many commercial insurers in the same market. At least one preliminary analysis using former Medicaid managed-care organizations as a proxy for a public option indicated private insurers may be able to use a public option's presence as leverage in negotiating lower provider payment rates with their networks of physicians and hospitals (Blumberg, Holahan, Wengle, et al. 2019). However, the analysis suggested modest premium savings, below 10 percent, could be achievable. Depending on private insurers' actual abilities to negotiate

better deals with providers and whether any prescription drug savings achieved by a public option would also be shared with private insurers, insurers may see their enrollment fall to levels that make remaining in the market disadvantageous. Whether this is a positive outcome depends on the objectives of establishing a public option.

In contrast, capping provider payment rates is likely to increase the number of private insurers participating in an affected market. Today, without market share, it is challenging for an insurer new to an area to negotiate favorable provider payment rates that allow it to set competitive premiums. Therefore, capping provider payment rates across all private insurers removes a significant barrier to market entry for additional insurers.

Modeling the Differences in Outcomes between a Public Option and Capped Provider Payment Rates

As noted above, the key differences in outcomes between a public option and capped payment rates are likely distributional, relating to (1) how the affordability of available plans differs under each reform type and relative to current law and (2) how these differences vary across enrollees of different subsidy eligibility levels. Consequently, including data on all insurance plan options in a particular area is essential for highlighting the potential differences in outcomes. Here, we use a spreadsheet model that accounts for these data, allowing us to focus on the distributional implications of a set of reforms in example rating areas. As noted, we make our assumptions about how premiums for different plans would be affected by the reforms explicit so others can modify those assumptions or perform sensitivity analyses to alternative approaches.

Modeling Assumptions

Our estimates assume the following:

- Additional reforms (e.g., more generous Marketplace subsidies) are not included with the public option or capped payment rates.
- For ease of exposition, the public option is introduced at the silver level only, but a public option at the other coverage tiers could easily be created and introduced simultaneously. The silver tier is necessary, at a minimum, because it is the tier to which premium tax credits are tied under current law. Additionally, enrollees with incomes up to 250 percent of the federal poverty level (FPL) must purchase silver-level coverage to enroll in cost-sharing reduction plans. More than one public option could be introduced in a given tier as well; for example, one public option plan could require higher deductibles but lower coinsurance than another. Here, only one silver-tier public option is introduced.
- We estimate the public option premium in each rating area in a manner consistent with our prior analyses.⁵ We proxy public option premiums at Medicare provider payment rates as equaling the premiums resulting from high insurer competition and reasonable hospital competition in a market, accounting for other rating region differences. The same cited earlier work provides evidence to support using this proxy. We use a regression-based technique to estimate the current-law benchmark premium in each rating area as a function of the number of competing insurers, level of hospital concentration, and other Marketplace characteristics. We then predict the public option premium at Medicare rates in each rating area, assuming five or more insurers compete and the hospital Herfindahl-Hirschman Index (HHI) is at least 5,000. Then, we apply the percent difference between the actual benchmark premium and predicted public option premium in a rating area to compute the savings difference associated with introducing a public option that uses Medicare payment rates. For the sensitivity analysis using Medicare rates plus 10 percent, we reduce calculated savings by 10 percent. We then add savings resulting from prescription drug cost-containment strategies, as described below.
- Private insurers currently operating in noncompetitive or minimally competitive insurance markets may reduce their costs when the public option, and thus greater competition, is introduced in their market. Both economic theory and earlier studies support this assumption. One way insurers can reduce costs is negotiating lower provider payment rates. We assume private insurers can lower their premiums to an extent consistent with the premium differential we currently see between private insurers in otherwise similar markets with and

without a competing Medicaid managed-care organization. Consistent with earlier work (Blumberg, Holahan, Wengle et al. 2019), we estimate a regression that uses the presence of a Medicaid insurance plan in the Marketplace as a proxy for the impact a public option could have on non-Medicaid insurers' premiums in that area.⁶ Based on the results of that regression analysis, we assume a public option will tend to lower premiums of competing insurers to a greater extent in less competitive areas. For example, private insurer premiums decrease by 5.3 percent in rating areas with two private insurers and not at all in areas with five or more competing insurers. Depending on how the public option premium compares with current-law premiums in the market, the private plans will have greater or weaker abilities to successfully negotiate lower payment rates with providers. For example, plans in already highly competitive areas will presumably be less able to achieve such savings, because their premiums are already lower because of existing competition.

- Capping provider payment rates has larger effects on the highest-priced insurers' premiums and smaller effects (or sometimes no effect) on lower-priced insurers' premiums.⁷ In essence, this approach decreases all provider payment rates to no more than the designated levels, so plans paying providers the most today see premiums decrease the most. Insurers paying providers at or below those rates today are unlikely to see decreases. We estimate the effect of capping provider payment rates on the lowest silver premium available in each rating region using a similar regression-based approach to that described above.⁸ However, this method would not work for plans priced above the benchmark; such plans vary in number across markets, and capping rates should have a larger effect on higher premiums. Therefore, we make another assumption that two-thirds of the difference between the current-law benchmark premium and silver premiums exceeding the benchmark is attributable to the difference in provider payment rates between the plans. We also conduct a sensitivity analysis of this assumption, where one-half of the difference is attributable to differences in payment rates. If more of the differential is attributable to payment rates differences, we have overstated the variance in private plan premiums in the capped payment rate simulations and vice versa.
- Prescription drug savings are achieved through requirements that manufacturers pay an affected insurer higher rebates than those currently provided to commercial insurers. These rebates are assumed to be halfway between those provided to Medicare and Medicaid under current law (Hwang and Kesselheim 2020). We assume only the public option is entitled to these larger rebates under a public option approach, but we assume these rebates are provided to all private insurers in the Marketplace under capped payment rates.

- Insurers maintain sufficient provider networks while taking advantage of capped provider payments.⁹
- The public option pays health care providers Medicare rates in the main results; Medicare rates plus 10 percent are used as a sensitivity test. Similarly, capped provider payment rates limit private insurer payment rates to Medicare levels (Medicare plus 10 percent in the sensitivity analysis).

Base Case Simulation Results

Table 1 shows full (unsubsidized) monthly premiums for a 40-year-old single enrollee in each of the plans offered in the Marketplace in California’s rating regions 6 (Alameda) and 16 (Los Angeles West) in 2020. Region 16 was a highly competitive insurance market, with eight insurers, whereas region 6 was far less competitive, with only two insurers that year.

Rating Region 6: Alameda County, California, Noncompetitive Insurance Marketplace

Full (presubsidy) premiums. The current-law benchmark insurance premium (second-lowest silver) in rating region 6 (the less competitive region) was substantially higher than in rating region 16 (\$546.19 versus \$362.61 per month) in 2020. Though these differences are not necessarily fully attributable to southern California insurance and hospital systems being more competitive than those in northern California, their premiums relative to each other are consistent with that national pattern. The typical premiums in the bronze and gold coverage tiers follow a similar pattern.

If a public option using Medicare provider payment rates were introduced into rating region 6, the option would have multiple effects on the Marketplace’s available insurance options:

- The public option would become the lowest-premium silver option in the market. At \$402.54 per month, the public option premium would be considerably lower than the current-law lowest-priced silver option, the Kaiser Permanente plan with a \$479.94 monthly premium. We estimate the public option would be 26.3 percent lower than the current-law benchmark plan because of lower medical claims costs and would be another 6.9 percent lower because of large prescription drug rebates required of manufacturers.
- Introducing the public option would inject new competition into this market. Other insurers would respond by lowering their premiums by 5.3 percent, the savings we estimate are

possible to achieve through more aggressive negotiations with providers. Consequently, full premiums for each plan across all metal tiers would be somewhat lower than under current law, making them more affordable for consumers buying coverage without tax credits.

- The benchmark premium would fall from \$546.19 under current law (for the Blue Shield of California silver 70 Trio health maintenance organization, or HMO) to \$454.50 with the public option. The large decrease would owe to (1) the Kaiser Permanente plan (the lowest-priced silver plan under current law) becoming the benchmark plan and (2) the roughly 5 percent decrease in private insurer premiums resulting from heightened competition from the public option.
- The differential between the highest and lowest premiums in the silver tier would increase relative to current law, whereas the differential between the highest and lowest premiums in the bronze and gold tiers would shrink modestly.

If private insurers' provider payment rates were capped at Medicare levels in rating region 6, the approach would have multiple effects on the Marketplace's available insurance options:

- All premiums would fall significantly across metal tiers, from about 26 percent decreases for the Kaiser Permanente and Blue Shield of California (hereafter "Blue Shield") HMO plans to about a 33 percent decrease for the Blue Shield preferred provider organization (PPO) plans (the highest-priced options under current law). The premiums would fall differentially across product lines because insurers with higher premiums today are assumed to currently pay providers higher rates than their lower-premium counterparts; capping provider payment rates would therefore drive provider payment rates closer to one another across product lines.
- The benchmark premium would still be associated with the silver 70 Trio HMO plan, as is the case under current law. However, the benchmark premium would be \$402.54 per month, compared with \$546.19 per month under current law.
- The benchmark premium under capped payment rates would be significantly lower than that in the public option, because decreases in private insurer premiums are much larger under capped rates. This significantly lower benchmark premium translates into larger federal savings than under the public option, because premium tax credits are tied to the benchmark premium.
- Capped provider payment rates would affect all insurers in this market to a greater extent than would the public option, thereby dramatically decreasing variation in premiums within

each coverage tier. The differentials between the lowest- and highest-priced insurers would drop by roughly 50 percent. This compression could create more intense competition across insurers, bringing higher-priced insurers into reach for more consumers.

- Reducing a substantial barrier to entry for new insurers, lower provider payment rates may prompt new entrants to a rating area, including possibly opening up avenues for additional broader network plans.

TABLE 1

Full (Unsubsidized) Monthly Premium for a 40-Year-Old Single Enrollee for Bronze, Silver, and Gold Plan Offerings in California Rating Regions 6 and 16 under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

Base case assumptions

Insurer	Plan name	CURRENT LAW			REFORM SCENARIOS			
		Rating region 6	Rating region 16	Public option	Capped rates	Public option	Capped rates	Capped rates
		Rating region 6	Rating region 16	Public option	Capped rates	Public option	Capped rates	Capped rates
Bronze-tier plans								
Blue Shield	60 PPO	495.64	NA	469.37	332.82	NA	NA	NA
Blue Shield	60 HDHP PPO	477.73	NA	452.41	320.80	NA	NA	NA
Kaiser Permanente	60 HMO	387.15	NA	366.63	284.17	NA	NA	NA
Kaiser Permanente	60 HSA HMO	368.18	NA	348.67	270.24	NA	NA	NA
Anthem	60 HMO	NA	335.92	NA	NA	335.92	288.33	288.33
Blue Shield	60 PPO	NA	417.60	NA	NA	417.60	299.35	299.35
Blue Shield	60 HDHP PPO	NA	402.51	NA	NA	402.51	288.54	288.54
Health Net Life	60 EnhancedCare PPO	NA	344.82	NA	NA	344.82	261.08	261.08
Health Net Life	60 HDHP EnhancedCare PPO	NA	342.06	NA	NA	342.06	258.99	258.99
Health Net of CA	60 PureCare HSP	NA	344.72	NA	NA	344.72	318.87	318.87
Kaiser Permanente	60 HMO	NA	314.54	NA	NA	314.54	278.14	278.14
Kaiser Permanente	60 HSA HMO	NA	299.13	NA	NA	299.13	264.51	264.51
L.A. Care	60 HMO	NA	287.21	NA	NA	287.21	262.95	262.95
Molina	Choice Care	NA	330.25	NA	NA	330.25	307.46	307.46
Oscar	60 EPO	NA	272.26	NA	NA	272.26	253.47	253.47
Silver-tier plans								
Blue Shield	70 PPO	634.05	NA	600.45	425.77	NA	NA	NA
Blue Shield	70 Trio HMO	546.19	NA	517.24	402.54	NA	NA	NA
Kaiser Permanente	70 HMO	479.94	NA	454.50	352.28	NA	NA	NA
Federal government	Public option	NA	NA	402.54	NA	NA	NA	NA

		CURRENT LAW				REFORM SCENARIOS			
		Rating region 6	Rating region 16	Public option	Capped rates	Rating Region 6	Public option	Capped rates	Rating Region 16
Insurer	Plan name	Rating region 6	Rating region 16	Public option	Capped rates	Rating Region 6	Public option	Capped rates	Rating Region 16
Anthem	70 HMO	NA	406.97	NA	NA	406.97	406.97	349.32	NA
Blue Shield	70 PPO	NA	534.22	NA	NA	534.22	534.22	382.95	NA
Blue Shield	70 Trio HMO	NA	452.30	NA	NA	452.30	452.30	361.30	NA
Health Net Life	70 EnhancedCare PPO	NA	490.52	NA	NA	490.52	490.52	371.40	NA
Health Net of CA	70 CommunityCare HMO	NA	365.90	NA	NA	365.90	365.90	338.46	NA
Kaiser Permanente	70 HMO	NA	389.94	NA	NA	389.94	389.94	344.81	NA
L.A. Care	70 HMO	NA	371.22	NA	NA	371.22	371.22	339.87	NA
Molina	Choice Care silver	NA	362.61	NA	NA	362.61	362.61	337.59	NA
Oscar	70 EPO	NA	362.33	NA	NA	362.33	362.33	337.33	NA
Federal government	Public option	NA	NA	NA	NA	NA	337.59	NA	NA
Gold-tier plans									
Blue Shield	80 PPO	748.81	NA	709.12	502.83	NA	NA	NA	NA
Blue Shield	80 Trio HMO	667.66	NA	632.27	492.07	NA	NA	NA	NA
Kaiser Permanente	80 HMO copayment	573.94	NA	543.52	421.27	NA	NA	NA	NA
Kaiser Permanente	80 HMO coinsurance	545.49	NA	516.58	400.39	NA	NA	NA	NA
Anthem	80 HMO	NA	449.60	NA	NA	449.60	449.60	385.91	NA
Blue Shield	80 PPO	NA	630.91	NA	NA	630.91	630.91	452.26	NA
Blue Shield	80 Trio HMO	NA	552.90	NA	NA	552.90	552.90	441.66	NA
Health Net Life	80 EnhancedCare PPO	NA	584.10	NA	NA	584.10	584.10	442.26	NA
Health Net of CA	80 CommunityCare HMO	NA	435.41	NA	NA	435.41	435.41	402.76	NA
Kaiser Permanente	80 HMO copayment	NA	466.31	NA	NA	466.31	466.31	412.35	NA
Kaiser Permanente	80 HMO coinsurance	NA	443.19	NA	NA	443.19	443.19	391.90	NA
L.A. Care	80 HMO	NA	383.79	NA	NA	383.79	383.79	351.37	NA
Molina	Choice Care gold	NA	373.74	NA	NA	373.74	373.74	347.95	NA
Oscar	80 EPO	NA	412.53	NA	NA	412.53	412.53	384.07	NA

Sources: Current-law premiums are from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. NA indicates the plan is not available in the region or scenario. AV is actuarial value. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care services plan. EPO is exclusive provider organization. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates.

Postsubsidy premiums. Table 2 shows the monthly household premium contribution for a 40-year-old single enrollee of two subsidy-eligible incomes in each of the region 6 insurance options in the bronze, silver, and gold tiers under current law, a public option, and capped provider payment rates. The illustrative income levels are 200 percent of FPL (\$25,520 for a single adult) and 400 percent of FPL (\$51,040 for a single adult). The full premiums delineated in the previous section would apply to higher-income enrollees and those ineligible for premium tax credits for other reasons (e.g., having an affordable offer of health insurance available through an employer).

If a public option using Medicare provider payment rates were introduced in region 6, the public option would be the lowest-priced silver plan offered. However, the presence of the public option would mean the benchmark (second-lowest-priced silver) premium would shift to a different plan with a lower premium. Consequently, the amount of the subsidies for all people eligible for them would decrease. Thus, required premium contributions for subsidized enrollees choosing the same coverage they have under current law would be higher in the presence of a public option. For the same reason, the lowest-contribution requirement for a silver plan would be higher than that under current law.

The public option would require a 40-year-old single enrollee with income of 200 percent of FPL to contribute \$86.06. However, the benchmark premium in this scenario is considerably lower than that under current law (\$454.50 versus \$546.19; table 1), and the public option premium is significantly lower than the benchmark premium that corresponds to it (\$402.54 versus \$454.50; table 1). Thus, this lowest-contribution requirement for the subsidized population would actually be higher with the public option in place than under current law. Under current law, for example, the silver Kaiser Permanente HMO is available to our illustrative enrollee for \$71.77 per month. However, the least expensive silver plan would be available to her for \$86.06 per month with the public option in place. Likewise, within each actuarial value tier and at each subsidized income level, the lowest household contribution requirement would be higher with a public option in place than under current law. Additionally, the household contribution required for those receiving subsidies for almost every private insurance option in each actuarial value tier would be higher under the public option than under current law.¹⁰

TABLE 2

Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level in California Rating Region 6 under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

Base case assumptions

Insurer	Plan name	200% of FPL			400% of FPL		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	87.47	152.89	68.30	365.43	430.84	332.82
Blue Shield	60 HDHP PPO	69.56	135.93	56.28	347.52	413.88	320.80
Kaiser Perm.	60 HMO	0.00	50.15	19.65	256.94	328.10	284.17
Kaiser Perm.	60 HSA HMO	0.00	32.18	5.72	237.97	310.14	270.24
Silver-tier plans							
Blue Shield	70 PPO	225.88	283.96	161.24	503.84	561.92	425.77
Blue Shield	70 Trio HMO	138.02	200.76	138.02	415.98	478.71	402.54
Kaiser Perm.	70 HMO	71.77	138.02	87.75	349.73	415.98	352.28
Federal gov.	Public option	NA	86.06	NA	NA	364.01	NA
Gold-tier plans							
Blue Shield	80 PPO	340.64	392.64	238.31	618.60	670.60	502.83
Blue Shield	80 Trio HMO	259.49	315.79	227.54	537.45	593.75	492.07
Kaiser Perm.	80 HMO copay	165.77	227.04	156.75	443.73	504.99	421.27
Kaiser Perm.	80 HMO coins.	137.32	200.10	135.87	415.28	478.05	400.39

Sources: Current-law premiums from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: FPL is federal poverty level. Blue Shield is Blue Shield of California. Kaiser Perm. is Kaiser Permanente. Gov. is government. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. Coins. is coinsurance. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates.

If two or more public option plans were introduced at the silver level (a situation not modeled here), the two public option plans could become both the lowest-premium and the second-lowest-premium plans in a rating region. If this were to occur, it would push the benchmark premium even lower than we show here, requiring consumers to pay still more to enroll in competing commercial plans than these results indicate.

Alternatively, if provider payment rates for private insurers were capped at Medicare levels in region 6, the distributional implications for subsidized enrollees would differ somewhat. Like under the public option, the absolute level of the premium tax credits would fall as the benchmark premium falls. For our illustrative 40-year-old single enrollee with income of 400 percent of FPL, the subsidy would fall to \$0, because the full benchmark premium would have decreased enough that the full premium would be below 9.78 percent of the enrollee's income. Under the caps, subsidized enrollees would find plans offered by insurers paying higher provider payment rates become less expensive than under

current law, whereas plans offered by those paying lower provider payment rates would become more expensive.

In this scenario, subsidized enrollees in the Kaiser Permanente bronze and silver plans, the lower-priced options in these actuarial value tiers, would pay more for their plans under capped rates than under current law. This is because the benchmark, here tied to the mid-priced Blue Shield HMO, would fall by a larger amount than the premiums for the lower-priced options. Consequently, the lower subsidy would outweigh the savings from choosing a lower-priced plan. For example, the subsidy for our illustrative enrollee with income of 200 percent of FPL would drop by \$143.65 per month relative to current law. But the lowest-priced silver Kaiser Permanente plan premium would drop by only \$127.66, because Kaiser Permanente's payment rates were already lower than Blue Shield's before the caps' implementation. So though the Kaiser Permanente plan's premium would fall, it would not make up for the drop in the subsidy, leaving the households choosing that plan to pay somewhat more.

Meanwhile, people with subsidies choosing the benchmark plan would pay the same amount as under current law for that option (their applicable percentage-of-income cap). Within each actuarial value tier of coverage, household contributions for the higher-priced (Blue Shield) plans would be smaller than under current law. These savings for the higher-priced plans in each tier materialize because premiums for the higher-priced plans decrease the most under capped payment rates, significantly decreasing the premium differences between higher- and lower-priced plans.

Comparing this scenario with the parallel public option scenario, however, we find household premiums for the same plan would be universally lower under capped rates, except for enrollees who would otherwise choose the public option if it were available. Because it would be the lowest-cost option if it were offered, the public option would provide a lower-cost silver plan than would any of the capped rate private silver plans. Private plans would be more affordable under capped rates because explicitly limiting private plan payment rates would have a much larger effect on private insurer premiums than would increasing competition through a public option. The higher subsidy under the public option (because of the higher benchmark premium) would counteract that and make the public option less expensive for subsidized households than the private plan under capped rates.

Rating Region 16: West Los Angeles, California, Competitive Insurance Marketplace

Full (presubsidy) premiums. As shown in table 1, full premiums in the coverage tier with the highest enrollment (silver) ranged from \$362.33 to \$534.22 per month under current law in 2020; the benchmark plan premium was only slightly more expensive than that for the lowest-priced insurer. Nine silver plan options were offered across the eight insurers participating in the region.

If a public option using Medicare provider payment rates were introduced into rating region 16, it would become the lowest-priced silver option in the market. However, its introduction cannot be expected to affect private plans' premiums in the area. This is because the market is already so highly competitive under current law that any negotiating leverage plans have with providers has already played out in their current premiums. The public option premium is estimated to be \$337.59 per month, and its savings relative to the lowest-priced private plans in the market would be entirely attributable to the assumed higher prescription drug rebates the public option would require (and which, in these base case estimates, are assumed to be unavailable to the competing private plans). Because the two lowest-premium plans in this market have such similar premiums (\$362.33 for Oscar's silver EPO and \$362.61 for Molina's Choice Care silver plan), introducing the public option would move the benchmark premium by less than 30 cents per month, not a noticeable change.

In addition to the modest premium savings it would offer, the public option could attract enrollees for reasons unrelated to price. This could be particularly true if it offers a provider network that is broader than or perceived as somehow superior to those offered by other lower-priced insurers in the market.

If private insurers' provider payment rates were capped at Medicare levels in rating region 16, all insurance plans' premiums in this market would be affected; the savings would range from 6.9 percent (prescription drug savings only) to 28.3 percent (savings for the higher-priced plan options). The benchmark premium would fall from \$362.61 to \$337.59 per month. Thus, the full premiums for all private plans would be lower than they are under current law. In addition, the premiums for each private plan option at all coverage tiers would be lower with capped provider payment rates than under the public option. Plus, the lowest-priced silver private insurance plan under this approach, Oscar's EPO, would have a full premium nearly identical to that of the public option, if that approach were taken instead.

Postsubsidy premiums. Table 3 shows the postsubsidy premium contribution required for our illustrative enrollee living in California's rating region 16 at two income levels under current law, the public option, and capped provider payment rates.

TABLE 3

Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level in California Rating Region 16 under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

Base case assumptions

Insurer	Plan name	200% of FPL			400% of FPL		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Anthem	60 HMO	111.33	111.61	88.76	335.92	335.92	288.33
Blue Shield	60 PPO	193.01	193.29	99.78	417.60	417.60	299.35
Blue Shield	60 HDHP PPO	177.92	178.20	88.97	402.51	402.51	288.54
Health Net Life	60 EnhancedCare PPO	120.23	120.51	61.51	344.82	344.82	261.08
Health Net Life	60 HDHP EnhancedCare PPO	117.47	117.75	59.42	342.06	342.06	258.99
Health Net of CA	60 PureCare HSP	120.13	120.41	119.30	344.72	344.72	318.87
Kaiser Perm.	60 HMO	89.95	90.23	78.57	314.54	314.54	278.14
Kaiser Perm.	60 HSA HMO	74.54	74.82	64.94	299.13	299.13	264.51
L.A. Care	60 HMO	62.62	62.90	63.38	287.21	287.21	262.95
Molina	Choice Care	105.66	105.94	107.89	330.25	330.25	307.46
Oscar	60 EPO	47.67	47.95	53.90	272.26	272.26	253.47
Silver-tier plans							
Anthem	70 HMO	182.38	182.66	149.75	406.97	406.97	349.32
Blue Shield	70 PPO	309.63	309.91	183.38	534.22	534.22	382.95
Blue Shield	70 Trio HMO	227.71	227.99	161.73	452.30	452.30	361.30
Health Net Life	70 EnhancedCare	265.93	266.21	171.83	490.52	490.52	371.40
Health Net of CA	70 CommunityCare HMO	141.31	141.59	138.89	365.90	365.90	338.46
Kaiser Perm.	70 HMO	165.35	165.63	145.24	389.94	389.94	344.81
L.A. Care	70 HMO	146.63	146.91	140.30	371.22	371.22	339.87
Molina	Choice Care silver	138.02	138.30	138.02	362.61	362.61	337.59
Oscar	70 EPO	137.74	138.02	137.76	362.33	362.33	337.33
Federal gov.	Public option	NA	113.28	NA	NA	337.59	NA
Gold-tier plans							
Anthem	80 HMO	225.01	225.29	186.34	449.60	449.60	385.91
Blue Shield	80 PPO	406.32	406.60	252.69	630.91	630.91	452.26
Blue Shield	80 Trio HMO	328.31	328.59	242.09	552.90	552.90	441.66
Health Net Life	80 EnhancedCare PPO	359.51	359.79	242.69	584.10	584.10	442.26
Health Net of CA	80 CommunityCare HMO	210.82	211.10	203.19	435.41	435.41	402.76
Kaiser Perm.	80 HMO copayment	241.72	242.00	212.78	466.31	466.31	412.35
Kaiser Perm.	80 HMO coinsurance	218.60	218.88	192.33	443.19	443.19	391.90
L.A. Care	80 HMO	159.20	159.48	151.80	383.79	383.79	351.37
Molina	Choice Care gold	149.15	149.43	148.38	373.74	373.74	347.95
Oscar	80 EPO	187.94	188.22	184.50	412.53	412.53	384.07

Sources: Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: FPL is federal poverty level. Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. Kaiser Perm. is Kaiser Permanente. Gov. is government. HMO is health maintenance organization. PPO is preferred provider organization. HDHP is high-deductible health plan. HSP is health care service plan. HSA is health savings account. EPO is exclusive provider organization. NA indicates plan not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates.

If a public option using Medicare provider payment rates were introduced in region 16, the postsubsidy household contributions required for subsidized enrollees taking up a private Marketplace plan would be almost identical to those faced under current law. This is because the benchmark premium would decrease by only 28 cents per month, and private plan premiums would be unaffected by the public option's introduction into this already highly competitive market. However, the public option could command lower net prescription drug prices through higher rebates than the commercial insurance plans in the market, meaning it would provide an insurance option for subsidized silver plan enrollees that would require lower household contributions than the lowest-priced option available under current law.

For example, the illustrative 40-year-old single enrollee with income of 200 percent of FPL could enroll in the public option for \$113.28 per month, compared with \$137.74 for the Oscar EPO, the lowest-contribution silver option under current law. For the same enrollee with income of 400 percent of FPL, the public option contribution would be \$337.59 per month, a savings of about \$25 per month compared with the lowest-priced silver option under current law. Again, if the public option offers a broader provider network or other valued differences in plan design, it could be more attractive to enrollees than the modest price difference alone would suggest.

If provider payment rates for private insurers were capped at Medicare levels in region 16 instead, subsidized enrollees would generally be required to contribute less to enroll in the private insurance options than they contribute under current law. Again, the higher the current-law premiums are relative to the benchmark plan, the greater the decrease in premiums under capped rates and the greater the savings for subsidized enrollees choosing those plans. For example, the Blue Shield PPO is the highest-priced silver plan under current law. Our illustrative 40-year-old enrollee with income of 400 percent of FPL would pay \$534.22 per month for that option under current law but only \$382.95 per month under the capped provider payment rates, a savings of more than \$150 per month. The same enrollee with income of 200 percent of FPL would save \$126.25 per month (\$183.38 versus \$309.63 under current law).

In a few exceptions, however, subsidized household premium contributions would increase very slightly for our illustrative enrollee with income below 400 percent of FPL choosing certain bronze-level coverage options. L.A. Care, Molina, and Oscar offer very competitively priced plans under current law, and, as such, would achieve minimal percent savings from provider payment rates being capped. For people of modest income buying these bronze-level plans, the premium savings relative to current law would be smaller than the cut in their subsidy due to the benchmark premium decreasing.

However, these are isolated occurrences, and the increases in household contributions are small (less than \$1 per month for L.A. Care, about \$2 per month for Molina, and about \$6 per month for Oscar).

Because private plan premiums under the public option are almost identical to those under current law, enrollee contributions under capped rates would generally fall below those required in the public option as well. However, the public option would be available to subsidized enrollees with incomes of 200 percent of FPL for a contribution about \$24.50 below that of the lowest-cost silver option under capped payment rates.

Sensitivity Analyses

Higher provider payment rates for public option and private insurer caps. As we have noted elsewhere (Blumberg et al. 2020), phase-in and/or political concerns may make it challenging to set public option payment rates or private insurance payment rate caps at Medicare levels, at least in the short run. Consequently, we present results for each approach in the same rating regions used in the base case analysis, instead assuming a public option or payment rate caps are set at Medicare levels plus 10 percent. We show these results in appendix tables A.1 through A.3, which parallel tables 1 through 3 for the base case. For rating region 6 (weak insurer competition), the sensitivity results and those for the base case differ as follows:

- The presubsidy benchmark premium under both the public option and capped rates would be higher than in the base case. This means the federal subsidy cost per enrollee would be higher with the higher payment rate caps than under the base case.
- With payment rates set to Medicare levels plus 10 percent, the public option would still be the lowest-priced silver option. However, because the public option would be more expensive than in the base case, it would not introduce sufficient additional price competition into the market to provide leverage or incentive for the private insurers to negotiate lower provider payment rates. Thus, premiums for the private plans would be the same as under current law, each higher than they would be under the base case public option.
- In this noncompetitive market, the implications for subsidized households of introducing a public option with higher payment rates would vary depending on the plan chosen. Those choosing the benchmark (Kaiser Permanente silver 70 HMO) would face the same percentage-of-income premium contribution as they would in the base case. But those choosing private plans in the silver and gold tiers would face postsubsidy premiums at least

modestly higher than under the base case public option, given the higher full premiums. For example, the public option full premium would be about \$55 higher per month than in the base case, but the benchmark premium would only be about \$25 higher per month. Therefore, the higher subsidy would not be large enough to offset the higher premiums. The exception to this would be the lower-priced bronze plans, for which the higher subsidy would outweigh the modestly higher premiums, making these plans less expensive after subsidies.

- The lowest-priced options under capped rates, those offered by Kaiser Permanente, are less expensive for subsidized households with the higher payment rate caps than in the base case. As indicated with the public option approach, the higher subsidy associated with a higher benchmark premium outweighs the higher premiums for these Kaiser Permanente options. The Blue Shield options, which have higher premiums, would generally cost subsidized households more than in the base case. The exception is the benchmark plan itself, for which households would still pay the applicable percentage-of-income cap.
- Higher provider payment rates in this sensitivity analysis mean capped payment rates would offer lower-premium options to families with subsidies than would the public option. For example, the lowest-priced silver option for our illustrative enrollee with income of 200 percent of FPL would be \$115.24 per month under the public option, which is the price for the public option. Under capped rates, the lowest-priced silver premium for the same person would be \$81.13 per month for the Kaiser Permanente HMO.

For rating region 16 (strong insurer competition), the sensitivity analysis results and those for the base case differ as follows:

- Assuming it would reimburse providers at Medicare rates plus 10 percent, the public option would be the fifth-lowest-premium silver option in this rating region (as opposed to the lowest-priced option assuming Medicare rates in the base case). However, the tight price competition among the lowest-priced private plans in this rating area means the benchmark premium does not differ significantly between this sensitivity analysis and the base case.
- Because the public option does not affect private plan premiums in the base case or sensitivity analysis, postsubsidy premiums for households purchasing private plans differ little across the two scenarios. The biggest difference is that under higher payment rates in the sensitivity analysis, the public option would not provide subsidized households with a lower-priced insurance option than they have under current law; choosing it would require households to spend somewhat more than their applicable percentage-of-income cap.

- Because two insurers (Oscar and Molina) already pay providers at roughly Medicare rates under current law, setting private insurers' provider payment rates at Medicare levels plus 10 percent would not change their premiums relative to the base case. However, the insurers paying higher provider payment rates would have higher premiums if higher payment rates were used. The biggest premium differences between the two scenarios would occur among higher-premium plans.
- The benchmark premium is the same in the base case and sensitivity analysis, but higher-priced insurers have higher premiums under the sensitivity analysis. Thus, higher payment rates would lead to higher postsubsidy premiums for households choosing insurance plans other than those offered by Oscar and Molina.
- With higher caps, capped provider payment rates would offer subsidized enrollees across income levels at least somewhat lower premium options than would the public option. The postsubsidy premium differences between the capped rate and public option approaches would be greatest for the highest-priced plan options.

Smaller share of premium differences assumed attributable to provider payment rate differences. No publicly available dataset provides representative information on the provider payment rates used by private nongroup insurers in or outside the Marketplaces. However, our previous work provides evidence that the most competitive markets have benchmark premiums consistent with those under provider payment rates roughly equal to Medicare's. In our capped rate base case analysis, we assume two-thirds of the difference in premiums between the benchmark silver plan and higher-premium silver plans is attributable to differences in provider payment rates. We then assume those provider payment rates are consistent across the same plans offered in each actuarial value tier of coverage. We assume this because provider payment rates seem to significantly affect premiums, but premiums are shaped by other factors, too. However, we lack data to estimate the extent to which payment rate differences drive premium differences. Thus, we include a sensitivity analysis of this assumption, assuming instead only 50 percent of the difference in premiums within a coverage tier owes to provider payment rate differences. Appendix tables B.1 through B.3 parallel the base case tables 1 through 3 but instead use the 50 percent assumption (instead of 67 percent). The only differences from the base case are for the capped rate results; this sensitivity analysis does not apply to current-law or public option estimates. We find the following for rating region 6 (weak insurer competition):

- The full premium for the Blue Shield PPO, the only plan with a premium higher than the benchmark under capped provider payment rates, would be higher under this alternate assumption (\$440.41 per month for our illustrative 40-year-old versus \$425.77 in the base case).
- Likewise, postsubsidy premiums for the Blue Shield PPO plans at all actuarial value tiers would be somewhat higher than in the base case. For example, a gold-level Blue Shield PPO enrollee with income of 200 percent of FPL would pay \$255.60 per month, compared with \$238.31 per month in the base case.

We find the following for rating region 16 (strong insurer competition):

- Full premiums would be higher under this assumption for all plans with premiums higher than the benchmark. For most plans, assuming provider payment rates contribute less to premium differences means capping rates has a smaller effect on premiums, leaving premiums higher than in the base case. The Molina and Oscar plans were already priced at levels that indicated they were paying providers less than Medicare rates under current law, so they would be unaffected by the caps in either case. Under reform, the savings generated for those insurers' plans would come solely from the assumed increase in prescription drug rebates, which is the same in the base case and the sensitivity analysis.
- Because full premiums are higher for plans priced higher than the benchmark under this assumption, the postsubsidy premiums for these plans would also be higher than in the base case. The higher the full premiums are relative to the benchmark, the larger the increase in postsubsidy premiums.
- This alternative assumption does not, however, materially change the relative advantages of capped payment rates versus the public option.

Conclusions

Introducing a public option paying regulated rates to providers and capping provider rates paid by private Marketplace insurers have both been discussed as potential strategies for improving health care affordability for households and lowering federal government subsidy costs. As demonstrated in the policies simulated here, both reforms can do so, but they would have significantly different effects on benchmark premiums and the affordability of private insurance plans before and after premium tax

credits. Plus, these implications differ considerably across markets with different levels of competition and thus private insurance premiums.

This analysis has two central limitations: First, it is based out of necessity on several assumptions. The ultimate effects of a public option or capped payment rates are based on many unknowns, most importantly,

- the initial provider payment rates, which will be the outcome of a political negotiations;
- the extent to which current differences in premiums reflect differences in provider payment rates;
- public and private insurers' abilities to develop provider networks at lower payment rates;
- and possible changes to insurer participation in markets in response to greater price competition.

We have made our assumptions explicit and based them on economic theory and available evidence, and we believe they are reasonable. However, we provide sensitivity analyses to other assumptions and acknowledge our findings on outcomes would differ if our assumptions proved to be faulty. Second, we focus on short-term effects of these reforms, and, as such, our analysis may not capture longer-term shifts in insurer behavior. Longer-term effects would depend largely on how initial provider payment rates change over time (e.g., whether rates would be negotiated annually, whether particular growth rates would be set in law, and if so, how they would be determined). Still, understanding short-term effects is critical for understanding the longer run, because they set the stage for what follows.

Directly capping provider payment rates of all private plans in a market can decrease private insurance plan premiums more than can introducing a public option. The former may increase competitive pressures in noncompetitive areas but will have little to no effect in competitive markets. Capping provider payment rates for all private plans can dramatically compress the variance in premiums across all plans, bringing higher and lower premiums closer and providing consumers a broader array of affordable health insurance options.

In assessing how either reform affects subsidized enrollees' plan affordability in particular, one must consider how it would alter the benchmark premium relative to private insurer premiums. For example, when using Medicare payment rates and our other base case assumptions, a public option can introduce a plan premium that would be more affordable to many consumers eligible for subsidies than the lowest-priced option available under the capped provider payment rates. However, if the

benchmark premium falls to a greater degree than private plans achieve savings, a public option can make private plans more expensive for subsidized enrollees. This could mean subsidized enrollees feel their plan choices are more limited with a public option in place, and this could decrease incentives for private insurers to participate in at least some of these markets.

And, as shown in one of our sensitivity analyses, if a public option were to pay providers even modestly above Medicare rates, it would have less potential to provide a more affordable health insurance option than would capping private payment rates. This is true in both competitive and noncompetitive areas. However, enrollees may value a public option over private plans for reasons beyond price. For example, a public option that offers a broad provider network may find a consumer niche in the Marketplaces, but achieving such a network would likely require that the public option pay providers above Medicare rates.

This analysis highlights the importance of clearly identifying the goals of a reform such as a Marketplace public option or capped provider payment rates. How important is federal cost containment, which will be driven by the postreform benchmark premium? How important is improved consumer affordability, and should that affordability goal emphasize subsidized or unsubsidized consumers? How negative would the effects be of a policy that provides a new public option but makes private options less affordable than they are under current law, potentially driving some or even many insurers out of these markets? The answers to these questions will lead policymakers to an approach that most effectively balances the trade-offs inherent in these strategies. Alternatively, it could lead them to consider a combination approach that both introduces a public option and caps provider payment rates for competing private insurers.

Appendix A. Sensitivity Analysis to Higher Provider Payment Rates

APPENDIX TABLE A.1

Full (Unsubsidized) Monthly Premium for a 40-Year-Old Single Enrollee under Current Law, a Public Option, and Capped Provider Payment Rates, 2020
In California rating regions 6 and 16

Insurer	Plan name	CURRENT LAW			REFORM SCENARIOS		
		Rating	Rating	Rating	Rating	Rating	Rating
		Region 6	Region 16	Region 6	Region 6	Region 16	Region 16
Bronze-tier plans							
Blue Shield	60 PPO	495.64	NA	495.64	403.98	NA	NA
Blue Shield	60 HDHP PPO	477.73	NA	477.73	389.39	NA	NA
Kaiser Permanente	60 HMO	387.15	NA	387.15	322.88	NA	NA
Kaiser Permanente	60 HSA HMO	368.18	NA	368.18	307.06	NA	NA
Anthem	60 HMO	NA	335.92	NA	NA	335.92	312.74
Blue Shield	60 PPO	NA	417.60	NA	NA	417.60	346.60
Blue Shield	60 HDHP PPO	NA	402.51	NA	NA	402.51	334.07
Health Net Life	60 EnhancedCare PPO	NA	344.82	NA	NA	344.82	303.57
Health Net Life	60 HDHP EnhancedCare PPO	NA	342.06	NA	NA	342.06	301.14
Health Net of CA	60 PureCare HSP	NA	344.72	NA	NA	344.72	320.93
Kaiser Permanente	60 HMO	NA	314.54	NA	NA	314.54	292.84
Kaiser Permanente	60 HSA HMO	NA	299.13	NA	NA	299.13	278.49
L.A. Care	60 HMO	NA	287.21	NA	NA	287.21	267.39
Molina	Choice Care	NA	330.25	NA	NA	330.25	307.46
Oscar	60 EPO	NA	272.26	NA	NA	272.26	253.47
Silver-tier plans							
Blue Shield	70 PPO	634.05	NA	634.05	516.80	NA	NA
Blue Shield	Silver 70 Trio HMO	546.19	NA	546.19	457.16	NA	NA
Kaiser Permanente	Silver 70 HMO	479.94	NA	479.94	400.27	NA	NA
Federal government	Public option	NA	NA	457.16	NA	NA	NA

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS							
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16					
		Public option	Capped rates	Public option	Capped rates	Public option	Capped rates				
Anthem	70 HMO	NA	406.97	NA	406.97	NA	378.89	NA	406.97	378.89	
Blue Shield	70 PPO	NA	534.22	NA	534.22	NA	443.39	NA	534.22	443.39	
Blue Shield	70 Trio HMO	NA	452.30	NA	452.30	NA	421.09	NA	452.30	421.09	
Health Net Life	70 EnhancedCare PPO	NA	490.52	NA	490.52	NA	431.84	NA	490.52	431.84	
Health Net of CA	70 CommunityCare HMO	NA	365.90	NA	365.90	NA	340.65	NA	365.90	340.65	
Kaiser Permanente	70 HMO	NA	389.94	NA	389.94	NA	363.03	NA	389.94	363.03	
L.A. Care	70 HMO	NA	371.22	NA	371.22	NA	345.61	NA	371.22	345.61	
Molina	Choice Care silver	NA	362.61	NA	362.61	NA	337.59	NA	362.61	337.59	
Oscar	70 EPO	NA	362.33	NA	362.33	NA	337.33	NA	362.33	337.33	
Federal government	Public option	NA	NA	NA	NA	NA	NA	NA	373.85	NA	
Gold-tier plans											
Blue Shield	80 PPO	748.81	NA	748.81	NA	610.34	NA	NA	NA	NA	
Blue Shield	80 Trio HMO	667.66	NA	667.66	NA	558.83	NA	NA	NA	NA	
Kaiser Permanente	80 HMO copayment	573.94	NA	573.94	NA	478.67	NA	NA	NA	NA	
Kaiser Permanente	80 HMO coinsurance	545.49	NA	545.49	NA	454.94	NA	NA	NA	NA	
Anthem	80 HMO	NA	449.60	NA	449.60	NA	418.58	NA	449.60	418.58	
Blue Shield	80 PPO	NA	630.91	NA	630.91	NA	523.64	NA	630.91	523.64	
Blue Shield	80 Trio HMO	NA	552.90	NA	552.90	NA	514.75	NA	552.90	514.75	
Health Net Life	80 EnhancedCare PPO	NA	584.10	NA	584.10	NA	514.22	NA	584.10	514.22	
Health Net of CA	80 CommunityCare HMO	NA	435.41	NA	435.41	NA	405.37	NA	435.41	405.37	
Kaiser Permanente	80 HMO copayment	NA	466.31	NA	466.31	NA	434.13	NA	466.31	434.13	
Kaiser Permanente	80 HMO coinsurance	NA	443.19	NA	443.19	NA	412.61	NA	443.19	412.61	
L.A. Care	80 HMO	NA	383.79	NA	383.79	NA	357.31	NA	383.79	357.31	
Molina	Choice Care gold	NA	373.74	NA	373.74	NA	347.95	NA	373.74	347.95	
Oscar	80 EPO	NA	412.53	NA	412.53	NA	384.07	NA	412.53	384.07	

Sources: Current-law premiums from CoveredCA.com; public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the region or scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates plus 10 percent; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates plus 10 percent.

APPENDIX TABLE A.2

Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020
In California rating region 6

Insurer	Plan name	200% of the Federal Poverty Level		400% of the Federal Poverty Level			
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	87.47	153.72	84.84	365.43	431.68	362.80
Blue Shield	60 HDHP PPO	69.56	135.81	70.25	347.52	413.77	348.20
Kaiser Permanente	60 HMO	0.00	45.23	3.74	256.94	323.19	281.70
Kaiser Permanente	60 HSA HMO	0.00	26.26	0.00	237.97	304.22	265.88
Silver-tier plans							
Blue Shield	70 PPO	225.88	292.13	197.66	503.84	570.09	475.61
Blue Shield	70 Trio HMO	138.02	204.27	138.02	415.98	482.23	415.98
Kaiser Permanente	70 HMO	71.77	138.02	81.13	349.73	415.98	359.08
Federal government	Public option	NA	115.24	NA	NA	393.20	NA
Gold-tier plans							
Blue Shield	80 PPO	268.33	406.89	291.20	618.60	684.85	569.15
Blue Shield	80 Trio HMO	187.18	325.74	239.69	537.45	603.70	517.65
Kaiser Permanente	80 HMO copayment	93.46	232.02	159.53	443.73	509.98	437.48
Kaiser Permanente	80 HMO coinsurance	65.01	203.57	135.80	415.28	481.53	413.75

Sources: Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: Blue Shield is Blue Shield of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates plus 10 percent; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates plus 10 percent.

APPENDIX TABLE A.3

Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020
In California rating region 16

Insurer	Plan name	200% of the Federal Poverty Level			400% of the Federal Poverty Level		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Anthem	60 HMO	111.33	111.33	113.17	335.92	335.92	312.74
Blue Shield	60 PPO	193.01	193.01	147.03	417.60	417.60	346.60
Blue Shield	60 HDHP PPO	177.92	177.92	134.50	402.51	402.51	334.07
Health Net Life	60 EnhancedCare PPO	120.23	120.23	104.00	344.82	344.82	303.57
Health Net Life	60 HDHP EnhancedCare PPO	117.47	117.47	101.57	342.06	342.06	301.14
Health Net of CA	60 PureCare HSP	120.13	120.13	121.37	344.72	344.72	320.93
Kaiser Perm.	60 HMO	89.95	89.95	93.27	314.54	314.54	292.84
Kaiser Perm.	60 HSA HMO	74.54	74.54	78.92	299.13	299.13	278.49
L.A. Care	60 HMO	62.62	62.62	67.82	287.21	287.21	267.39
Molina	Choice Care	105.66	105.66	107.89	330.25	330.25	307.46
Oscar	60 EPO	47.67	47.67	53.90	272.26	272.26	253.47
Silver-tier plans							
Anthem	70 HMO	182.38	182.38	179.32	406.97	406.97	378.89
Blue Shield	70 PPO	309.63	309.63	243.82	534.22	534.22	443.39
Blue Shield	70 Trio HMO	227.71	227.71	221.52	452.30	452.30	421.09
Health Net Life	70 EnhancedCare PPO	265.93	265.93	232.27	490.52	490.52	431.84
Health Net of CA	70 CommunityCare HMO	141.31	141.31	141.08	365.90	365.90	340.65
Kaiser Perm.	70 HMO	165.35	165.35	163.46	389.94	389.94	363.03
L.A. Care	70 HMO	146.63	146.63	146.04	371.22	371.22	345.61
Molina	Choice Care silver	138.02	138.02	138.02	362.61	362.61	337.59
Oscar	70 EPO	137.74	137.74	137.76	362.33	362.33	337.33
Federal gov.	Public option	NA	149.26	NA	NA	373.85	NA
Gold-tier plans							
Anthem	80 HMO	225.01	225.01	219.01	449.60	449.60	418.58
Blue Shield	80 PPO	406.32	406.32	324.07	630.91	630.91	523.64
Blue Shield	80 Trio HMO	328.31	328.31	315.18	552.90	552.90	514.75
Health Net Life	80 EnhancedCare PPO	359.51	359.51	314.65	584.10	584.10	514.22
Health Net of CA	80 CommunityCare HMO	210.82	210.82	205.80	435.41	435.41	405.37
Kaiser Perm.	80 HMO copayment	241.72	241.72	234.57	466.31	466.31	434.13
Kaiser Perm.	80 HMO coinsurance	218.60	218.60	213.04	443.19	443.19	412.61
L.A. Care	80 HMO	159.20	159.20	157.74	383.79	383.79	357.31
Molina	Choice Care gold	149.15	149.15	148.38	373.74	373.74	347.95
Oscar	80 EPO	187.94	187.94	184.50	412.53	412.53	384.07

Sources: Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.
Notes: Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. Kaiser Perm. is Kaiser Permanente. Gov. is government. HMO is health maintenance organization. PPO is preferred provider organization. HDHP is high-deductible health plan. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates plus 10 percent; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates plus 10 percent.

Appendix B. Sensitivity Analysis to a Smaller Share of Premiums Being Attributable to Differences in Provider Payment Rates

APPENDIX TABLE B.1

Full (Unsubsidized) Monthly Premium for a 40-Year-Old Single Enrollee under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating regions 6 and 16

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16	
		Public option	Capped rates	Public option	Capped rates	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	495.64	NA	469.37	344.27	NA	NA
Blue Shield	60 HDHP PPO	477.73	NA	452.41	331.83	NA	NA
Kaiser Permanente	60 HMO	387.15	NA	366.63	284.17	NA	NA
Kaiser Permanente	60 HSA HMO	368.18	NA	348.67	270.24	NA	NA
Anthem	60 HMO	NA	335.92	NA	NA	335.92	294.43
Blue Shield	60 PPO	NA	417.60	NA	NA	417.60	321.71
Blue Shield	60 HDHP PPO	NA	402.51	NA	NA	402.51	310.09
Health Net Life	60 EnhancedCare PPO	NA	344.82	NA	NA	344.82	276.07
Health Net Life	60 HDHP EnhancedCare PPO	NA	342.06	NA	NA	342.06	273.86
Health Net of CA	60 PureCare HSP	NA	344.72	NA	NA	344.72	319.38
Kaiser Permanente	60 HMO	NA	314.54	NA	NA	314.54	281.81
Kaiser Permanente	60 HSA HMO	NA	299.13	NA	NA	299.13	268.01
L.A. Care	60 HMO	NA	287.21	NA	NA	287.21	264.06
Molina	Choice Care	NA	330.25	NA	NA	330.25	307.46
Oscar	60 EPO	NA	272.26	NA	NA	272.26	253.47

Insurer	Plan name	CURRENT LAW				REFORM SCENARIOS			
		Rating region 6		Rating region 16		Rating Region 6		Rating Region 16	
		Rating region 6	Rating region 16	Public option	Capped rates	Public option	Capped rates	Public option	Capped rates
Silver-tier plans									
Blue Shield	Silver 70 PPO	634.05	NA	600.45	440.41	NA	NA	NA	NA
Blue Shield	Silver 70 Trio HMO	546.19	NA	517.24	402.54	NA	NA	NA	NA
Kaiser Permanente	Silver 70 HMO	479.94	NA	454.50	352.28	NA	NA	NA	NA
Federal government	Public option	NA	NA	402.54	NA	NA	NA	NA	NA
Anthem	70 HMO	NA	406.97	NA	NA	406.97	356.71	356.71	356.71
Blue Shield	70 PPO	NA	534.22	NA	NA	534.22	411.55	411.55	411.55
Blue Shield	70 Trio HMO	NA	452.30	NA	NA	452.30	376.25	376.25	376.25
Health Net Life	70 EnhancedCare PPO	NA	490.52	NA	NA	490.52	392.72	392.72	392.72
Health Net of CA	70 CommunityCare HMO	NA	365.90	NA	NA	365.90	339.01	339.01	339.01
Kaiser Permanente	70 HMO	NA	389.94	NA	NA	389.94	349.37	349.37	349.37
L.A. Care	70 HMO	NA	371.22	NA	NA	371.22	341.30	341.30	341.30
Molina	Choice Care silver	NA	362.61	NA	NA	362.61	337.59	337.59	337.59
Oscar	70 EPO	NA	362.33	NA	NA	362.33	337.33	337.33	337.33
Federal government	Public option	NA	NA	NA	NA	NA	NA	NA	NA
Gold-tier plans									
Blue Shield	80 PPO	748.81	NA	709.12	520.12	NA	NA	NA	NA
Blue Shield	80 Trio HMO	667.66	NA	632.27	492.07	NA	NA	NA	NA
Kaiser Permanente	80 HMO copayment	573.94	NA	543.52	421.27	NA	NA	NA	NA
Kaiser Permanente	80 HMO coinsurance	545.49	NA	516.58	400.39	NA	NA	NA	NA
Anthem	80 HMO	NA	449.60	NA	NA	449.60	394.07	394.07	394.07
Blue Shield	80 PPO	NA	630.91	NA	NA	630.91	486.04	486.04	486.04
Blue Shield	80 Trio HMO	NA	552.90	NA	NA	552.90	459.93	459.93	459.93
Health Net Life	80 EnhancedCare PPO	NA	584.10	NA	NA	584.10	467.64	467.64	467.64
Health Net of CA	80 CommunityCare HMO	NA	435.41	NA	NA	435.41	403.41	403.41	403.41
Kaiser Permanente	80 HMO copayment	NA	466.31	NA	NA	466.31	417.79	417.79	417.79
Kaiser Permanente	80 HMO coinsurance	NA	443.19	NA	NA	443.19	397.08	397.08	397.08
L.A. Care	80 HMO	NA	383.79	NA	NA	383.79	352.86	352.86	352.86
Molina	Choice Care gold	NA	373.74	NA	NA	373.74	347.95	347.95	347.95
Oscar	80 EPO	NA	412.53	NA	NA	412.53	384.07	384.07	384.07

Source: Current-law premiums from CoveredCA.com; public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the region or scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates. Fifty percent of the full premium differential in each tier is assumed to be attributable to differences in provider payment rates.

APPENDIX TABLE B.2

Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020
In California rating region 6

Insurer	Plan name	200% of the Federal Poverty Level		400% of the Federal Poverty Level			
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	87.47	152.89	79.75	365.43	430.84	344.27
Blue Shield	60 HDHP PPO	69.56	135.93	67.31	347.52	413.88	331.83
Kaiser Permanente	60 HMO	0.00	50.15	19.65	256.94	328.10	284.17
Kaiser Permanente	60 HSA HMO	0.00	32.18	5.72	237.97	310.14	270.24
Silver-tier plans							
Blue Shield	70 PPO	225.88	283.96	175.89	503.84	561.92	440.41
Blue Shield	70 Trio HMO	138.02	200.76	138.02	415.98	478.71	402.54
Kaiser Permanente	70 HMO	71.77	138.02	87.75	349.73	415.98	352.28
Federal government	Public option	NA	86.06	NA	NA	364.01	NA
Gold-tier plans							
Blue Shield	80 PPO	340.64	392.64	255.60	618.60	670.60	520.12
Blue Shield	80 Trio HMO	259.49	315.79	227.54	537.45	593.75	492.07
Kaiser Permanente	80 HMO copayment	165.77	227.04	156.75	443.73	504.99	421.27
Kaiser Permanente	80 HMO coinsurance	137.32	200.10	135.87	415.28	478.05	400.39

Source: Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: Blue Shield is Blue Shield of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rate premiums assume caps for all plans are set at Medicare provider payment rates. Fifty percent of the full premium differential in each tier is assumed to be attributable to differences in provider payment rates.

APPENDIX TABLE B.3

Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating region 16

Insurer	Plan name	200% of the Federal Poverty Level			400% of the Federal Poverty Level		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Anthem	60 HMO	111.61	111.61	94.86	335.92	335.92	294.43
Blue Shield	60 PPO	193.29	193.29	122.14	417.60	417.60	321.71
Blue Shield	60 HDHP PPO	178.20	178.20	110.52	402.51	402.51	310.09
Health Net Life	60 EnhancedCare PPO	120.51	120.51	76.50	344.82	344.82	276.07
Health Net Life	60 HDHP EnhancedCare PPO	117.75	117.75	74.29	342.06	342.06	273.86
Health Net of CA	60 PureCare HSP	120.41	120.41	119.82	344.72	344.72	319.38
Kaiser Permanente	60 HMO	90.23	90.23	82.24	314.54	314.54	281.81
Kaiser Permanente	60 HSA HMO	74.82	74.82	68.44	299.13	299.13	268.01
L.A. Care	60 HMO	62.90	62.90	64.49	287.21	287.21	264.06
Molina	Choice Care	105.94	105.94	107.89	330.25	330.25	307.46
Oscar	60 EPO	47.95	47.95	53.90	272.26	272.26	253.47
Silver-tier plans							
Anthem	70 HMO	182.66	182.66	157.14	406.97	406.97	356.71
Blue Shield	70 PPO	309.91	309.91	211.98	534.22	534.22	411.55
Blue Shield	70 Trio HMO	227.99	227.99	176.68	452.30	452.30	376.25
Health Net Life	70 EnhancedCare PPO	266.21	266.21	193.15	490.52	490.52	392.72
Health Net of CA	70 CommunityCare HMO	141.59	141.59	139.44	365.90	365.90	339.01
Kaiser Permanente	70 HMO	165.63	165.63	149.80	389.94	389.94	349.37
L.A. Care	70 HMO	146.91	146.91	141.73	371.22	371.22	341.30
Molina	ChoiceCare silver	138.30	138.30	138.02	362.61	362.61	337.59
Oscar	70 EPO	138.02	138.02	137.76	362.33	362.33	337.33
Federal gov.	Public option	NA	113.28	NA	NA	337.59	NA
Gold-tier plans							
Anthem	80 HMO	225.29	225.29	194.51	449.60	449.60	394.07
Blue Shield	80 PPO	406.60	406.60	286.47	630.91	630.91	486.04
Blue Shield	80 Trio HMO	328.59	328.59	260.36	552.90	552.90	459.93
Health Net Life	80 EnhancedCare PPO	359.79	359.79	268.07	584.10	584.10	467.64
Health Net of CA	80 CommunityCare HMO	211.10	211.10	203.84	435.41	435.41	403.41
Kaiser Permanente	80 HMO copayment	242.00	242.00	218.22	466.31	466.31	417.79
Kaiser Permanente	80 HMO coinsurance	218.88	218.88	197.51	443.19	443.19	397.08
L.A. Care	80 HMO	159.48	159.48	153.29	383.79	383.79	352.86
Molina	Choice Care gold	149.43	149.43	148.38	373.74	373.74	347.95
Oscar	80 EPO	188.22	188.22	184.50	412.53	412.53	384.07

Source: Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

Notes: Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. Gov. is government. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rate premiums assume caps for all plans are set at Medicare provider payment rates. Fifty percent of the full premium differential in each tier is assumed to be attributable to differences in provider payment rates.

Notes

- ¹ Within each nongroup market rating region, the Health Insurance Policy Simulation Model uses Marketplace benchmark premiums and average premiums at each metal tier consistent with Marketplace data, but it does not currently model competing premiums within metal tiers in each rating region.
- ² “RBRVS Overview,” American Medical Association, accessed February 24, 2021, <https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview>.
- ³ The Medicare program achieves both broad provider networks and reasonably low provider payment rates simultaneously by prohibiting higher rates and balanced billing for Medicare enrollees. Because Medicare enrollees account for a large share of total health care spending (because they are elderly or have significant disabilities), few health care providers can opt out of participating with the Medicare program. The same is not true of those with nongroup health insurance, a small segment of the total health insurance market. In addition, Medicare Advantage plans can negotiate in-network provider payment rates close to Medicare payment rates and much lower than commercial payment rates. This is because of a provision in the Social Security Act that prohibits out-of-network providers from charging more than Medicare fee-for-service payment rates to treat Medicare beneficiaries.
- ⁴ See, for example, the [Choose Medicare Act](#), S. 1261, 116th Cong. (2019–20).
- ⁵ See pages 7 and 8 of Blumberg and colleagues (2020).
- ⁶ We estimated a regression with a dependent variable equal to the silver premium for each plan offered by a non-Medicaid insurer in 2019 in every Marketplace rating region nationally. Independent variables were rating region population; average Medicare wage index; binary variables for whether the rating region had two, three, four, or five or more insurers; interaction terms between the number of insurers in the rating region and whether a Medicaid insurer participated in the region that year; census region indicators (south, northeast, west); an indicator for whether the state had a pure community-rated nongroup insurance market; an indicator for whether the rating region was urban; an indicator for whether the rating region was in a Medicaid expansion state; an indicator for whether the rating region was in a federally facilitated Marketplace state; and indicators for hospital market concentration in the rating region (HHI between 2,501 and 5,000, HHI between 5,001 and 7,500, and HHI between 7,501 and 10,000). We compute the average effect on a private insurance premium of a Medicaid plan competing in the market as the difference between (1) the coefficient on the indicator for there being two insurers in the market and (2) the coefficient on the interaction term for there being two insurers competing and a Medicaid insurer present. We then compute the percentage effect by comparing that negative dollar difference with the average premium for insurers in markets with two non-Medicaid insurers competing.
- ⁷ We estimated capped payment rate savings for the lowest-priced and the second-lowest-priced silver plans using parallel regressions, the first with a dependent variable equal to the lowest silver premium in each rating region and the second with a dependent variable equal to the second-lowest silver premium in each rating region. Independent variables in each regression were rating region population; Medicare average wage index; hospital HHI; indicators for whether a Medicaid insurer, Blue Shield–affiliated insurer, a co-op, a national insurer, a provider-sponsored insurer, or a regional insurer participated in the market; an indicator for whether the rating region is in a state with pure community-rated nongroup markets; and indicators for the number of competing insurers in the Marketplace in the rating region (one, two, three, or four, with five or more excluded from the category). We used each regression to predict the expected premium if the market had at least five competing insurers and hospital HHI of at least 5,000. We used the difference between the average actual premium (lowest silver or second-lowest silver) and the predicted premium to calculate the expected savings if provider payment rates were capped at Medicare rates. For premiums above the benchmark premium, we assume in the base case that the plan premium falls by the estimated savings for the benchmark plan *plus two-*

thirds of the difference between that plan's and the benchmark's premiums. In the sensitivity analyses, we limit the additional savings to one-half the difference between the two premiums. We then computed the expected savings as a percentage of the current premium and applied this percent savings to the insurer's same product offered at different actuarial values. For example, we estimated capped payment rates at Medicare levels in California's rating region 16 would lower the Blue Shield silver PPO premium by about 28 percent. We then applied that 28 percent savings to Blue Shield bronze and gold PPO plans in the same rating region.

- ⁸ We estimate a regression with a dependent variable equal to the lowest-priced silver plan in the rating area and the same independent variables in the regression used to estimate the public option premium. In the same manner, we compute the percent change in premiums for the lowest-priced silver plan under highly competitive market conditions.
- ⁹ Lower payment rates may cause longer-run changes in supply, but those changes are beyond the scope of this analysis, which focuses on short-term effects.
- ¹⁰ Though not shown, one exception to this is the two bronze-tier Kaiser Permanente HMO plans would continue to be available at no household premium contribution for the illustrative 40-year-old with very low income (e.g., 150 percent of FPL).

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About the Author

Linda Blumberg is an Institute fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the *California v. Texas* and *King v. Burwell* cases, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a “Road Map to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed that state’s comprehensive health reforms in 2006.

Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. She has served on the Cancer Policy Institute’s advisory board and has served on the *Health Affairs* editorial board. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy.

Blumberg received her PhD in economics from the University of Michigan.

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How the American Rescue Plan Will Improve Affordability of Private Health Coverage

Karen Pollitz (<https://www.kff.org/person/karen-pollitz/>)

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The [American Rescue Plan](https://www.congress.gov/bill/117th-congress/house-bill/1319?q=%7B%22search%22%3A%5B%22hr+1319%22%5D%7D&s=1&r=1) (ARP), recently signed into law by President Biden, increases and expands eligibility for Affordable Care Act (ACA) premium subsidies for people enrolled in marketplace health plans. The law also creates new, temporary premium subsidies for COBRA continuation coverage; and it temporarily changes the rules for year-end tax reconciliation of marketplace premium subsidies. These changes will improve the affordability of coverage for individuals who are already enrolled in marketplace health plans, and will provide millions more an opportunity to newly sign up for coverage with increased financial assistance this year. The law also made changes to the [Medicaid](https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/) program designed to increase coverage, expand benefits, and adjust federal financing.

Expanded Marketplace Premium Subsidies

Under ARP, ACA marketplace premium subsidies are substantially enhanced for people at every income level and, for the first time, offered to those with income above 4 times the federal poverty level (FPL).

People up to 150% FPL can now get silver plans for zero premium with vastly reduced deductibles. Previously, marketplace premium subsidies were partial; no matter how poor, people had to contribute something toward the cost of the benchmark silver plan (i.e., the second lowest cost silver plan in their area). Those with income at 100% FPL had to contribute 2.07% of household income (\$264 per year in 2021) toward a benchmark plan; at 150% FPL that amount increased to 4.14% of household income (\$792 per year). Now under ARP, the benchmark marketplace plan will be fully subsidized for people earning up to 150% FPL. Cost sharing subsidies were already most generous at this income level (the average silver plan deductible for

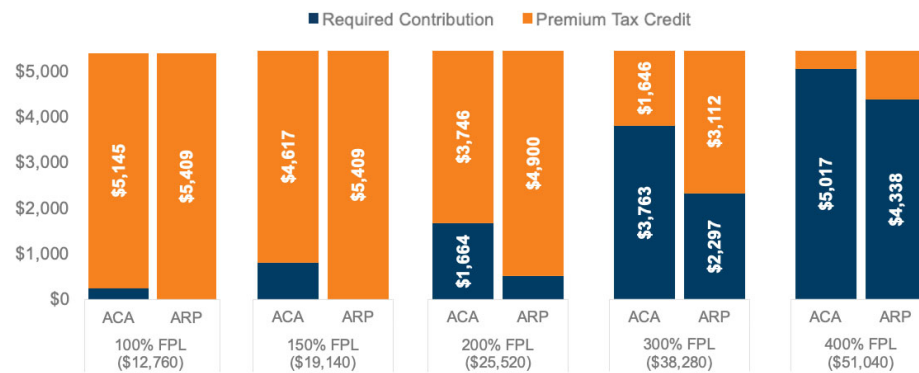
people at 150% FPL is **\$177** (<https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/>) this year). As a result, low income people now can qualify for premium-free silver plans with modest deductibles for covered health benefits.

Premium subsidies will also increase for people at higher income levels among those currently eligible for help with incomes up to 400% of the poverty level.

Premium tax credits will increase for people at every income level. (Figure 1) People with income of 200% FPL had been required to contribute \$1,664 toward the cost of the benchmark marketplace plan this year; now under the ARP they will have to contribute just \$510. At income of 400% FPL, people were required to contribute up to \$5,017 toward the benchmark plan premium, now they will be required to contribute no more than \$4,338 toward that plan.

Figure 1

Average Annual Benchmark Premium (\$5,409) Contribution and Tax Credit for a 40-year-old in 2021 Under ACA and ARP



Source: KFF, "Health Insurance Marketplace Calculator." Mar 10, 2021.

KFF

Figure 1: Average Annual Benchmark Premium (\$5,409) Contribution and Tax Credit for a 40-year-old in 2021 Under ACA and ARP

People with income above 400% FPL will be newly eligible for marketplace premium subsidies. Under the ACA, people with income above 400% FPL were not eligible for marketplace premium subsidies. Now, they will be required to contribute no more than 8.5% of household income toward the benchmark plan. This change will provide limited relief to younger marketplace participants – for example, for 24-year-olds in most areas, the unsubsidized age-rated benchmark plan premium already costs less than 8.5% of income for someone at 401% FPL – but will offer substantial relief for older individuals, where the unsubsidized premium averages nearly 25% of household income for someone at that same income level who is 64 years old. (Figure 2) Before this change, when they were ineligible for premium subsidies, some people with income above 400% FPL bought their insurance outside of the marketplace, or bought non-ACA compliant plans (such as short term policies). These individuals may want to return to the marketplace where coverage may now be more affordable and more comprehensive. The Biden Administration has reopened marketplace enrollment through May 15.

The ARP premium subsidy enhancements are effective during 2021 and 2022.

These changes to marketplace premium subsidies are temporary, in effect only during calendar years 2021 and 2022. The specifics and timeline for implementation of these changes is yet to be determined. However, once implemented, current enrollees may be able to sign into their marketplace account to increase the amount of advanced premium tax credit (APTC) they receive, thereby lowering their monthly health plan premium payment for the remainder of this year. Subsidies for current enrollees are retroactive to the beginning of this calendar year and can also be claimed as tax refunds when people file their 2021 tax return next year.

In HealthCare.gov states, current enrollees will also be able to change plans during the COVID enrollment period, which currently extends through May 15, 2021. People covered in state-based marketplaces should check with their marketplace for information about their ability to change plans as the new premium subsidies are implemented. Presently, some state-based marketplaces offer a COVID enrollment period when only uninsured individuals can sign up.

Enhanced Subsidies for Unemployed People

The ARP provides for enhanced marketplace subsidies for people who receive or are approved to receive unemployment insurance (UI) benefits during any week in 2021. The ARP also extends the current federal supplement (\$300 per week) to state UI benefits through September 6, 2021. The federal UI supplement is not taken into account in determining eligibility for Medicaid or CHIP.

When UI recipients apply for marketplace subsidies, special rules will be in effect during 2021.

Household income in excess of 133% FPL will be disregarded for purposes of

Figure 2

Average Annual Benchmark Premium in 2021 for a 24-year-old and 64-year-old at 401% of Poverty Under ACA and ARP

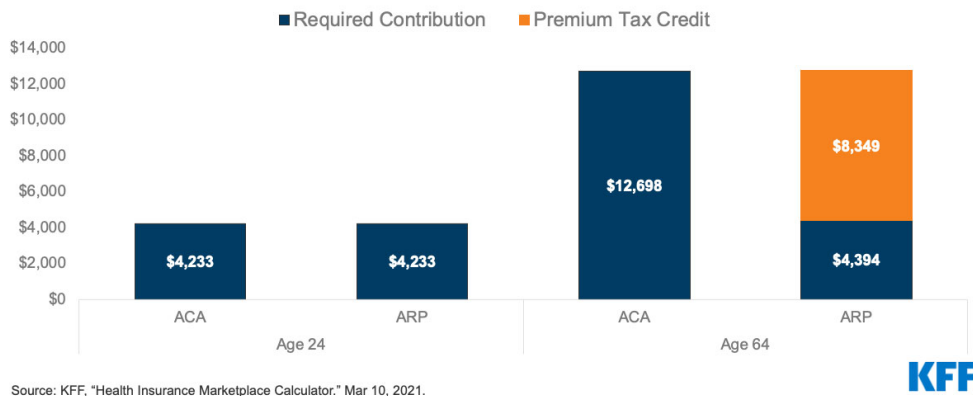


Figure 2: Average Annual Benchmark Premium in 2021 for a 24-year-old and 64-year-old at 401% of Poverty Under ACA and ARP

determining eligibility for marketplace premium and cost sharing subsidies in 2021. As a result, people who receive UI benefits at any time in 2021 will be eligible for a zero-premium benchmark silver plan with comprehensive cost sharing subsidies this year.

People receiving UI benefits will be considered "applicable taxpayers" during 2021. Normally under the ACA, to be eligible for marketplace subsidies, a person must qualify to be an "applicable taxpayer" which requires having an income of at least 100% FPL. Under the ARP, for 2021 only, people who receive UI benefits are defined to be an applicable taxpayer. That can help some UI recipients with income below the federal poverty level who live in states that have not adopted the ACA Medicaid expansion; they were otherwise in the "coverage gap," ineligible for both Medicaid and marketplace subsidies.

These enhanced marketplace subsidies for UI recipients are only for the 2021 coverage year.

Congress would need to enact further legislation to extend UI subsidy enhancements beyond this year.

People receiving UI benefits will still have to meet other requirements to be eligible for marketplace subsidies. In particular, married individuals must file a joint return to be eligible for subsidies. Using the married-filing-separately filing status generally makes a person ineligible for subsidies, though an exception is available for people who experience domestic abuse.

In addition, people receiving UI benefits may still be ineligible for marketplace subsidies if they have access to job-based health benefits that meet ACA standards for affordability and minimum value. The affordability of job-based coverage will continue to be measured based on household income, including UI benefits and amounts above 133% FPL.

Premium Tax Credit Repayment Holiday for 2020

When people apply for marketplace premium subsidies, they do so based on their estimated annual income for that tax year. Later, when they file federal tax returns for that year, people must reconcile their actual income with the amount of premium tax credit they received based on estimated income, and repay some or all of any excess premium tax credit (or receive an additional credit if actual income was lower than anticipated). Caps on the repayment amount apply, but if actual income exceeds 400% FPL, people must repay the entire amount of excess premium tax credit they received during the year.

Recognizing that the pandemic caused greater-than-usual economic disruption and uncertainty in 2020, the ARP waives repayment of any excess premium tax credit received by marketplace participants during that year.

Implementation questions remain to be addressed. Before the ARP was enacted, the Internal Revenue Service (IRS) had already finalized 2020 tax forms and schedules, which provide for APTC reconciliation and repayment of excess credits. Further action by the IRS will likely be forthcoming to educate the public about this new protection, advise on how to use it when filing the 2020 tax return, and to refund amounts to people who may have already filed their 2020 tax return with repayments.

Temporary COBRA Premium Subsidies for 2021

The ARP provides for temporary COBRA premium subsidies for up to 6 months during 2021. Subsidies will cover 100% of the monthly cost of COBRA while people are eligible. The law requires the former employer to pay the COBRA premium for subsidy-eligible individuals; the federal government will then reimburse the former employer for this cost.

The COBRA premium subsidies can be paid for coverage months no earlier than April 1, 2021 and no later than September 30, 2021. The subsidy can end earlier than September 30 in some circumstances. It ends when COBRA coverage is exhausted; so for example, someone who first became eligible for COBRA due to a job layoff on March 1, 2020 could continue in that plan for 18 months, or through August 2021. That person could claim the COBRA premium subsidy starting in April 2021, but the subsidy would stop when COBRA exhausts at the end of August. People also lose

eligibility for the COBRA premium subsidy once they become eligible for other job-based coverage. If this happens, people must notify their COBRA plan administrator or risk owing a penalty.

The subsidy is for people whose COBRA qualifying event involves termination of employment or reduction in hours worked. People are not eligible for the COBRA subsidy if they quit voluntarily. Nor are they eligible for subsidies if COBRA resulted from other qualifying events, including death of or divorce from the covered employee, the covered employee becoming entitled to Medicare, or loss of dependent child status.

People who became eligible for COBRA earlier in the pandemic can still elect it. Normally, people have up to 60 days from their qualifying event to elect COBRA continuation coverage. During the pandemic, however, people have additional time to elect COBRA (<https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01>), thanks to a COVID disaster relief notice issued by the Departments of Labor and Treasury. Their new COBRA election deadline will be the earlier of (1) one year from the date the person's election period would otherwise have ended, or (2) 60 days after the announced end of the COVID National Emergency. For example, a person who was laid off early in 2020 and whose deadline for electing COBRA was April 1, 2020 can now take until April 1, 2021 to elect COBRA. Going forward, a person who becomes newly eligible for COBRA can have her election period extended by up to 1 year (or until 60 days following the end of the National Emergency, whichever is earlier.) This emergency rule applies to election of COBRA arising from all qualifying events.

People who became eligible for COBRA earlier in the pandemic can have coverage start prospectively. Normally, once elected, COBRA coverage dates back to the qualifying event and premiums have to be paid retroactive to that point in time. This will remain the rule for subsidy-eligible people whose qualifying event occurs on or after April 1, 2021

However, under the ARP a special rule applies for subsidy-eligible individuals whose COBRA qualifying event pre-dates enactment of the ARP and who have not yet elected COBRA; or for such individuals if they previously elected COBRA but subsequently discontinued it, and who otherwise remain eligible for COBRA. When these individuals elect COBRA, coverage will commence on the first day of April 2021. Their COBRA coverage will not extend back in time before that date and they will not owe COBRA premiums prior to that date.

Eligible individuals who were already paying for COBRA when the law passed can also claim the subsidy.

COBRA premium subsidies are not counted as income to the individual. Subsidies will not affect a person's tax liability or eligibility for other income-related benefits.

People eligible for COBRA subsidies may also be eligible for marketplace subsidies or Medicaid. Just being eligible for COBRA does not affect a person's eligibility for marketplace subsidies or Medicaid. Those who have a choice will want to weigh their out of pocket costs (for premiums and cost sharing, net of subsidies), as well as any differences in plan provider networks, covered benefits, and other plan features. Generally, once a person enrolls in COBRA, she won't have an opportunity to choose marketplace coverage again until the earlier of the next open enrollment period or the date when she exhausts COBRA coverage.

When COBRA premium subsidies end, people can continue unsubsidized enrollment in COBRA. Of course, for many, unsubsidized COBRA may prove unaffordable. Generally, if a person terminates (or stops paying the premium for) COBRA before it exhausts, this loss of coverage does not make a person eligible for a special enrollment period (SEP) in the marketplace.

However, the marketplace has broad authority to recognize new SEP qualifying events. It remains to be seen if HealthCare.gov and state-based marketplaces will recognize termination of COBRA premium subsidies as a qualifying event and allow people the option to switch to more affordable marketplace plans and subsidies at that time.

Other ARP Changes and Affordability

Stimulus payments – The ARP provides for stimulus payments up to \$1,400 for qualifying individuals in 2021. These payments are considered tax credits and are not counted as income for purposes of tax liability or eligibility for income-based programs and benefits.

Exemption of UI benefits from federal income tax in 2020 – The ARP also included a provision exempting the first \$10,200 in UI benefits paid to an individual in 2020 from inclusion in that individual's adjusted gross income for that year, which will also lower countable income for the purposes of marketplace premium subsidies. As a result of this change, people who participated in the marketplace in 2020 may find they were eligible for greater premium tax credits than they claimed during the year. If so, people can receive unclaimed 2020 APTC as a refundable tax credit when they file their 2020 federal income tax return. People who already filed their 2020 return before the law was enacted should be able to claim the refund, as well.

Next steps?

These significant changes to make private coverage more affordable were enacted after many people had already enrolled in 2021 marketplace plans, after HealthCare.gov and state-based marketplaces had announced a time-limited special COVID enrollment opportunity, and after the 2020 tax filing season was underway. It will take time for federal and state agencies to implement these changes, including updates to marketplace subsidy eligibility systems, drafting of model notices, and

revision of tax forms. The Department of Health and Human Services has [announced](https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace) (<https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace>) that the enhanced ACA premium subsidies will be available through HealthCare.gov beginning April 1, but other changes in the ARP may take more time. Under the current special COVID enrollment period, people will have until May 15 to newly sign up for coverage or change plans to take advantage of the additional help.

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Introducing a Public Option or Capped Provider Payment Rates into Concentrated Insurer and Hospital Markets

John Holahan and Michael Simpson

March 2021

In recent years, we have conducted several analyses of public option and capped provider payment rate proposals, policies primarily intended to reduce health care spending (Blumberg et al. 2019, 2020; Blumberg, Simpson, and Buettgens 2019). Here and in two accompanying papers (Gangopadhyaya and O'Brien 2021; Holahan and Simpson 2021a, 2021b), we consider such policies that would be introduced into either the nongroup health insurance market alone or both the nongroup and employer insurance markets. For this analysis, we consider reforms that would introduce these options only into markets where either insurers or hospitals or both are concentrated. Though a public option and capped rates are controversial policy tools, limiting such reforms to markets where provider or insurer concentration has led to higher costs might make them more politically acceptable, because the reforms would not interfere in competitive markets.

We show introducing a public option into nongroup markets only in concentrated areas would increase coverage and reduce spending almost as much as introducing them nationwide (i.e., in both concentrated and competitive areas). Introducing these reforms into concentrated markets has a considerable impact, because 42 percent of the population below age 65 lives in a region with a concentrated hospital market and 55 percent live in a region with either a concentrated hospital or nongroup insurance market. In addition, because premiums in concentrated markets are higher, premium reductions can be larger under reforms. Finally, even though the public option or capped rates are applied to concentrated markets, we find some spillover to competitive markets, because the

reforms affect firms providing insurance to workers in both concentrated and competitive markets. The savings resulting from the public option or capped rates in nongroup markets is relatively small; savings are greater when the public option is extended to employer markets, and greater yet when payment rates by all insurers are capped.

We consider concentration in both hospital and insurance markets. When the hospital market is concentrated, payments for health services are high because the limited number of hospital options gives hospitals considerable market power in negotiating with private insurers. When insurance markets are concentrated, particularly in the nongroup market, costs are high because, though insurers may have leverage relative to hospitals, they have fewer incentives to pass on the savings. Consequently, insurance premiums are higher than they would be absent additional competition or rate regulation. Across rating regions established under the Affordable Care Act, insurer and hospital concentration overlaps considerably.

As we have described elsewhere (Blumberg et al. 2020), the public option would be a government-developed insurance plan that uses a fee schedule and pays providers (doctors, hospitals, and prescription-drug manufacturers) rates below those typical of commercial insurers. Capped payment rates would establish maximum rates any insurer would pay providers. The public option could be introduced alone or with capped provider payment rates, as with Medicare Advantage. The public option could be available in, and thereby increase competition in, the markets with only one or two insurers, as well as in markets with high hospital concentration. Individuals would have to enroll in a new plan to take advantage of the full cost savings. The competition from a public option could result in more aggressive negotiations between private insurers and providers, resulting in lower private plan premiums. If private insurers cannot successfully negotiate payment rates with providers, they may have to leave the market.

Capping provider payment rates would require all providers to accept payments no higher than a specified rate, typically lower than commercial insurers' current rates. As noted, capped rates could be implemented alone or along with a public option, as they currently work in Medicare Advantage. Capped provider payments would allow consumers to take advantage of cost savings with any participating insurer (i.e., without having to enroll in a public option), because those insurers would benefit from the capped provider payment rates. Unlike implementing a public option alone, implementing capped rates alone would likely result in more private insurers entering and staying in markets.

In this paper, we estimate the effects of applying a public option or capped provider payment rates just in concentrated markets. Payment rates in competitive markets are unaffected. We consider hospital markets concentrated if the hospital Herfindahl-Hirschman Index (HHI) is 5,000 or greater and insurer markets concentrated if they have one or two insurers. The reforms would decrease premiums in concentrated markets. With lower caps on payment rates in concentrated markets, provider payment rates could drop to the level seen in some competitive markets.

We also analyze approaches that would extend the public option or capped provider payment rates to both nongroup and employer insurance markets. To take advantage of potential savings from a public option, an employer would have to switch coverage for the firm's workers into that new plan. Consistent with our earlier work, we assume a firm's decision about whether to switch into the public option varies with its wages and size: The smaller the firm and the lower its average wage, the more likely it will switch from its current insurance to the public option. Large and high-wage firms would be more likely to remain with their current coverage, despite its higher payment rates relative to those for the public option, because they can tailor benefit packages, cost sharing, out-of-pocket limits, and provider networks to their employees' needs. We also assume employers would have to save at least 20 percent in premiums to make switching sufficiently attractive.

As noted, the reforms simulated do not affect payment rates in competitive markets. In concentrated markets, we set payment rates at Medicare levels in public option 1, Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals in public option 2, and Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals in public option 3. In public options 4 and 5, the public option is available to employers in concentrated hospital markets. In concentrated markets, public option 4 would pay providers Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals. Public option 5 would pay Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. At firms with employees living in both concentrated and competitive areas, hospital and provider payments would be reduced only for employees in concentrated areas. However, the resulting premium reductions would be spread across the entire firm. In the two capped provider payment rate options we examine, capped rates would be introduced into concentrated nongroup and employer markets. The first of those reforms, capped rates 1, sets payment rates at Medicare plus 10 percent for professionals and plus 25 percent for hospitals. The second reform, capped rates 2, pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. In each policy option, we assume prescription drug savings would apply in both concentrated and competitive markets. We also assume legislation establishing a public option would set prescription drug rebates halfway between those for Medicare and Medicaid and would take effect nationally, reflecting that prescription drugs are sold in a national market, not local markets. Markets for prescription drugs differ from those for hospitals and professionals, and the arguments for exempting competitive areas do not apply to prescription drugs; under the reforms examined, access to prescription drugs is unlikely to be affected, because drugs are priced nationally. We estimate elsewhere these savings approximate a 30 percent cut relative to commercial payments (Hwang and Kesselheim 2020).

Characteristics of Concentrated and Competitive Markets

Table 1 shows that 117 million people live in a concentrated hospital market in 2022, whereas 160 million reside in a competitive hospital market. Including concentrated nongroup insurance markets, 154 million people live in a concentrated hospital or insurer market (or where both are concentrated).¹ Those living in competitive markets tend to have higher average family incomes than those in concentrated markets (\$77,800 versus \$64,700). Forty-two percent of the population below age 65 live in a concentrated hospital market, and 55 percent live where either the hospital or insurance market is concentrated (table 1). In addition, almost all rural residents live in concentrated markets, far more than urban residents. On the other hand, 58 percent of those in concentrated hospital markets live in urban markets, and 67 percent of those in concentrated insurer or hospital markets live in urban markets. Thus, a policy targeted at concentrated markets will have a larger impact on urban areas.

TABLE 1
Characteristics of Concentrated and Competitive Regions, 2022

	Hospital markets ^a		Hospital markets and/or ACA nongroup insurance markets ^b	
	Competitive	Concentrated	Competitive	Concentrated
Population				
Millions under age 65	160	117	124	154
Share under age 65	58%	42%	45%	55%
Average age	38.8	40.0	38.6	39.9
Average age of people younger than 65	31.8	32.1	31.7	32.1
Health insurance coverage among people under 65				
Employer	54%	54%	54%	53%
ACA-compliant nongroup	6%	5%	6%	5%
Medicaid/CHIP	26%	25%	26%	26%
Other public	2%	4%	2%	4%
Uninsured	12%	11%	11%	11%
Short-term, limited duration plan	1%	1%	1%	1%
Average family income among people under 65				
Thousands of dollars	77.8	64.7	78.0	67.7
As a share of FPL	400%	336%	399%	351%
Share of population below age 65 in				
Urban areas	70%	30%	54%	46%
Rural areas	7%	93%	6%	94%
Share of people under 65 living in concentrated/competitive areas in				
Urban areas	98%	58%	98%	67%
Rural areas	2%	42%	2%	33%
Millions of people under 65 if hospital concentration threshold were HHI > 2,500				
	87	190	77	201

Source: Health Insurance Policy Simulation Model (HIPSM), 2021.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program. FPL = federal poverty level. HHI = Herfindahl-Hirschman Index. HIPSM models coverage and incomes by public-use microdata areas (PUMAs). PUMA borders do not always align with those for rating regions established under the Affordable Care Act.

^a Concentrated hospital markets (HHI > 5,000) only; used in nongroup and employer reforms.

^b Concentrated hospital markets (HHI > 5,000) and/or concentrated ACA nongroup insurers (2 or fewer); used in nongroup-only reforms.

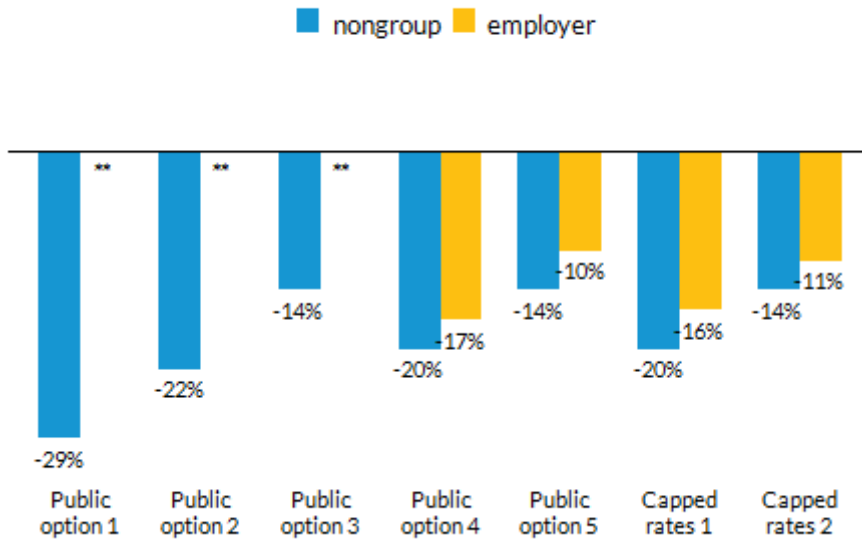
Table 1 also shows the number of people affected under a less restrictive definition of hospital concentration; using HHI of 2,500, per the Federal Trade Commission guideline (rather than 5,000), the number of people living in concentrated hospital regions would be 190 million (rather than 117 million), meaning a public option or capped rates would affect more rating regions and more people.

Highlights of Findings

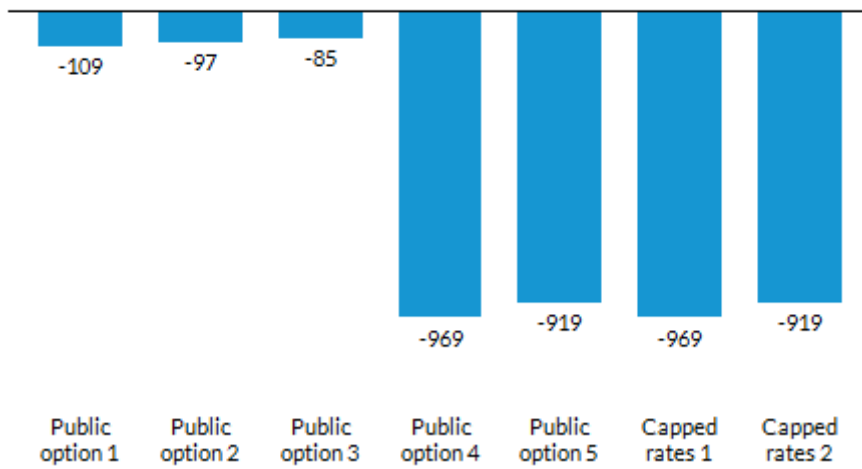
In this section, and in figure 1 and table 2, we summarize our main findings; supplementary tables at the end of the paper show additional details. All estimates assume reforms are fully implemented in 2022. We acknowledge considerable uncertainty surrounding these estimates, which we detail in the methods section. Our primary limitation is the absence of ideal data sources, which forces us to make assumptions and use proxy measures in some areas.

FIGURE 1
Summary of Effects of Reform Options on Concentrated Areas, 2022

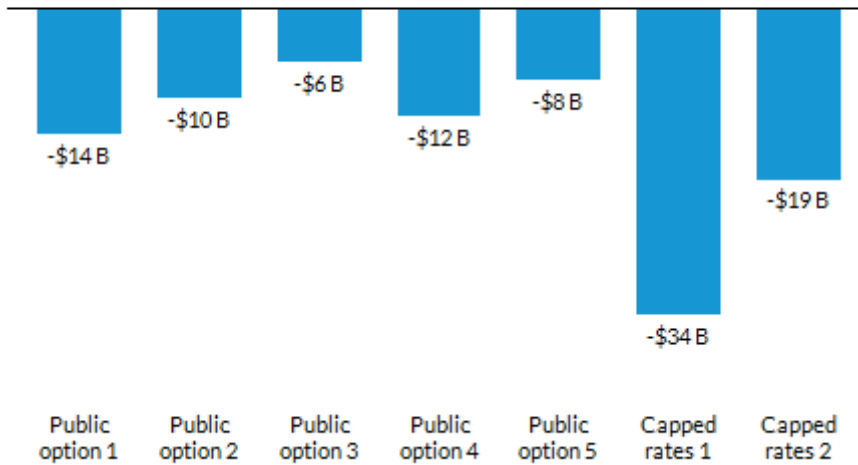
On median premiums



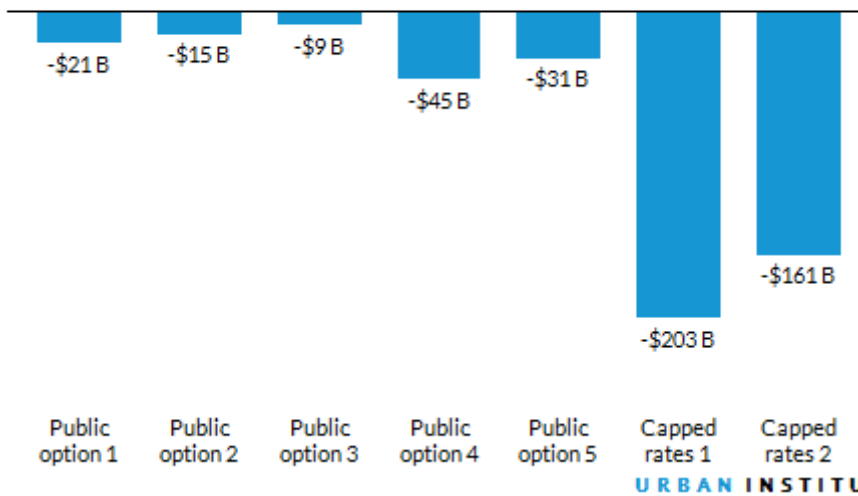
On thousands of people uninsured



On the federal deficit



On health system spending



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Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022.

- **Premium and coverage in the nongroup market.** We estimate a nongroup public option would lower median premiums by 14 to 29 percent in concentrated markets. The greatest reductions in premiums would occur under reforms with the greatest impact on provider payment rates. We estimate premiums in competitive markets would fall by 7 percent, because we apply increases in prescription-drug rebates to all areas. The coverage effects would be small;

additional policies that expand subsidies would be needed to improve coverage, but we do not consider them here.

- **Federal household and employer health spending in the nongroup market.** Lower nongroup premiums would result in lower federal spending, primarily on premium tax credits; the reduction would range from \$6 to \$14 billion. Household spending would fall by \$3 to \$7 billion, about 1 percent of aggregate household spending. Employer spending would be unaffected.
- **Premiums and coverage in the employer market.** A public option or capped provider payment rates tend to lower premiums about the same in concentrated employer and nongroup markets. Under reforms that extend the public option to employer markets, we estimate median premiums for participating employers would fall by 10 to 17 percent. Reductions in premiums would be larger for options with greater reductions in provider payment rates. Offering the public option or capped payment rates in the employer market could reduce the number of people uninsured by 919,000 to 969,000.
- **Employer and household spending.** Extending the public option or capped rates to the employer market would have significant effects. When the public option is extended to employer markets, employer spending falls from between \$10 to \$16 billion in 2022. Savings under capped provider payment rates are greater, ranging from \$91 to \$117 billion. With a public option alone, household spending falls by \$13 to \$19 billion; under capped rates, household spending falls by \$62 to \$75 billion. Savings for employers and households are significantly larger under capped rates because all employers benefit; under the public option many employers choose not to participate given limited savings.
- **Federal spending and income tax revenue.** Economic research indicates employers convert savings on premiums into higher wages for their workers, which are taxable and therefore contribute to a reduction in the federal deficit. When the reforms are introduced into the employer market, the federal deficit falls by \$8 to \$12 billion under a public option and by \$19 to \$34 billion under capped rates.
- **National health spending.** National health spending on the nonelderly falls by less than 1 percent when the public option is limited to the nongroup market in concentrated areas. If a public option is available to employers as well, spending by all payers could fall by as much as 2 percent, depending on the payment rates used. Under capped provider payment rates, spending by all payers could fall by as much as 10 percent.
- **The effect of limiting policy to concentrated markets only.** When the nongroup market reforms in concentrated markets simulated here are extended nationally, spending by employers, households, and the health system changes little, particularly in the nongroup market. That is, extending these reforms to competitive nongroup markets does not generate much savings. Extending the public option and capped rates to employer markets nationally would have larger effects on employer, household, and health system spending. When rate cuts are available only in concentrated areas under a public option, only firms with a

significant share of employees in concentrated areas will save enough to select into the public option. Many more firms will select the option when all employees see savings under a national reform. Savings under capped rates increase with the number of employees eligible. For example, extending public option 4 to all markets would reduce national health spending by \$111 billion more than limiting the reform to concentrated markets (\$156 billion versus \$45 billion); extending capped rates 1 to all markets would reduce national health spending by \$129 billion more than limiting the reform to concentrated markets (\$331 billion versus \$203 billion).

TABLE 2

Public Option and Capped Provider Payment Rate Reform Options for Concentrated Markets, 2022

Reform	Availability of public option	Payment policy ^a	Change									
			In median nongroup premiums ^b	In median employer premiums ^c	In number of uninsured	In the federal deficit ^d	In employer spending	In household spending	In health system spending			
Public option 1	Nongroup in concentrated hospital or insurer markets	Medicare rates										
Public option 2	Nongroup in concentrated hospital or insurer markets	Medicare rates plus 10% for professionals and plus 25% for hospitals	-29%	NA	-109,000	-\$14 B	*	-\$7 B (-1%)	-\$21 B (-1%)			
Public option 3	Nongroup in concentrated hospital or insurer markets	Medicare rates plus 15% for professionals and plus 60% for hospitals	-22%	NA	-97,000	-\$10 B	*	-\$5 B (-1%)	-\$15 B (-1%)			
Public option 4	Nongroup and employer markets; concentrated hospital markets; subset of firms choose public option	Medicare rates plus 10% for professionals and plus 25% for hospitals	-14%	NA	-85,000	-\$6 B	*	-\$3 B (-1%)	-\$9 B (**)			
Public option 5	Nongroup and employer markets; concentrated hospital markets; subset of firms choose public option	Medicare rates plus 15% for professionals and plus 60% for hospitals	-20%	-17%	-969,000	-\$12 B		-\$16 B (-2%)	-\$45 B (-2%)			
Capped rates 1	Nongroup and employer markets; concentrated hospital markets; all employers pay lower rates	Medicare rates plus 10% for professionals and plus 25% for hospitals	-14%	-10%	-919,000	-\$8 B		-\$10 B (-1%)	-\$31 B (-1%)			
			-20%	-16%	-969,000	-\$34 B		-\$117 B (-15%)	-\$75 B (-13%)	-\$203 B (-10%)		

Reform	Availability of public option	Payment policy ^a	Change						
			In median nongroup premiums ^b	In median employer premiums ^c	In number of uninsured	In the federal deficit ^d	In employer spending	In household spending	In health system spending
Capped rates 2	Nongroup and employer markets; concentrated hospital markets; all employers pay lower rates	Medicare rates plus 15% for professionals and plus 60% for hospitals	-14%	-11%	-919,000	-\$19 B	-\$91 B (-11%)	-\$62 B (-10%)	-\$161 B (-8%)

Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

^a Prescription drug prices in each reform scenario are assumed to be halfway between Medicare and Medicaid prices in all (concentrated and unconcentrated) markets.

^b This column shows the change in the median nongroup benchmark premium in concentrated markets.

^c This column shows the change in median premiums in concentrated markets among employers providing the public option to their workers in public options 4 and 5. In capped rates 1 and 2, this column shows the change in median premiums for all employers in concentrated markets.

^d Estimates in this column equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

Projected Impacts of Public Option and Capped Provider Payment Rate Proposals Limited to Concentrated Markets

In the results below, we present estimated changes in median nongroup and employer premiums, health insurance coverage, and health care spending by households, employers, and the federal government. We show the estimated increase in federal income tax revenue that results when employers save on health insurance costs and pass those savings on to workers via higher wages, which, in turn, results in higher tax payments. We show the impact on the federal deficit, which is a combination of the reduction in federal government spending (primarily from lower spending on Marketplace premium tax credits) and the increased income tax revenue.

All estimates assume the reforms are fully phased in and in equilibrium in 2022. This means the supply of services is assumed to expand to meet the increased demand for services. (We also assume services provided are unaffected by decreased provider payments.) In reality, it is more likely the reforms would require a multiyear phase-in, over which payment rates would decrease toward target levels. How long the phase-in would take would determine the underlying savings to households, employers, and the federal government. The slower the pace of payment rate reductions, the less potentially disruptive to the health system and the more politically feasible the reform will likely be. The results below are for policies exempting competitive markets (except when estimating prescription-drug savings), which reduces premiums in all nongroup markets by 7 percent.

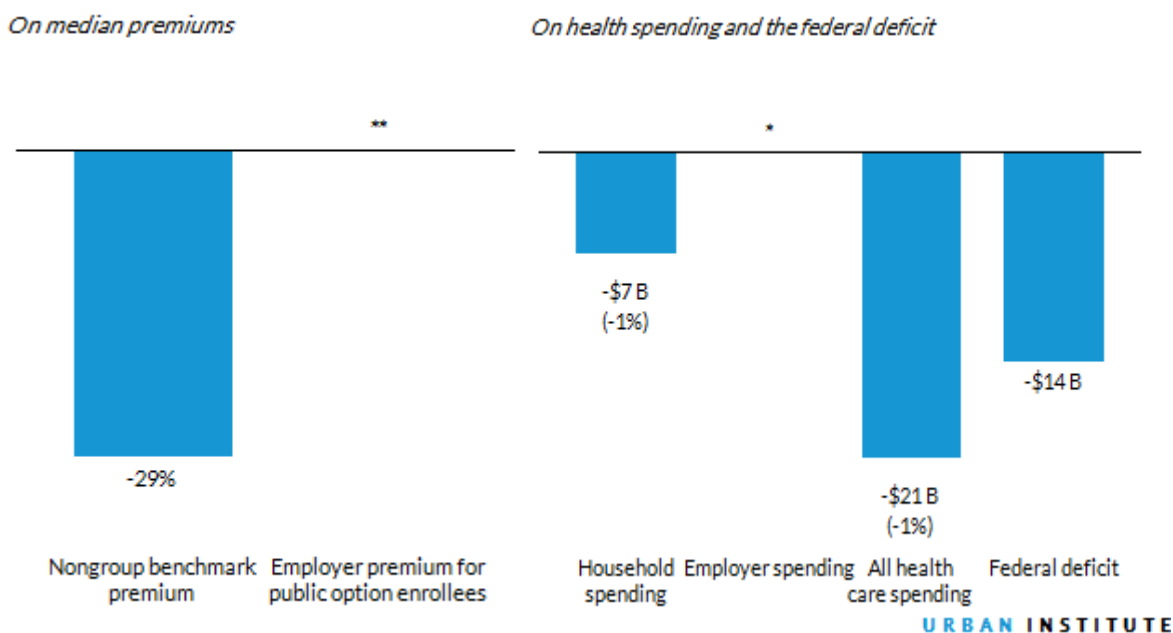
Public Option 1: Medicare Rates in Nongroup Markets

- a public option in the private nongroup insurance market in concentrated areas
- pays Medicare rates to hospitals and professionals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all nongroup markets

Premium and coverage effects. Under this reform, the median benchmark premium in the nongroup market falls by 29 percent in concentrated markets. The number of uninsured people falls by 109,000, a small effect because the reform only affects households facing full, unsubsidized nongroup premiums.

Health care spending. Because benchmark nongroup premiums fall in concentrated markets and tax credits are tied to premiums, tax credits also fall in these areas. Federal health spending, and thus the federal deficit, falls by \$14 billion, or 3 percent. Aggregate household spending falls by \$7 billion, or 1 percent. Employer spending is essentially unaffected. Overall health spending falls by \$21 billion, or 1 percent.

FIGURE 2
Effects of Public Option 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

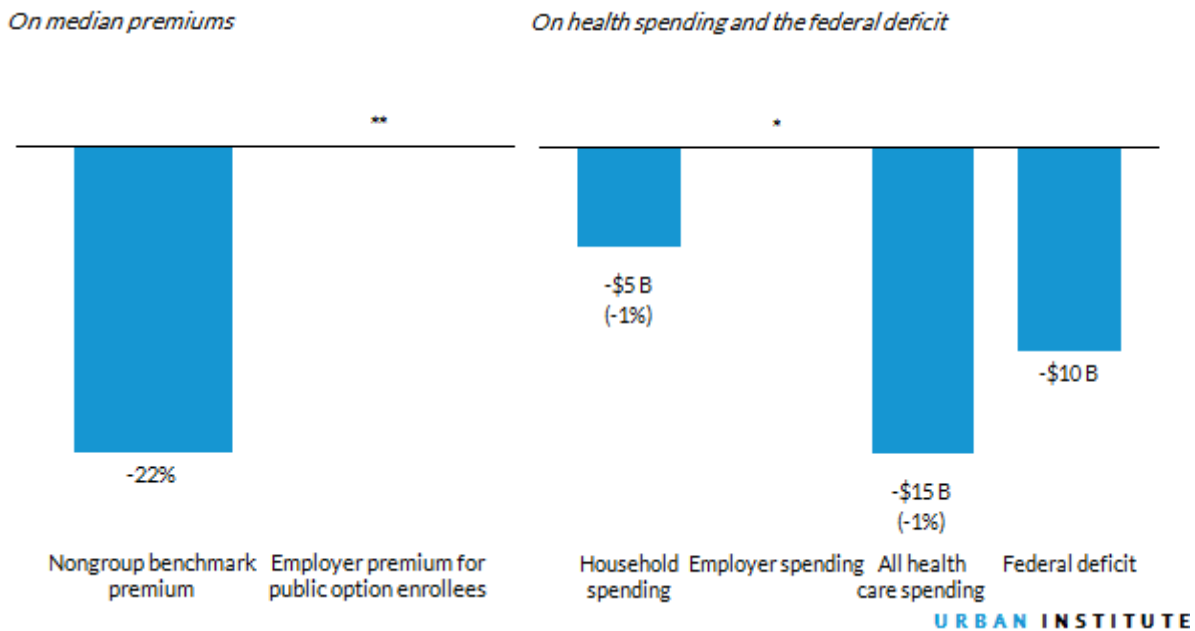
Public Option 2: Medicare Rates with Modest Upward Adjustments in Nongroup Markets

- a public option in nongroup markets in concentrated areas
- pays Medicare rates plus 10 percent for providers and plus 25 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all nongroup markets

Premium and coverage effects. The median benchmark premium falls by 22 percent in this scenario, because higher provider payment rates than those in public option 1 reduce the impact on premiums, meaning premium savings are lower. The impact on the uninsured population is also smaller; 97,000 fewer people are uninsured.

Health care spending. Federal health spending, primarily on Marketplace premium tax credits, falls by \$10 billion. Aggregate household spending falls by \$5 billion, or 1 percent. Again, employer spending is largely unaffected. Overall spending falls by \$15 billion, or 1 percent.

FIGURE 3
Effects of Public Option 2



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

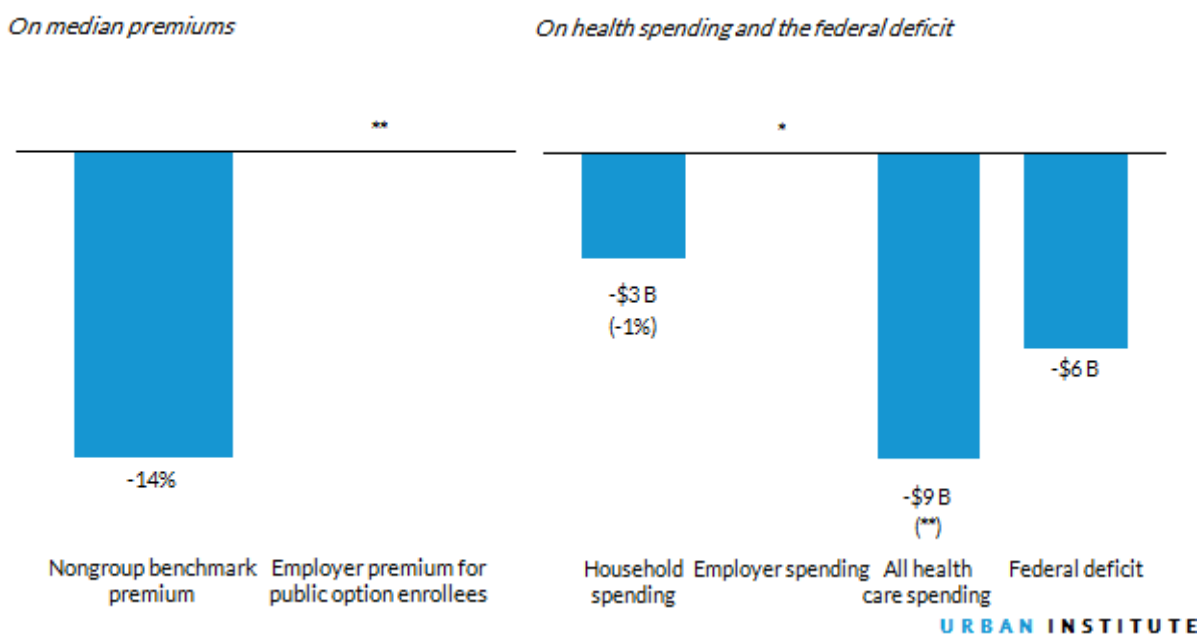
Public Option 3: Medicare Rates with Large Upward Adjustments in Nongroup Markets

- a public option in private nongroup insurance markets in concentrated areas
- pays Medicare rates plus 15 percent for providers and plus 60 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all nongroup markets

Premium and coverage effects. Premiums fall by 14 percent because of the higher provider payment rates. The number of uninsured falls by 85,000, which is a smaller reduction than under public options 1 and 2 because of the smaller reduction in premiums.

Health care spending. Federal health spending falls by \$6 billion, because smaller reductions in premiums under this reform mean smaller savings than under public options 1 and 2. Aggregate household spending falls by \$3 billion, or 1 percent. Employer spending is again unaffected. Overall spending falls by \$9 billion, or less than 0.5 percent.

FIGURE 4
Effects of Public Option 3



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

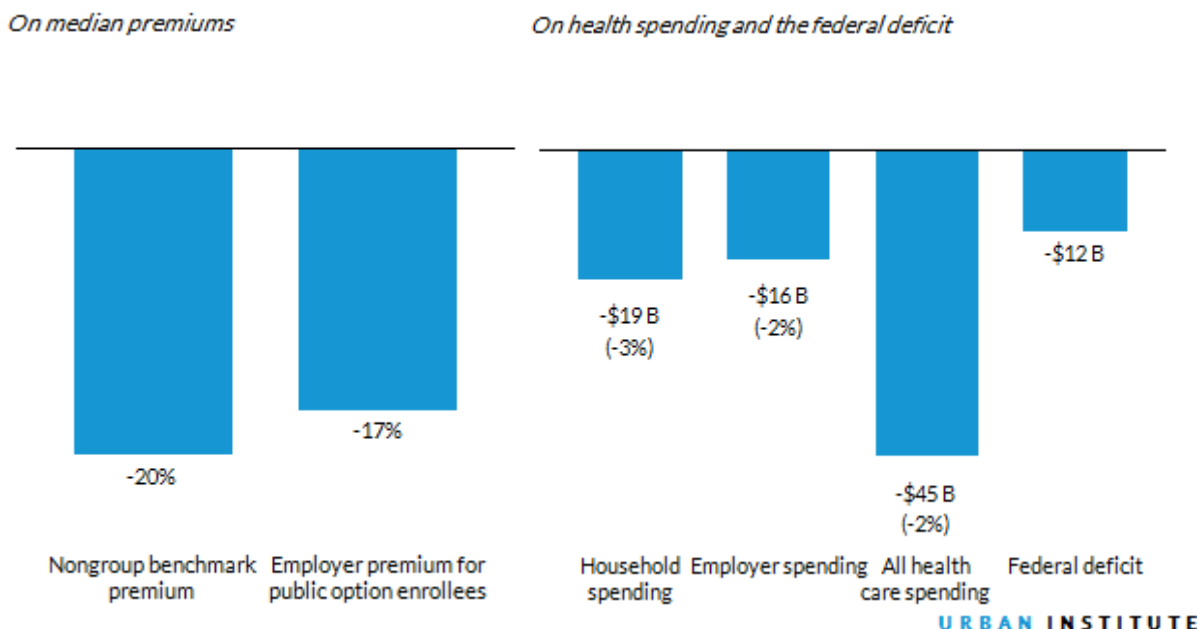
Public Option 4: Payment Rates Modestly above Medicare Levels in Nongroup and Employer Markets

- a public option available to employer and nongroup insurance markets in concentrated areas
- public option pays Medicare rates plus 10 percent for professionals and 25 percent for hospitals in concentrated markets
- public option prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median premiums fall by 20 percent in nongroup markets and by 17 percent for employers choosing the public option. Employer coverage increases by 1.2 million people (not shown), and the number of people uninsured falls by 969,000.

Health care spending. Federal spending, primarily on premium tax credits, declines by \$10 billion, or 2 percent. Aggregate household spending falls by \$19 billion, or by 3 percent. Employer spending falls by \$16 billion, or 2 percent. Lower employer spending on health care results in higher wages and, in turn, increases federal tax payments, generating \$2 billion in new tax revenue. The net effect on the federal deficit is a \$12 billion reduction. Overall health spending declines by \$45 billion, or 2 percent.

FIGURE 5
Effects of Public Option 4



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

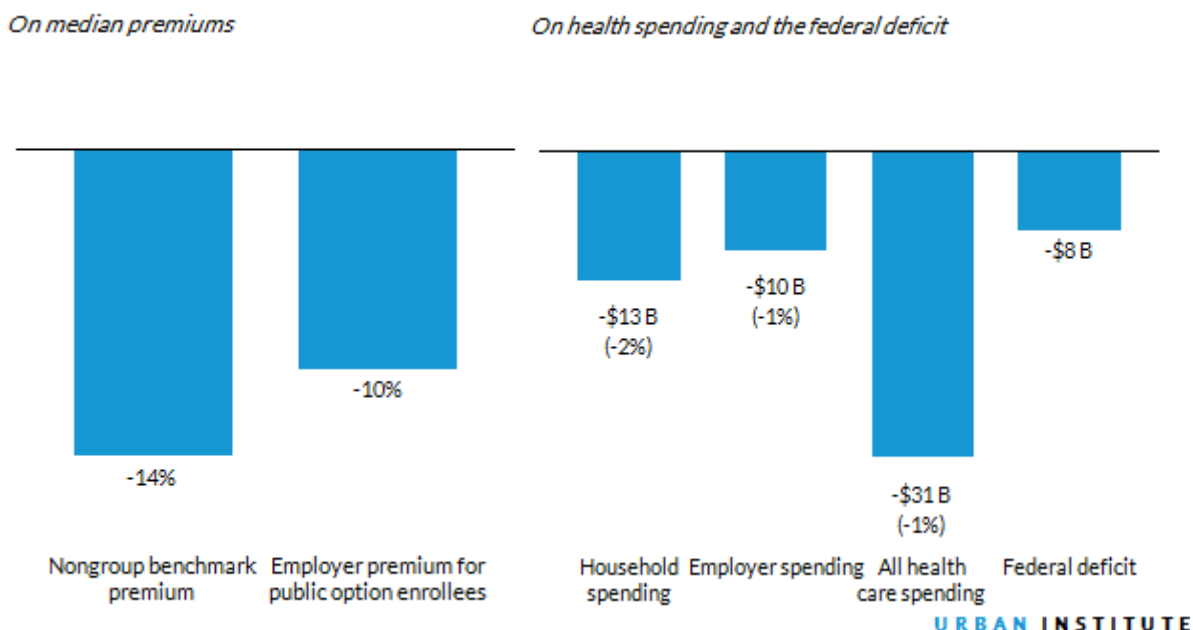
Public Option 5: Payment Rates Considerably above Medicare Levels in Nongroup and Employer Markets

- a public option available to employer and nongroup insurance markets in concentrated areas
- public option pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in concentrated markets
- public option prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Because of higher payment rates, premiums fall only by 14 percent in the nongroup market. Premiums for employers choosing the public option fall by 10 percent. Extending the new, less expensive public option to the employer market increases employer coverage by 1.1 million people and reduces the number of people uninsured by 919,000.

Health care spending. Spending by the federal government falls by almost \$8 billion, less than in public option 4 because the higher provider payment rates reduce the impact on premiums. Households save \$13 billion, or 2 percent. Employers save \$10 billion, or 1 percent. Employer savings translate to increased wages, which results in about \$500 million in new federal revenues. The federal deficit is reduced by \$8 billion. Overall spending declines by \$31 billion, or 1 percent.

FIGURE 6
Effects of Public Option 5



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billions. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

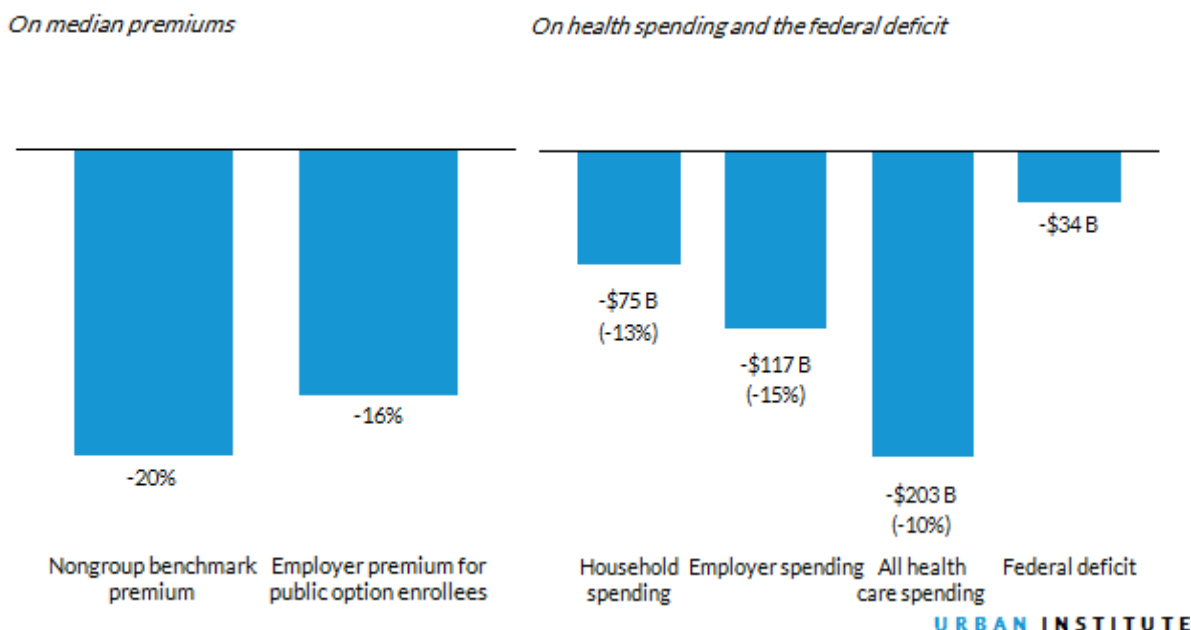
Capped Rates 1: Payment Rates Capped Somewhat above Medicare Levels in the Nongroup and Employer Markets

- payment rates capped for all insurers in employer and nongroup markets in concentrated areas
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Premiums fall by 20 percent in nongroup markets and by 16 percent in employer markets. About 1.2 million people gain employer coverage, and 969,000 fewer people are uninsured.

Health care spending. Capped provider payment rates decrease spending more than public option-only reforms because all insurers benefit from capped provider payment rates. Federal spending falls by \$10 billion, or 2 percent, almost entirely because of lower premium tax credits in the nongroup market. Household spending falls by \$75 billion, or 13 percent. Employers save \$117 billion, or 15 percent. As employers pass savings on to workers via higher wages, tax payments increase by \$24 billion, reducing the federal deficit by \$34 billion. Overall spending falls by \$203 billion, or 10 percent.

FIGURE 7
Effects of Capped Rates 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

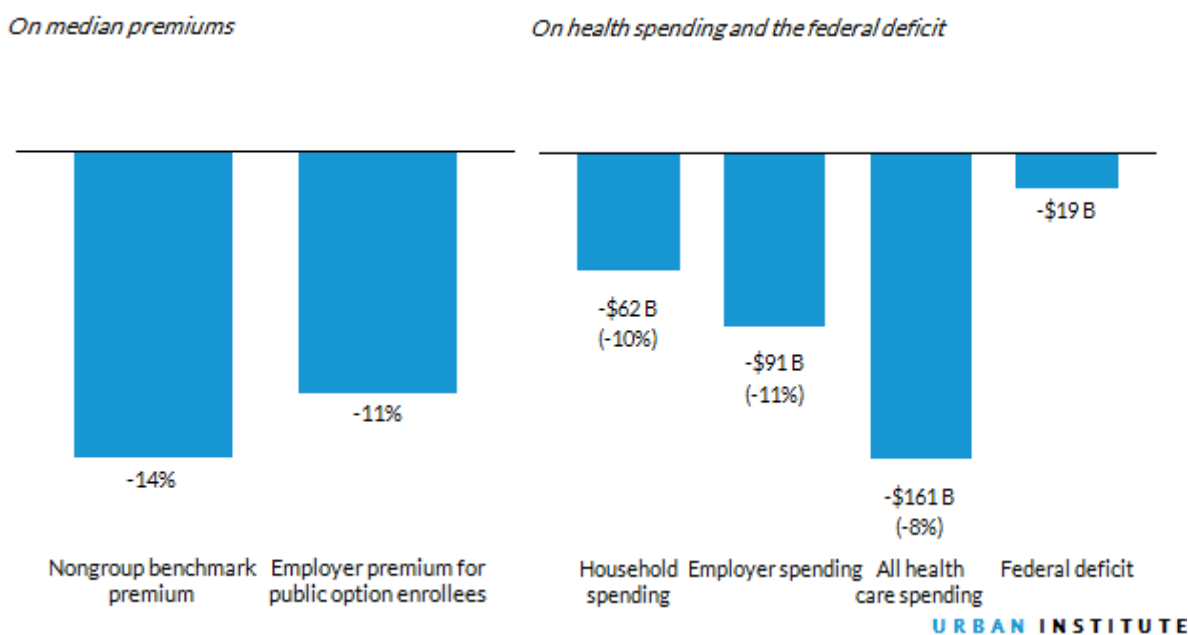
Capped Rates 2: Payment Rates Capped Considerably above Medicare Levels in the Nongroup and Employer Markets

- payment rates capped for all insurers in employer and nongroup markets in concentrated areas
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Premiums fall by 14 percent in the nongroup market and 11 percent in the employer market. The number of people uninsured falls by 919,000.

Health care spending. Under this reform, savings are smaller than under capped rate 1 because of the higher provider payment rates. Households save \$62 billion, or 10 percent. Employers save \$91 billion, or 11 percent. Federal spending on subsidies falls by almost \$8 billion. Increased tax revenues (because of higher wages) total almost \$12 billion. Thus, the net effect on the deficit is a \$19 billion reduction. Overall spending falls by \$161 billion, or 8 percent.

FIGURE 8
Effect of Capped Rates 2



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Impact of Extending Reforms to All Regions

Introducing a public option or capping provider payment rates in concentrated areas in the nongroup market would capture most of the reductions in uninsurance, medical spending, and the federal deficit that would result from a similar reform applied nationally (table 3), because most of the reductions in uninsurance, medical spending, and the federal deficit resulting from a national reform would occur in concentrated markets. That is, if public option 2 were extended to all areas, spending would decrease very little because competition in nongroup markets without concentrated hospital or insurer markets have, by our estimation, already lowered prices to about Medicare levels. The reform modeled pays providers whichever is lower: Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals or the current rates providers receive. Thus, most of these regions would see no change in payment rates under reform (other than the prescription drug savings all regions get). Because costs change little, uninsurance also changes little.

TABLE 3

Additional Effect of Expanding Reform to Competitive Areas, 2022

Change	Public option 2	Public option 4	Capped rates 1
In uninsurance			
Thousands of people	-12	-149	-149
Percent	12	15	15
In the federal deficit^a			
Billions of dollars	*	-16	-19
In employer spending			
Billions of dollars	*	-70	-85
Percent ^b	**	435	72
In household spending			
Billions of dollars	*	-40	-42
Percent ^b	**	214	56
In health system spending			
Billions of dollars	*	-111	-129
Percent ^b	**	246	63

Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.

^a Estimates in this row equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.

^b Percentages are additional percent savings beyond those for a reform affecting only competitive areas.

* = less than +/- \$500 million. ** = less than +/- 0.5 percent.

If reforms that involve employer-sponsored insurance, like public option 4 and capped rates 1, were extended to all areas, spending would decrease more. Prices paid in these markets have farther to fall than those in the nongroup market, and low prices are not as strongly linked to concentrated areas. If extended to all areas, capped rates 1 would result in additional savings of \$85 billion for

employers, \$42 billion for households, and \$129 billion overall relative to implementing the reform in concentrated regions alone. This is because more people with employer-sponsored insurance would be exposed to the reduced rates (both in firms in competitive regions and in firms spanning both concentrated and competitive regions). Applying the public option in employer markets nationwide would result in greater savings than implementing it in concentrated regions alone for two reasons: First, employers who choose the public option in the restricted reform (because many of their employees are in concentrated regions) would incur reduced costs for any employees living in competitive regions. Second, more firms would choose to participate in the public option because the savings would be great enough to make the change worthwhile (reaching an assumed 20 percent savings threshold, as described below). For example, if public option 4 were applied nationwide, employer and household spending would fall by an additional \$70 billion and \$40 billion, respectively, and health system savings would be \$111 billion greater than if it were implemented only in concentrated areas.

Discussion

In this analysis, we examine seven public option and capped provider payment rate proposals that would apply only to concentrated markets; competitive markets would not have a public option, and their hospital and professional payment rates would not be reduced. Competitive markets, however, would benefit from reductions in prescription drug prices under the reforms. The proposals vary by whether they are limited to the nongroup market, whether the public option is extended to the employer market, or whether capped provider payment rates apply to both the nongroup and employer markets. The impacts also depend on how payment rates are established: whether at Medicare levels, a relatively small multiple above Medicare rates, or a larger multiple above such rates. Targeting concentrated markets is intended to focus cost-cutting measures on the most expensive markets. We know from past research that both insurer and hospital concentration result in higher premiums.

We show public option policies have fairly large effects on nongroup premiums in all simulations. Premiums are higher under current law in concentrated markets and thus have farther to fall. We also show that limiting public option policies to the concentrated nongroup markets affects coverage little. Public option policies provide savings to the federal government and households by lowering premiums, but these effects are fairly small because the nongroup market is relatively small.

Extending the public option to employers reduces the number of people uninsured by nearly 1 million and provides more savings to the federal government. Employers see substantial savings from lower premiums and, in response, increase wages. Tax revenues increase, reducing the federal deficit by between \$500 million and \$2 billion. The largest effects occur under capped rates 1 and 2, under which provider payment rates are capped for all insurers. All employers benefit and, in turn, workers' wages and federal tax revenues increase. Under capped rates 1 and 2, we estimate the federal deficit drops by \$19 to \$34 billion in 2022.

The coverage and spending effects of any public option proposal are greater the more payment rates are reduced. The largest savings come from reducing payment rates to Medicare levels in a public option in the nongroup market. But such large payment rate cuts, even in concentrated markets, may not be politically feasible, especially if extended to the employer market. A public option that pays higher rates, Medicare plus 15 percent for health care professionals and plus 60 percent for hospitals, may be more feasible. But extending this public option to the employer market would have a small effect on premiums and thus on federal, household, and employer spending. Capping payment rates to all providers by all insurers in concentrated markets, even at Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in the employer market, would greatly reduce government, household, and employer spending on health care, because it extends to payments by all insurers.

Introducing a public option with lower provider payment rates would lower premiums and household and employer spending. But, concentrated markets would also lose federal dollars. And many of these concentrated markets are in rural areas, possibly contradicting goals of protecting providers in these areas. Nonetheless, most concentrated markets are in urban areas, and payment rate cuts in these markets may be less controversial.

Finally, we show that limiting a public option and capped provider payment rates to concentrated markets still achieves significant savings. Extending the reforms to competitive markets has few benefits for the nongroup market, but it reduces employer, household, and system spending, because more firms would choose to enroll workers in the public option. If we had used a less restrictive definition of hospital concentration, more rating regions and more people would be affected, but the proposals might thereby be less appealing. Still, with a more expansive definition of hospital concentration, the reforms would offset costs in more markets and federal, aggregate employer, household, and overall spending would be lower.

Methods

Our analysis relies on the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of an array of proposed health care policy reforms for the nonelderly (US residents below age 65 not enrolled in Medicare). We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. For example, the current version accounts for each state's Marketplace premiums and enrollment after the 2020 open enrollment period. Enrollment in each state under current law affects how the model simulates policy alternatives.

We begin each simulation with a current-law baseline in 2022 that includes the estimated effects of, and a partial recovery from, the COVID-19 recession. For this analysis, we assume the federal medical assistance percentage for Medicaid and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated

the department planned to extend its public health emergency declaration through calendar year 2021.² This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates, but it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

We then estimate the effects of implementing each of the seven reforms modeled. Each reform affects prescription drug prices in all regions but professional and hospital payment rates in concentrated regions only. The different simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employer) in which the public option and/or capped provider payment rates are available. All estimates assume reforms are fully phased in and in equilibrium in 2022.

Because Medicare does not provide benefits to nondisabled nonelderly people, we estimate possible Medicare payment rates for those people. We assume Medicare rates for people with nongroup insurance would equal what payment rates would be if the region had a highly competitive insurance market and a reasonably competitive hospital market, and these rates vary significantly by rating region. We then set payments by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, according to the assumption for each reform, the share of spending for each type of service within regions, and if the region is concentrated. Concentrated areas see reduced payments for all services and drugs, whereas competitive areas see only reduced payments for drugs.

We use a different approach for people with employer-sponsored insurance. We obtained estimates of the ratio of commercial insurers' payment rates to Medicare payment rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to estimate costs for people in concentrated areas with employer-based insurance entering the public option or having provider payments capped. For all reforms, prices for prescription drugs in all areas are set halfway between those paid by Medicare and Medicaid after rebates.

Under both a public option and capped provider payment rates, all nongroup insurance enrollees see savings. HIPSM implicitly assumes all enrollees are affected by the public option, because we assume the Marketplace benchmark premium would decrease by the percent difference between the public option and baseline premiums. For people with employer-sponsored insurance, only those in firms opting in to the public option would see savings. We assume firms that are small, pay lower average wages, and expect significant savings from the switch are more likely to choose the public option than large firms, those paying higher wages, and those expecting small savings. Capped rates 1 and 2 limit all provider payments in concentrated areas, reducing payments for everyone with employer-sponsored coverage. We discuss additional methodological issues in an earlier report (Blumberg et al. 2020).

Limitations

Uncertainty surrounds our estimates of the impacts of a public option or capping provider payment rates for several reasons: a lack of data on commercial payment rates in the nongroup market, the relevance of claims data to estimate the ratio of commercial payment rates to Medicare rates in the employer market, the need to estimate households' and firms' decisions to participate in the public option, and the need to make assumptions about the savings possible from regulating prescription drug prices. For each factor, different data can be used and assumptions made. Thus, our results may differ from actual results or those projected in other analyses.

- For the nongroup reform estimates, we lack actual payment rate data. We estimate Medicare payment rates using regression analyses. We assume markets with a large number of insurers and low hospital concentration have payment rates that approximate Medicare prices and thus premiums. Markets lacking these characteristics have been shown to have higher premiums. We estimate high premiums in markets with high insurer and hospital concentration will decrease to the levels seen in more competitive markets. But, the high premiums we observe in noncompetitive regions could owe to factors other than higher provider payment rates.
- We assume the public option is the benchmark plan. We cannot estimate how many people choose plans that have higher premiums than the benchmark. To the extent individuals enroll in more expensive plans, our estimates of nongroup reforms may underestimate household spending.
- We use data from FAIR Health, which collects data from a large number of firms. However, the data do not contain all private plans in a state or substate area. Thus, the contributing insurers may not be entirely representative, despite their very large amount of data. Further, these data cover plans for 75 percent of the privately insured population in the United States, but they include some Medicare Advantage and other plans participating in the nongroup market.
- FAIR Health provided us data on payment for professionals and outpatient facilities representing 47 percent of total professional spending and 42 percent of total outpatient facility spending. However, the services may not fully represent the ratio of average commercial payment rates to Medicare rates. More importantly, FAIR Health does not release substate data on commercial payment rates for inpatient hospital services; our estimates include all inpatient services provided in the state, but lacking this information could lead to some error at the substate level.
- We have made assumptions about employer take-up of the public option by firm size, wages, and expected savings. Take-up of the public option is assumed to be higher for small and low-wage firms, and we assume a firm will choose the public option only when the resulting savings exceed 20 percent. Our assumptions are somewhat arbitrary, and different

assumptions would have different results. Our capped rate simulations estimate the extreme case of all employers choosing the public option.

- Employers may gravitate to the public option over time. Our analysis assumes the policy is fully phased in and in equilibrium in 2022 and therefore accounts for all long-term employer behavior.
- In our estimates of prescription drug savings, we assume drug pricing rebates from various private payers are the same across the country. If the mix of drugs consumed varies geographically, our rebates may be estimated with error. In addition, Medicare pharmacy benefit manufacturers differ by geography, with some getting better rebates from manufacturers than others. Thus, Medicare rebates could differ across states, but we do not account for this.
- We estimate rebates for the public option would lead to prescription-drug prices halfway between Medicaid, Medicare, and Medicaid prices, or 30 percent below commercial insurance prices. These prices seem reasonable because they are lower than those currently achieved in Medicaid and considerably lower than those in other Western nations. We may also have underestimated the savings a public option could achieve. However, it has been politically difficult to achieve lower drug prices in the US, so we are cautious in our estimates. Any differences or errors in our savings estimates would be tempered by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

Supplementary Tables

TABLE 4

Rating Region – Level Distribution of Changes in Nongroup and Employer Premiums in Concentrated Areas under Nongroup and Employer Reforms, 2022

Percent change from current-law premiums

	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Nongroup^a							
Percentile							
10th	-43	-37	-31	-39	-34	-39	-34
25th	-41	-33	-22	-35	-27	-35	-27
50th (median)	-29	-22	-14	-20	-14	-20	-14
75th	-16	-9	-6	-7	-5	-7	-5
90th	-8	-4	-1	-4	**	-4	**
All employers^b							
Percentile							
10th	NA	NA	NA	-6	-4	-20	-15
25th	NA	NA	NA	-4	-3	-19	-15
50th (median)	NA	NA	NA	-3	-2	-17	-13
75th	NA	NA	NA	-3	-2	-15	-12
90th	NA	NA	NA	-2	-1	-14	-11
Employers offering public option^b							
Percentile							
10th	NA	NA	NA	-22	-15	-18	-14
25th	NA	NA	NA	-20	-13	-17	-13
50th (median)	NA	NA	NA	-17	-10	-16	-11
75th	NA	NA	NA	-13	-7	-14	-10
90th	NA	NA	NA	-10	-3	-13	-9

Source: Health Insurance Policy Simulation Model, 2021

Notes: NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.

^a These rows show the change in the median nongroup benchmark premium in concentrated markets.

^b These rows show the change in the median premiums in concentrated markets among employers providing the public option to their workers in public options 4 and 5. For capped rates 1 and 2, it shows the change in median premiums for all employers in concentrated markets.

** = less than +/- 0.5%.

TABLE 5

Health Insurance Coverage of the Nonelderly Population under Current Law and Nongroup and Employer Reforms Affecting Concentrated Areas, 2022

Coverage (thousands of people)		Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Insured (MEC)		244,113	244,221	244,210	244,197	245,082	245,032	245,082	245,032
Employer		149,325	149,266	149,266	149,269	150,506	150,461	150,506	150,461
Traditional		149,325	149,266	149,266	149,269	122,760	127,418	0	0
Public option		0	0	0	0	27,745	23,042	150,506	150,461
Private nongroup		14,960	15,045	15,037	15,030	14,683	14,683	14,683	14,683
Medicaid/CHIP		71,162	71,245	71,241	71,233	71,228	71,223	71,228	71,223
Other public		8,665	8,665	8,665	8,665	8,665	8,665	8,665	8,665
Uninsured (no MEC)^a		33,333	33,225	33,236	33,249	32,365	32,414	32,365	32,414
Total		277,446	277,446	277,446	277,446	277,446	277,446	277,446	277,446
<i>Changes from current law (thousands of people)</i>									
Insured (MEC)			109	97	85	969	919	969	919
Employer			-60	-59	-56	1,180	1,135	1,180	1,135
Traditional			-60	-59	-56	-26,565	-21,907	-149,325	-149,325
Public option			0	0	0	27,745	23,042	150,506	150,461
Private nongroup			85	77	69	-278	-278	-278	-278
Medicaid/CHIP			84	79	71	66	62	66	62
Other public			0	0	0	0	0	0	0
Uninsured (no MEC)^a			-109	-97	-85	-969	-919	-969	-919
Total			0	0	0	0	0	0	0
<i>Change from current law (%)</i>									
Insured (MEC)			**	**	**	0.4	0.4	0.4	0.4
Employer			**	**	**	0.8	0.8	0.8	0.8
Traditional			0.0	0.0	0.0	-17.8	-14.7	-100.0	-100.0
Public option			NA	NA	NA	NA	NA	NA	NA
Private nongroup			0.6	0.5	0.5	-1.9	-1.9	-1.9	-1.9
Medicaid/CHIP			0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other public			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsured (no MEC)^a			-0.3	-0.3	-0.3	-2.9	-2.8	-2.9	-2.8
Total			0.0	0.0	0.0	0.0	0.0	0.0	0.0

Source: Health Insurance Policy Simulation Model, 2021.

Notes: MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. NA = not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.

^a Includes those without insurance and those with short-term limited-duration plans.

** = less than +/- 0.05%.

TABLE 6

Health Spending for the Nonelderly Population under Current Law and Nongroup and Employer Reforms Affecting Concentrated Areas, 2022

Health spending (millions of dollars)

Reform	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Household	587,856	580,748	582,843	584,581	569,335	574,547	512,629	526,283
Federal government	467,105	453,521	457,561	461,167	456,710	459,321	456,710	459,321
State government	220,370	220,393	220,394	220,393	220,343	220,361	220,343	220,361
Employers	800,116	800,008	800,015	800,011	784,040	789,928	683,145	709,011
Providers	27,475	27,389	27,393	27,397	27,359	27,395	27,359	27,395
Total, all payers	2,102,923	2,082,058	2,088,205	2,093,548	2,057,786	2,071,552	1,900,185	1,942,370
<i>Change from current law (millions of dollars)</i>								
Household	—	-7,109	-5,013	-3,275	-18,522	-13,309	-75,227	-61,573
Federal government	—	-13,584	-9,544	-5,938	-10,395	-7,784	-10,395	-7,784
State government	—	23	24	23	-27	-9	-27	-9
Employers	—	-108	-101	-105	-16,076	-10,188	-116,971	-91,105
Providers	—	-86	-83	-79	-117	-80	-117	-80
Total, all payers	—	-20,865	-14,717	-9,375	-45,137	-31,370	-202,738	-160,552
Federal tax offset from ESI change	—	NA	NA	NA	2,029	528	23,620	11,596
<i>Change from current law (%)</i>								
Household	—	-1.2	-0.9	-0.6	-3.2	-2.3	-12.8	-10.5
Federal government	—	-2.9	-2.0	-1.3	-2.2	-1.7	-2.2	-1.7
State government	—	**	**	**	**	**	**	**
Employers	—	**	**	**	-2.0	-1.3	-14.6	-11.4
Providers	—	-0.3	-0.3	-0.3	-0.4	-0.3	-0.4	-0.3
Total, all payers	—	-1.0	-0.7	-0.4	-2.1	-1.5	-9.6	-7.6

Source: Health Insurance Policy Simulation Model, 2021.

Notes: NA = not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.** = less than +/- 0.05%.

Notes

- ¹ Throughout this paper, areas with concentration in either hospital or nongroup insurer markets or both markets are referred to as “concentrated markets;” areas with concentration only in the hospital market are called “concentrated hospital markets.”
- ² Norris Cochran (acting Secretary of Health and Human Services), letter to state governors regarding extension of COVID-19 public health emergency, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>

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John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Michael Simpson is a principal research associate in the Health Policy Center with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

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Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets

Updated Estimates

John Holahan and Michael Simpson

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This brief updates a previous report on the impacts of a public option or capped provider payment rate health reform proposals published in March 2020 (Blumberg et al. 2020). In this update, we provide estimates for 2022, using a revised current-law baseline in the Health Insurance Policy Simulation Model (HIPSM) that reflects changes in economic conditions resulting from the COVID-19 pandemic. In this and two accompanying papers (Holahan and Simpson 2021a, 2021b), we analyze public option and capped provider payment rate proposals that apply to the nongroup health insurance market only and some that would apply both in the nongroup and employer health insurance markets. We show the anticipated impacts on premiums in both the nongroup and employer markets, the number of people uninsured, and spending by employers, households, and the federal government. We also show the effect on national health expenditures.

We first consider a public option and capped provider payment rates introduced in the nongroup market alone. This is the most frequently proposed approach for such reforms (Blumberg et al. 2019, 2020; Blumberg, Simpson, and Buettgens 2019). However, other proposals would also extend a public option to the employer market.¹ Because the number of people enrolled in employer coverage is more than nine times that in nongroup coverage and employer-based plans tend to pay health care providers higher rates than do nongroup insurers, introducing the public option or capping provider payment rates in both markets will have much greater effects than if the policies are introduced in the nongroup market alone.

What Is a Public Option?

A public option is a government-sponsored insurance plan that pays providers (doctors, hospitals, prescription drug manufacturers) according to a defined payment schedule and set of benefits. As an insurer, the federal government ultimately bears the risk associated with the plan. Payment rates under a public option are generally assumed to be lower than those typical of commercial insurers, with the federal government using its purchasing and/or negotiating power to lower health care spending for enrollees. A public option could be available in nongroup or employer markets or both, and one or multiple public options could be offered in a particular market, with multiple plans offering different actuarial values or cost-sharing structures. Here, we simply discuss a single public option.

A public option could be made available either nationally or in particular geographic areas. It could be implemented alone or in conjunction with regulated limits on rates paid by competing private insurers in the same markets (hereafter called “capped provider payment rates”). Combined, the approaches would be similar to the Medicare program’s structure, or more specifically, the offering of private Medicare Advantage plans that compete with the traditional Medicare fee-for-service plan (a type of public option). Taking advantage of a public option introduced alone would require consumers (e.g., households and/or employer groups) to enroll in a newly established insurance plan. However, depending on how the public option’s provider payment schedule is set relative to that for commercial plans in a given market, competition from the public option may result in more aggressive negotiation between private insurers and providers for lower rates, possibly lowering private insurance premiums as well. But, if private insurers cannot maintain sufficient market share because of (1) an inability to negotiate lower payment rates with providers or (2) other consumer preferences for a public option, competition from a public option may reduce the number of private insurers competing in at least some areas.

How Would Capping Provider Payment Rates Work?

Capping provider payment rates for all private insurers in particular markets or nationwide has been proposed as an alternative to a public option (or, as noted above, in conjunction with one).² This approach would limit the payment rates insurers could pay health care providers in the applicable markets. Generally, payment rates would be capped at lower levels than those typical of private insurers today, or the growth rate of such caps would be constrained to lower premiums and health care spending over time. The capped rates could apply to insurers in nongroup or employer markets or both. A central advantage of capped provider payment rates over a public option is that consumers could obtain the full benefit of lower provider payment rates while being enrolled with their preferred insurer. In addition, capped provider payment rates likely result in more private insurers entering or staying in markets, compared with a public option implemented alone. Under capped payment rates, insurers would not need large numbers of enrollees to leverage and achieve competitive payment rates with providers.

Policy Approaches Modeled

The updated analyses presented here rely on the same methodology as our earlier work (Blumberg et al. 2020); estimates are produced for 2022, using the Urban Institute’s Health Insurance Policy Simulation Model (Buettgens and Banthin 2020).

We first look at public option proposals implemented only in the nongroup market. As noted, this would be a new, qualified health plan that would compete with private insurance plans already in these markets. It would follow the same rules applied to private plans in those markets, including participating in risk adjustment. The public option would likely become the lowest-priced silver plan or the benchmark plan (the second-lowest-premium silver plan) in many rating regions, particularly if it pays providers Medicare-like rates.³ However, it may not become either low-priced offering if its provider payment rates are set above Medicare levels. If the nongroup public option becomes the lowest-priced silver option or second-lowest-priced option, the benchmark premium will drop, thereby reducing the cost of federal premium subsidies and costs for some households.

Next, we analyze approaches that would extend the public option or capped provider payment rates to employer insurance markets, too. To take advantage of potential savings from a public option, an employer would have to switch coverage for the firm’s workers into that new plan. Consistent with our earlier work, we assume a firm’s decision to switch into the public option varies by its wages and size; the lower the average wage and the smaller the firm, the more likely they will switch from their current insurance to the public option. Large and high-wage firms would be more likely to remain with their current coverage, because they could vary benefit packages, cost sharing, and out-of-pocket limits. Some may view paying somewhat higher provider payment rates as worthwhile, because it allows them to tailor benefits and provider networks to employees’ needs or wishes. We also assume employers would have to save at least 20 percent in premiums to make switching sufficiently attractive.

We analyze several levels of provider payment rates. The following reforms are modeled in nongroup markets alone:

- Public option 1 sets provider payment rates at Medicare levels.
- Public option 2 sets provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals.
- Public option 3 sets provider payment rates at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals.

In the next two simulations, a public option is introduced into employer markets in addition to nongroup markets. All simulations including the employer markets assume provider payment rates above Medicare levels, because the impact on health care providers would be much larger, and we assume using Medicare rates would be too disruptive to the health care system, at least in the near term.

- Public option 4 sets provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals.
- Public option 5 sets provider payment rates at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals.

The next two reforms simulated introduce capped provider payment rates into both the nongroup and employer markets:

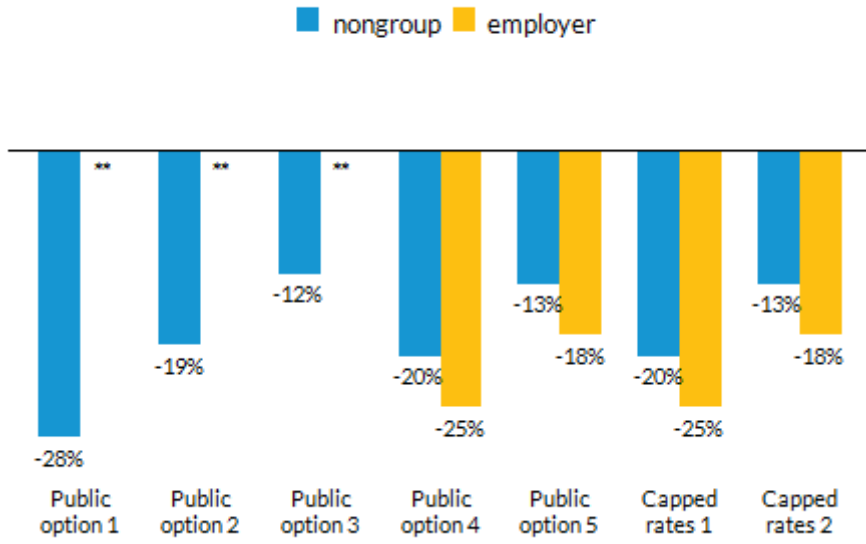
- Capped rates 1 sets provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals.
- Capped rates 2 sets provider payment rates at Medicare levels plus 15 percent for professionals and 60 percent for hospitals.

In each reform, we also assume federal implementation of prescription drug reforms that would require prescription drug manufacturers to provide the public option or private insurers operating under regulated payment limits rebates halfway between those currently provided to the Medicare and Medicaid programs. This health-care-cost-containment policy and its rebate levels would be set nationally, because drugs are sold in a national market. We estimate these increased rebates would reduce average current prescription drug prices facing commercial insurers by approximately 30 percent (Hwang and Kesselheim 2020).

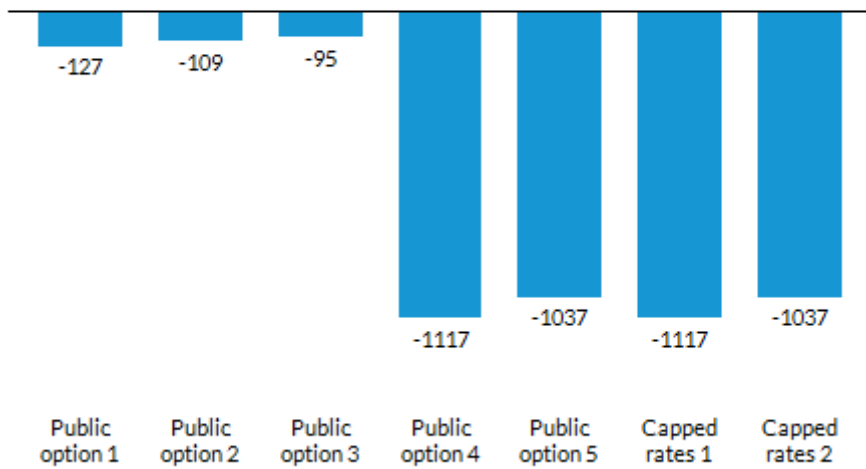
Highlights of Findings

Table 1 and figure 1 summarize our main findings; supplementary tables at the end of the paper show additional details. All estimates assume reforms are fully implemented in 2022. We acknowledge considerable uncertainty surrounding these estimates, which we detail in the methods section. Our primary limitation is the absence of ideal data sources, which forces us to make assumptions and use proxy measures in some areas.

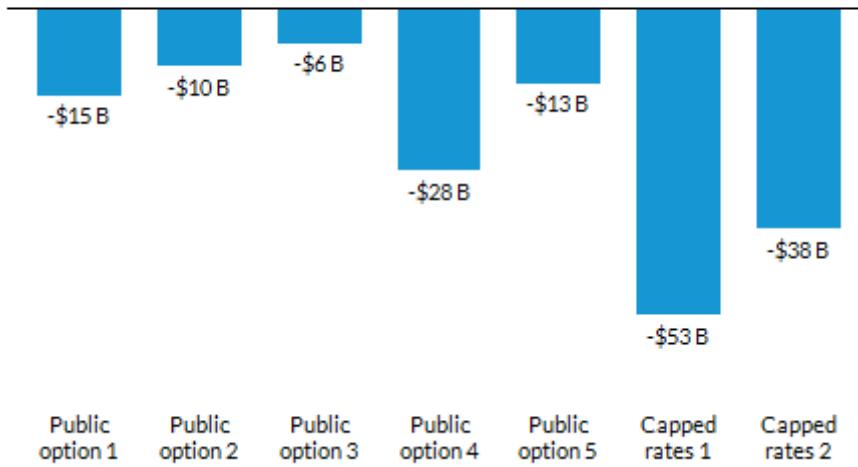
FIGURE 1
Summary of Effects of Reform Options, 2022
On median premiums



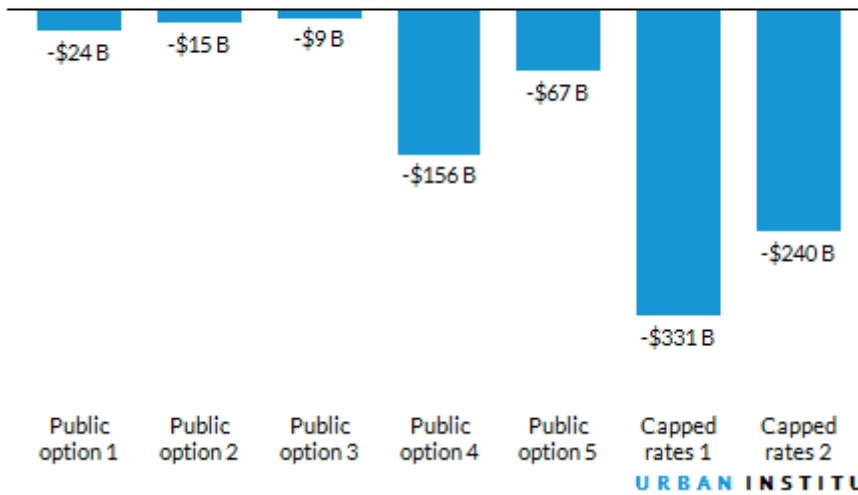
On thousands of people uninsured



On the federal deficit



On health system spending



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Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

** = less than +/- 0.5%.

- Bottom-line effects.** First, private and government savings are greater the more provider payment rates are reduced relative to current law. Second, extending reforms to both the nongroup and employer markets has greater effects on the outcomes measured here than

does limiting the reforms to the nongroup market. Third, capped provider payment rates have more significant impacts than public options.

- **Premiums and coverage in the nongroup market.** We estimate a nongroup public option using the specified provider payment rates could lower premiums by 12 to 28 percent. The greatest reduction in premiums occurs under reforms that reduce provider payment rates the most. We estimate the effects on insurance coverage to be very small. Policies that enhance and expand subsidies are needed to significantly increase insurance coverage, but we do not consider them here.⁴
- **Federal, household, and employer health spending in the nongroup market.** Because nongroup premiums are lower, federal spending on premium tax credits declines by \$6 to \$15 billion. Household spending falls by \$3 to \$8 billion, about 1 percent of household spending; the effects are, however, fully concentrated among nongroup enrollees, so their savings are larger. Employer spending is virtually unaffected. National health spending declines slightly.
- **Premiums and coverage in the employer market.** A public option or capped provider payment rates tend to lower premiums more in employer markets than nongroup markets, because provider payment rates in employer markets tend to be higher today. When the public option is extended to employer markets using the payment rates analyzed, we estimate premiums for participating employers fall by 18 to 25 percent. Nongroup premiums in these same simulations fall by 13 to 20 percent. Reductions in premiums are larger for options with greater reductions in provider payment rates, which we assume are directly related. We estimate offering the public option or capped provider payment rates in the employer market could reduce the number of people uninsured by more than 1 million. Far more people in employer markets would be affected by capped provider rates than by the public options, because we estimate many employers would choose not to participate in the public option.
- **Employer and household spending in the employer market.** Extending the public option or capped rates to the employer market significantly affects spending. Employers save \$32 to \$86 billion under public option-only reforms, but their savings under capped rates range from \$145 to \$202 billion. Household spending falls by \$27 to \$58 billion under public options reforms but by \$87 to \$118 billion under capped rates.
- **Federal spending and income tax revenue in the employer market.** As employers spend less on premiums, economic research indicates they convert the savings into higher wages for their workers. Because those higher wages are taxable, the federal deficit decreases. The federal deficit falls by \$13 to \$28 billion when a public option is introduced into the employer market but declines by \$38 to \$53 billion under capped rates.
- **National health spending.** National health spending on the nonelderly falls by less than 1 percent under the public option reforms limited to the nongroup market. If a public option is available in the nongroup and employer markets, total health spending falls by as much as 7 percent, depending on the payment rates used. Under the capped rate reforms, national health spending could fall by as much as 16 percent.

TABLE 1

Public Option and Capped Provider Payment Rate Reform Options in All Markets, 2022

Reform	Availability of public option	Payment policy ^a	Change						
			In median nongroup premiums	In median employer premiums ^b	In number of uninsured	In the federal deficit ^c	In employer spending	In household spending	In health system spending
Public option 1	Nongroup insurance markets	Medicare rates	-28%	NA	-127,000	-\$15 B	*	-\$8 B (-1%)	-\$24 B (-1%)
Public option 2	Nongroup insurance markets	Medicare rates plus 10% for professionals and plus 25% for hospitals	-19%	NA	-109,000	-\$10 B	*	-\$5 B (-1%)	-\$15 B (-1%)
Public option 3	Nongroup insurance markets	Medicare rates plus 15% for professionals and plus 60% for hospitals	-12%	NA	-95,000	-\$6 B	*	-\$3 B (-1%)	-\$9 B (**)
Public option 4	Nongroup and employer markets; subset of firms	Medicare rates plus 10% for professionals and plus 25% for hospitals	-20%	-25%	-1,117,000	-\$28 B	-\$86 B (-11%)	-\$58 B (-10%)	-\$156 B (-7%)
Public option 5	Nongroup and employer markets; subset of firms	Medicare rates plus 15% for professionals and plus 60% for hospitals	-13%	-18%	-1,037,000	-\$13 B	-\$32 B (-4%)	-\$27 B (-5%)	-\$67 B (-3%)
Capped rates 1	Nongroup and employer markets; all employers pay lower rates	Medicare rates plus 10% for professionals and plus 25% for hospitals	-20%	-25%	-1,117,000	-\$53 B	-\$202 B (-25%)	-\$118 B (-20%)	-\$331 B (-16%)
Capped rates 2	Nongroup and employer markets; all employers pay lower rates	Medicare rates plus 15% for professionals and plus 60% for hospitals	-13%	-18%	-1,037,000	-\$38 B	-\$145 B (-18%)	-\$87 B (-15%)	-\$240 B (-11%)

Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

^a Prescription drug prices in each reform scenario are assumed to be halfway between Medicare and Medicaid prices in all markets.

^b This column shows the change in median premiums in all markets among employers providing the public option to their workers in public options 4 and 5. In capped rates 1 and 2, this column shows the change in median premiums for all employers in all markets.

^c Estimates in this column equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

Projected Impacts of Public Option and Capped Provider Payment Rate Proposals

In this section, we present our detailed estimates of each of the seven reforms modeled. We include estimates of changes in median nongroup and employer premiums, health insurance coverage, and health care spending by households, employers, and the federal government. For federal spending effects, we show the impact on the federal deficit, which is a combination of the direct reduction in federal government spending on health care programs (primarily from lower spending on Marketplace premium tax credits) and the increased income tax revenue from lower employer spending on nontaxable health insurance benefits.

All estimates assume the reforms are fully phased in and in equilibrium in 2022. This means the supply of services is assumed to expand to meet any increased demand for services. In reality, it is more likely the reforms would require a multiyear phase-in, over which payment rates would decrease toward target levels. How long the phase-in would take would determine the underlying savings to households, employers, and the federal government. The slower the pace of payment rate reductions, the less potentially disruptive to the health system and the more politically feasible a reform will likely be. But, the resulting savings will be lower as well.

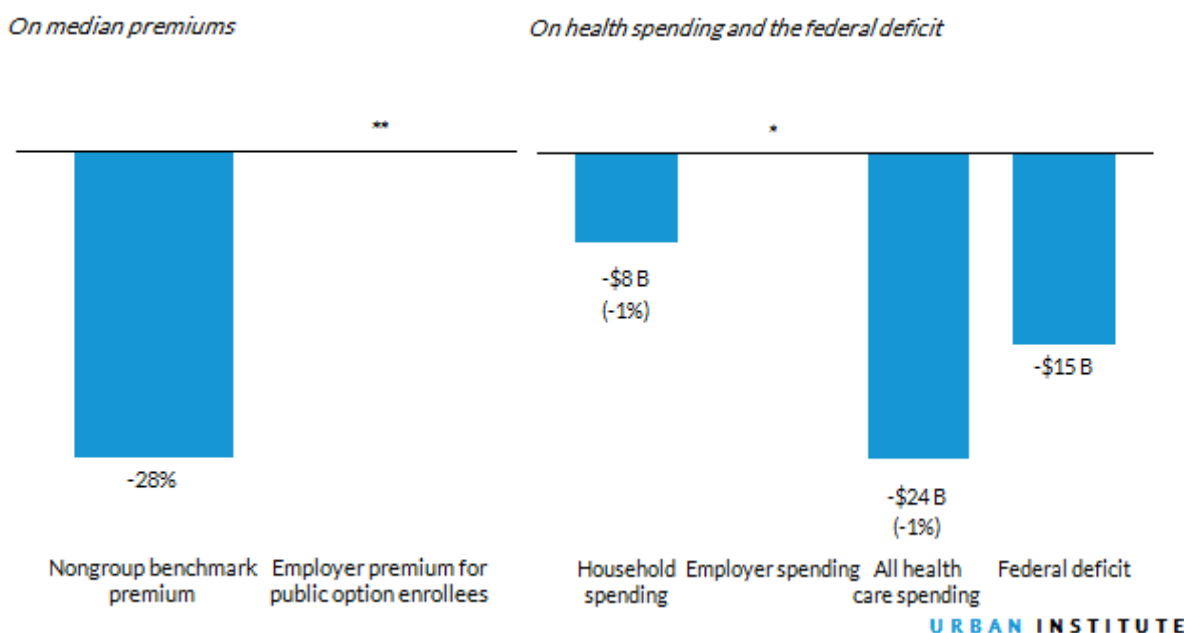
Public Option 1: Medicare Rates in Nongroup Markets

- public option in all private nongroup insurance markets nationally
- pays Medicare rates for hospitals and professionals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median benchmark premium in the nongroup market falls by 28 percent. The number of people uninsured falls by 127,000, a small effect because only households facing full, unsubsidized nongroup premiums are affected.

Health care spending. Because tax credits are tied to premiums, tax credits fall as benchmark nongroup premiums fall. Federal health spending, and thus the federal deficit, falls by \$15 billion. Household spending falls by \$8 billion, or 1 percent. Employer spending is essentially unaffected. Overall health spending falls by \$24 billion, or 1 percent.

FIGURE 2
Effects of Public Option 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

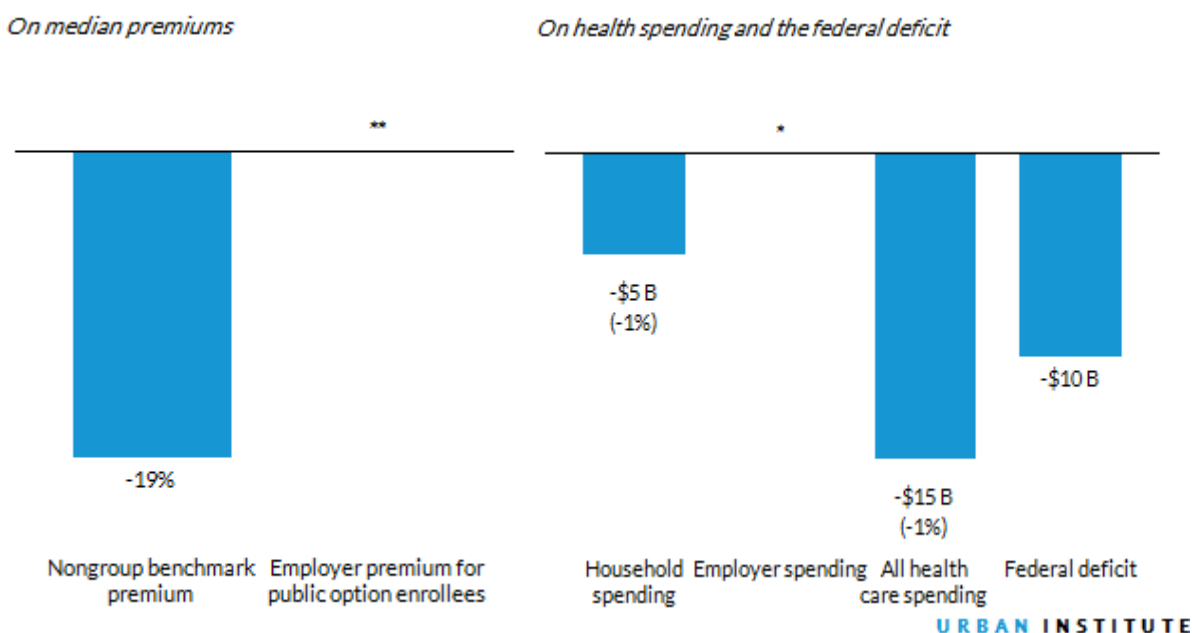
Public Option 2: Medicare Rates with Modest Upward Adjustments in Nongroup Markets

- public option introduced in all nongroup markets nationally
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. This reform decreases the median benchmark premium less than public option 1 (19 percent versus 28 percent) because it uses higher provider payment rates. It also has a modestly smaller effect on the uninsured population, which decreases by 109,000 people.

Health care spending. Federal health spending, primarily on Marketplace premium tax credits, falls by \$10 billion. Aggregate household spending falls by \$5 billion, or 1 percent. Again, employer spending is largely unaffected. Overall spending falls by \$15 billion, or 1 percent.

FIGURE 3
Effects of Public Option 2



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

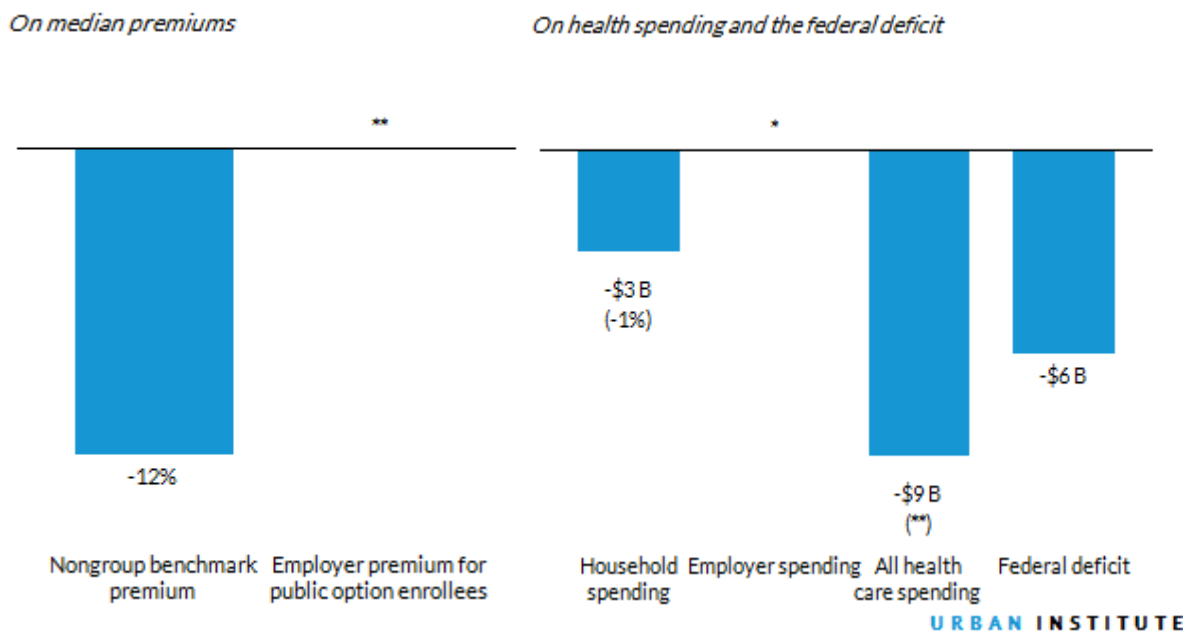
Public Option 3: Medicare Rates with Large Upward Adjustments in Nongroup Markets

- public option in all private nongroup insurance markets nationally
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median benchmark premium falls by 12 percent, a smaller effect than under the first two reforms because of the higher provider payment rates. The number of people uninsured falls by 95,000, again a smaller effect than under the first two reforms because the smaller reduction in premiums attracts fewer new enrollees.

Health care spending. Federal health spending falls by \$6 billion, because smaller reductions in premiums mean lower premium tax credit savings than under public options 1 and 2. Household spending falls by \$3 billion, or 1 percent. Employer spending is again unaffected. Overall spending falls by \$9 billion, or less than 0.5 percent.

FIGURE 4
Effects of Public Option 3



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

Public Option 4: Payment Rates Modestly above Medicare Levels in Nongroup and Employer Markets

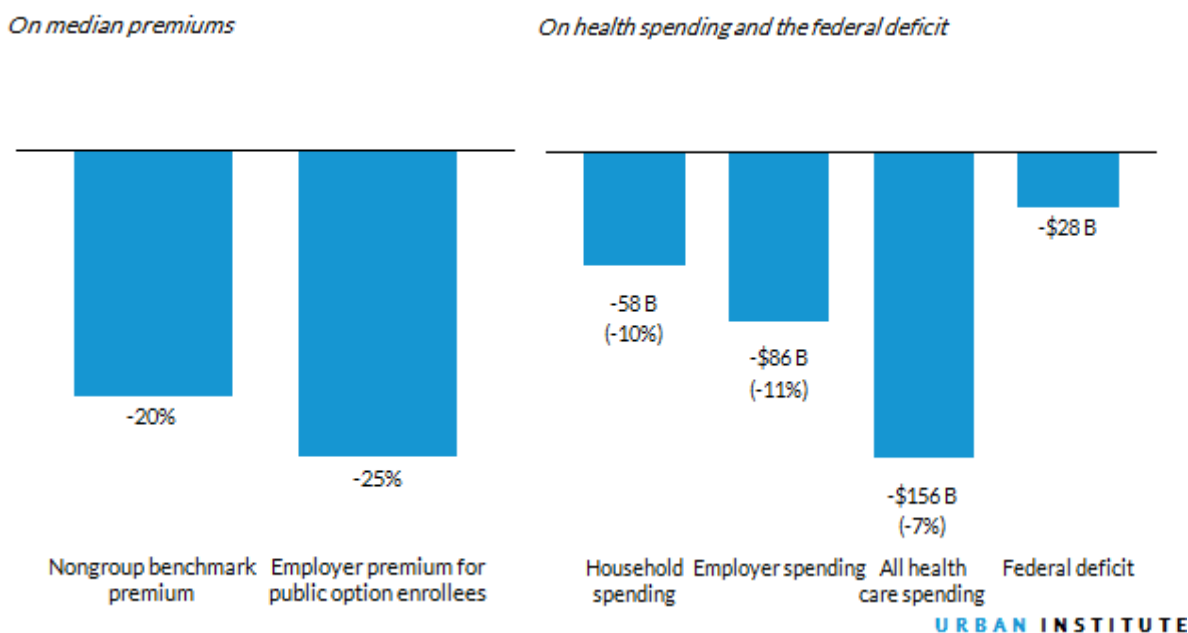
- public option available to all employer and nongroup insurance markets nationally
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums fall by 20 percent in nongroup markets and by 25 percent for employers choosing the public option. Employer coverage increases by 1.3 million people (not shown), and the number of people uninsured falls by 1.1 million.

Health care spending. Federal spending, primarily on premium tax credits, declines by \$12 billion, or 2.5 percent. Household spending falls by \$58 billion, or 10 percent. Employer premium spending falls by \$86 billion, or 11 percent. Lower employer spending on health care results in higher employee wages and, in turn, increases federal tax payments, generating \$17 billion in new tax revenue; the net effect on the federal deficit is a \$28 billion reduction. Overall spending declines by \$156 billion, or 7 percent.

FIGURE 5

Effects of Public Option 4



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

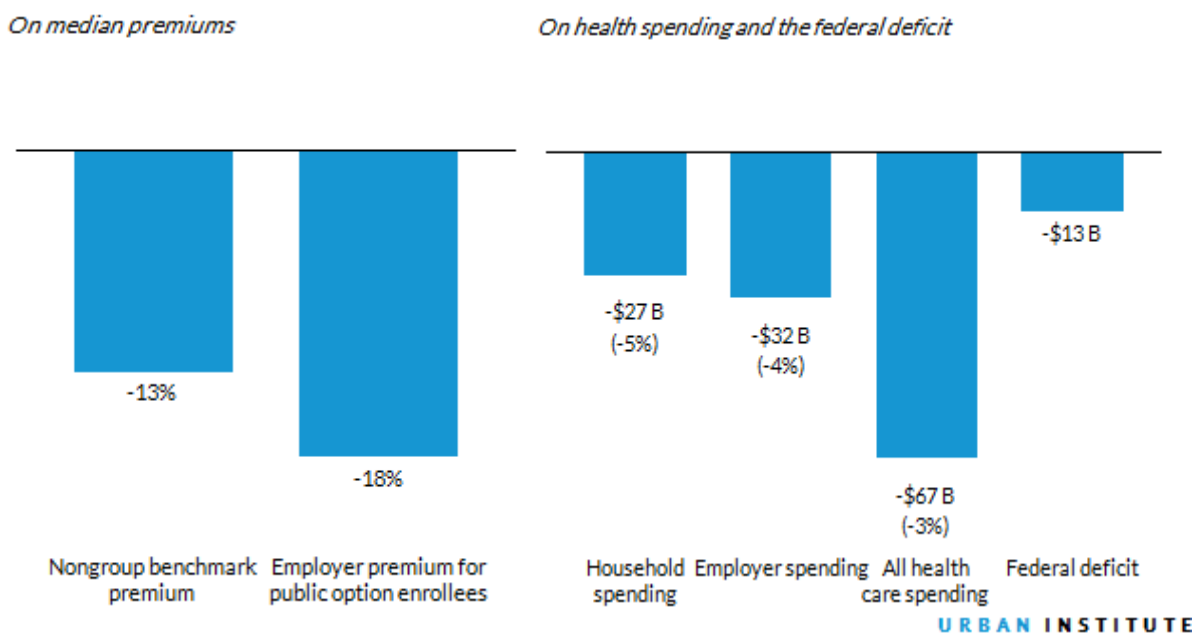
Public Option 5: Payment Rates Considerably above Medicare Levels in Employer and Nongroup Markets

- public option available to all employer and nongroup insurance markets nationally
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Because this reform uses higher payment rates than public option 4, median benchmark premiums fall by 13 percent in the nongroup market and by 18 percent among employers choosing the public option. Introducing the public option, a new and less expensive insurance option, into the employer market increases employer coverage by 1.2 million people and reduces the number of people uninsured by 1.0 million.

Health care spending. Federal government spending falls by \$8 billion, less than under public option 4 because the higher provider payment rates reduce the reform’s impact on premiums. Households save \$27 billion, or 5 percent. Employers save \$32 billion in premiums, or 4 percent. Employer savings translate to increased taxable wages, thereby generating about \$5 billion in new federal revenues. The federal deficit declines by \$13 billion. Overall spending decreases by \$67 billion, or 3 percent.

FIGURE 6
Effects of Public Option 5



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billions. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

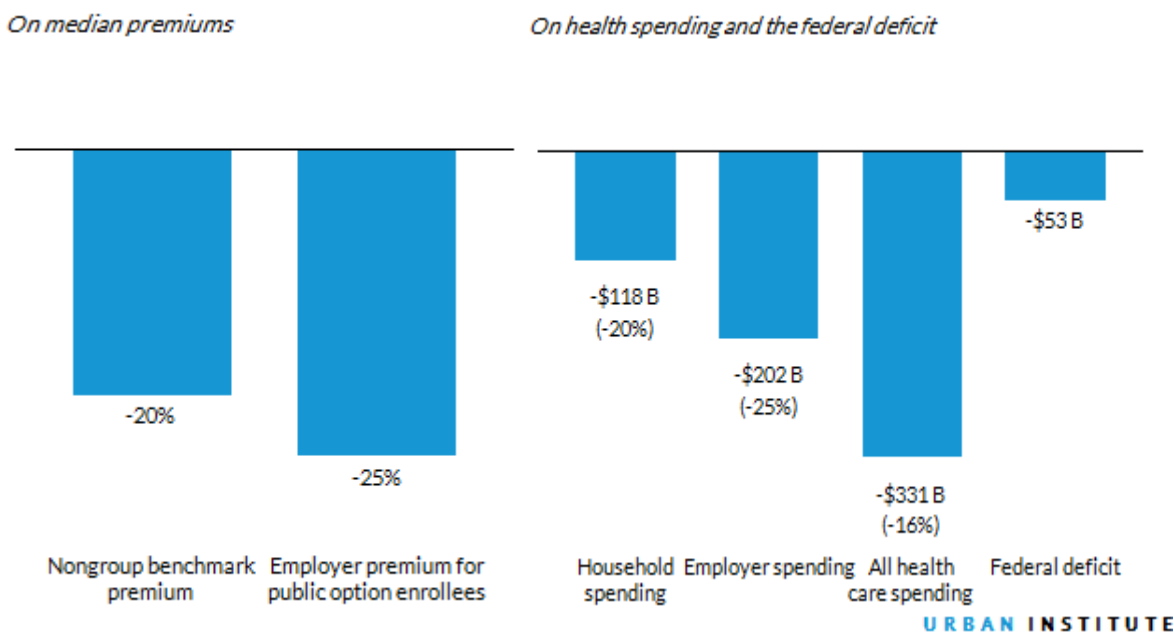
Capped Rates 1: Payment Rates Capped Somewhat above Medicare Levels in Employer and Nongroup Markets

- payment rates capped for all insurers in all employer and nongroup insurance markets
- rates capped at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums fall by 20 percent in nongroup markets and by 25 percent in employer markets. Employer coverage increases by 1.3 million people, and the number of people uninsured falls by 1.1 million.

Health care spending. Capped provider payment rates have greater effects on health care spending than do public option-only reforms, because almost all enrollees in all insurance plans benefit from capped payment rates. Federal spending falls by \$12 billion, or 2.5 percent, almost completely from lower premium tax credits in the nongroup market. Household spending falls by \$118 billion, or 20 percent. Employer premium spending falls by \$202 billion, or 25 percent. As employers pass savings on to workers via higher wages, tax payments increase by \$41 billion and the federal deficit decreases by \$53 billion. Overall health spending falls by \$331 billion, or 16 percent.

FIGURE 7
Effects of Capped Rates 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Capped Rates 2: Payment Rates Capped Considerably above Medicare Levels in the Employer and Nongroup Markets

- payment rates capped for all insurers in all employer and nongroup insurance markets
- rates capped at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums fall by 13 percent in nongroup markets and by 18 percent in employer markets. The number of people uninsured falls by 1.0 million.

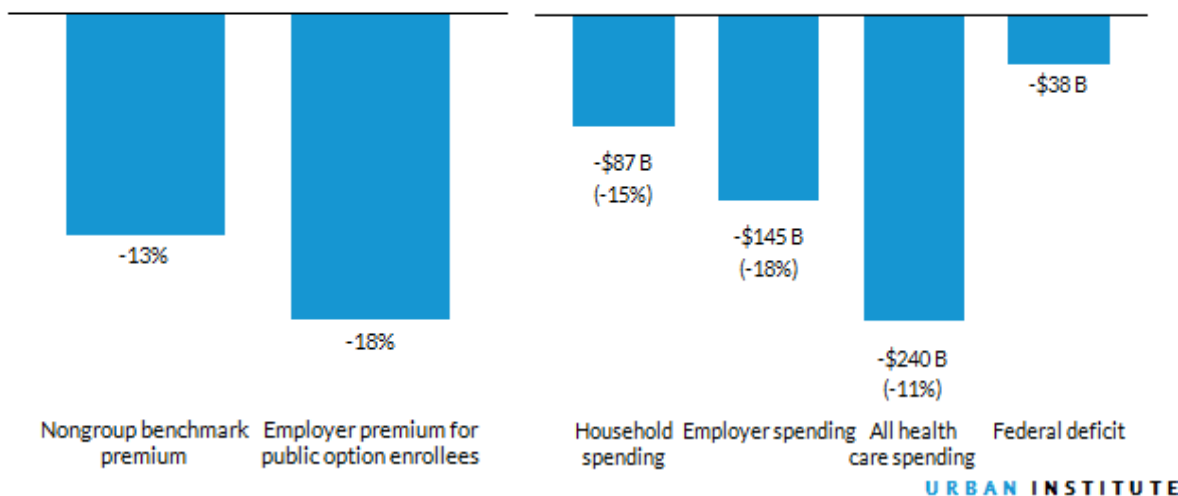
Health care spending. Savings under this reform are smaller than under capped rates 1 because the provider payment rates are higher. Household savings are \$87 billion, or 15 percent. Employers save \$145 billion in premiums, or 18 percent. Federal spending on subsidies falls by almost \$8 billion. Increased tax revenues from higher wages total almost \$30 billion. Thus, the net effect on the deficit is a \$38 billion reduction.

FIGURE 8

Effects of Capped Rates 2

On median premiums

On health spending and the federal deficit



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Discussion

This analysis shows health reforms that reduce prices insurers pay to hospitals, physicians, and other professionals to rates similar to those used by the Medicare program and reduce prescription drug prices below Medicare prices could significantly reduce insurance premiums and government, employer, and household spending. A public option and capped provider payment rates can also reduce the number of people uninsured while increasing cash wages and federal income tax revenues.

The magnitude of these reforms' effects depends on the amount by which provider payment rates are reduced. For example, reducing payment rates to Medicare levels in the nongroup market would reduce median benchmark premiums by 28 percent, the number of people uninsured by 127,000, the federal deficit by \$16 billion, and overall health care spending by \$24 billion. In contrast, setting provider payment rates at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals reduces median benchmark premiums by 12 percent, the number of people uninsured by 95,000, the federal deficit by \$6 billion, and total national health care spending by \$9 billion. Extending the reforms modeled to the employer market as well results in similar differences in premiums and spending.

We also show extending the public option to both employer and nongroup markets has significant implications. Median premiums for employers choosing the public option fall by 18 to 25 percent. The number of people uninsured falls by between 1.0 and 1.1 million, far more than under a policy limited to the nongroup market but still a small relative increase in the number of people enrolled in employer-based coverage. Savings to the federal government are considerably higher under reforms extended to the employer market for two reasons: (1) spending on Marketplace premium tax credits declines, and (2) federal tax revenues increase as employers switch to the public option and pass the savings on premiums to their workers via higher wages. Finally, the impact on national health spending is greater because the scope of the policy is much greater; the health care system would save \$67 to \$156 billion under a public option but \$240 to \$331 billion under capped rates. When implemented in nongroup markets alone, such reforms result in savings ranging from \$9 to \$24 billion.

Lastly, we show capping provider payment rates has significantly greater effects than a public option alone. With the public option, employers can drop their current coverage and enroll workers in the public option. We assume not all employers would do so: Many smaller, lower-wage firms would find it attractive to purchase coverage in the public option. Larger, higher-wage firms may be more likely to prefer providing benefits independently, allowing them to tailor benefit packages, cost sharing, and provider networks to meet their workers' needs. Some employers would not find it prohibitively costly to pay higher premiums for insurance plans using higher provider payment rates. Capped rates apply to all insurers; thus, most employers would benefit regardless of the insurance plan in which their workers were enrolled.

Public option-only reforms and capped provider payment rate reforms would have very different effects on the federal deficit, even if both policies impact both nongroup and employer markets and set provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent

for hospitals. Subsidy costs and new tax revenues would reduce the deficit by \$28 billion under the public option and by \$53 billion under capped rates. Reductions in national health spending would also differ markedly, at \$156 billion under a public option versus \$331 billion under capped rates.

However, options that reduce health care spending the most would also significantly reduce provider revenues, potentially leading to disruptions in the health care delivery system, at least in the near term. This partially depends on how fast payment rates are reduced. Policies that provide the greatest savings to the federal government and health care system overall may be the least politically feasible. Provider payment rates could be lower if public option policies were limited to the nongroup market. But if such reforms are extended further to the employer market, provider payment rates would likely have to be set higher. Future research should explore where the caps could be set and how to govern their growth over time without significantly disrupting the health care system.

Methods

Our analysis relies on the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of a broad array of proposed health care policy reforms for the nonelderly (US residents below age 65 not enrolled in Medicare). We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. For example, the current version accounts for each state's Marketplace premiums and enrollment after the 2020 open enrollment period. Enrollment in each state under current law affects how the model simulates policy alternatives.

We begin each simulation with a current-law baseline in 2022 that includes the estimated effects of, and a partial recovery from, the COVID-19 recession. For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the department planned to extend its public health emergency declaration through calendar year 2021.⁵ This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates, but it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

We then estimate the effects of implementing each of the seven public option or capped rate reforms. Each reform affects professional and hospital payment rates and prescription drug prices in all regions. The different simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employers) in which the public option and/or capped provider payment rates are available. All estimates assume reforms are fully phased in and in equilibrium in 2022.

Because Medicare does not provide benefits to nondisabled, nonelderly people, we estimate possible Medicare payment rates for those people. We assume Medicare rates for people with nongroup insurance would equal what payment rates would be if the region had a highly competitive insurance market and reasonably competitive hospital market, and these rates vary significantly by rating region. We then set payments by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, according to the assumption for each reform and the share of spending for each service type within the region.

Our approach differs for people with employer-sponsored insurance. We obtained estimates of the ratio of commercial insurer payment rates to Medicare rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to estimate costs for people with employer-based insurance entering the public option or having provider payments capped. For all public option or capped payment rate reforms, prices for prescription drugs in all areas are set halfway between those paid by Medicare and Medicaid after rebates.

Savings in the nongroup market apply to all enrollees under either a public option or capped provider payment rates. The model implicitly assumes all enrollees are affected by the public option because we assume the Marketplace benchmark premium would decrease by the percent difference between the public option and baseline premiums. For people with employer-sponsored insurance, only those in firms opting in to the public option see savings. We assume firms that are small, pay lower average wages, and expect significant savings are more likely to choose the public option than large firms, those paying higher wages, and those expecting small savings from the switch. Capped rates 1 and 2 limit all provider payments in all areas, reducing payments for everyone with employer-sponsored coverage. We discuss additional methodological issues in our earlier report (Blumberg et al. 2020).

Limitations

Uncertainty surrounds our estimates of the impacts of a public option or capping provider payment rates for several reasons: a lack of data on commercial payment rates in the nongroup market, the relevance of claims data to estimate the ratio of commercial payment rates to Medicare rates in the employer market, the need to estimate households' and firms' decisions to participate in the public option, and the need to make assumptions about the savings from regulating prescription drug prices. For each factor, different data can be used and assumptions made. Thus, our results may differ from actual results or those projected in other analyses.

- For the nongroup reform estimates, we lack actual payment rate data. We estimate Medicare payment rates using regression analyses. We assume markets with a large number of insurers and low hospital concentration have payment rates that approximate Medicare prices and thus premiums. Markets without these characteristics tend to have higher premiums. We estimate high premiums in markets with high insurer and hospital concentration will decrease to the levels seen in more competitive markets. But, the high premiums we observe in noncompetitive regions could owe to factors other than higher provider payment rates.

- We assume the public option is the benchmark plan. We cannot estimate how many people choose plans that have higher premiums than the benchmark. To the extent individuals enroll in more expensive plans, we may underestimate household spending in nongroup reform estimates.
- We use data from FAIR Health, which collects data from a large number of firms. However, the data do not contain all private plans in a state or substate area. Thus, the contributing insurers may not be entirely representative, despite their very large amount of data. Further, though the data include plans covering 75 percent of the privately insured population in the United States, they include some Medicare Advantage plans and plans participating in the nongroup market.
- FAIR Health provided us with data on payments for professional and outpatient facilities representing 47 percent of total professional spending and 42 percent of total outpatient facility spending. However, the services may not fully represent the average ratio of commercial insurer payment rates to Medicare rates. More importantly, FAIR Health does not release substate data on commercial payment rates for inpatient hospital services; our estimates include all inpatient services provided in the state, but lacking this information could lead to some error at the substate level.
- We have made assumptions about employer take-up of the public option by firm size, wages, and expected savings. Take-up of the public option is assumed to be higher for small, low-wage firms, and we assume a firm chooses the public option only when the resulting savings exceed 20 percent. Our assumptions are somewhat arbitrary, and different assumptions would have different results. Our capped rate simulations estimate the extreme case of all employers choosing the public option.
- Employers may gravitate to the public option over time. Our analysis assumes the policy is fully phased in and in equilibrium and therefore accounts for all long-term employer behavior.
- In our estimates of prescription drug savings, we assume drug pricing rebates from various private payers are the same across the country. If the mix of drugs consumed varies geographically, our rebates may be estimated with error. Medicare's pharmacy benefit manufacturers differ by geography, with some getting better rebates from manufacturers than others. Thus, Medicare rebates could differ across states, but we do not account for this.
- We estimate rebates for the public option would lead to prescription drug prices halfway between Medicaid and Medicare prices, or 30 percent below commercial insurance prices. These prices seem reasonable because they are less than those currently achieved in Medicaid and considerably less than in other western nations. We may also have underestimated the savings a public option could achieve. However, it has been politically difficult in the US to achieve lower drug prices, so we are cautious in our estimates. Any differences or errors in our savings estimates would be tempered by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

Supplementary Tables

TABLE 2
Rating Region – Level Distribution of Changes in Nongroup and Employer Premiums in Nongroup and Employer Reforms, 2022
Percent change from current-law premiums

	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Nongroup^a							
Percentile							
10th	-43	-34	-27	-36	-28	-36	-28
25th	-40	-32	-21	-33	-23	-33	-23
50th (median)	-28	-19	-12	-20	-13	-20	-13
75th	-17	-7	-5	-9	-5	-9	-5
90th	-12	-4	**	-5	-1	-5	-1
All employers							
Percentile							
10th	NA	NA	NA	-14	-7	-28	-21
25th	NA	NA	NA	-13	-6	-28	-21
50th (median)	NA	NA	NA	-12	-5	-26	-19
75th	NA	NA	NA	-11	-4	-25	-18
90th	NA	NA	NA	-10	-3	-24	-17
Employers offering public option^b							
Percentile							
10th	NA	NA	NA	-27	-22	-27	-20
25th	NA	NA	NA	-26	-20	-26	-19
50th (median)	NA	NA	NA	-25	-18	-25	-18
75th	NA	NA	NA	-24	-17	-24	-17
90th	NA	NA	NA	-22	-13	-23	-15

Source: Health Insurance Policy Simulation Model, 2021.

Notes: NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.

^a These rows show the change in the median nongroup benchmark premium.

^b These rows show the change in the median premiums among employers providing the public option to their workers in public options 4 and 5. For capped rates 1 and 2, they show the change in median premiums for all employers.

** = less than +/- 0.5%.

TABLE 3

Health Insurance Coverage of the Nonelderly Population under Current Law and Nongroup and Employer Reforms, 2022

Coverage (thousands of people)	Current law						Capped rates		Capped rates 2
	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	1	2		
Insured (MEC)	244,113	244,240	244,208	245,230	245,150	245,230	245,230	245,150	
Employer	149,325	149,258	149,264	150,649	150,573	150,649	150,649	150,573	
Traditional	149,325	149,258	149,264	75,847	107,989	0	0	0	
Public option	0	0	0	74,802	42,584	150,649	150,649	150,573	
Private nongroup	14,960	15,056	15,034	14,664	14,667	14,664	14,664	14,667	
Medicaid/CHIP	71,162	71,261	71,245	71,251	71,245	71,251	71,251	71,245	
Other public	8,665	8,665	8,665	8,665	8,665	8,665	8,665	8,665	
Uninsured (no MEC)^a	33,333	33,206	33,239	32,216	32,297	32,216	32,216	32,297	
Total	277,446	277,446	277,446	277,446	277,446	277,446	277,446	277,446	
<i>Change from current law (thousands of people)</i>									
Insured (MEC)	127	109	95	1,117	1,037	1,117	1,117	1,037	
Employer	-67	-64	-61	1,324	1,248	1,324	1,324	1,248	
Traditional	-67	-64	-61	-73,479	-41,336	-149,325	-149,325	-149,325	
Public option	0	0	0	74,802	42,584	150,649	150,649	150,573	
Private nongroup	95	83	73	-296	-294	-296	-296	-294	
Medicaid/CHIP	99	90	83	90	83	90	90	83	
Other public	0	0	0	0	0	0	0	0	
Uninsured (no MEC)^a	-127	-109	-95	-1,117	-1,037	-1,117	-1,117	-1,037	
Total	0	0	0	0	0	0	0	0	
<i>Change from current law (%)</i>									
Insured (MEC)	0.1	**	**	0.5	0.4	0.5	0.5	0.4	
Employer	**	**	**	0.9	0.8	0.9	0.9	0.8	
Traditional	0.0	0.0	0.0	-49.2	-27.7	-100.0	-100.0	-100.0	
Public option	NA	NA	NA	NA	NA	NA	NA	NA	
Private nongroup	0.6	0.6	0.5	-2.0	-2.0	-2.0	-2.0	-2.0	
Medicaid/CHIP	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	
Other public	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Uninsured (no MEC)^a	-0.4	-0.3	-0.3	-3.4	-3.1	-3.4	-3.4	-3.1	
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

Source: Health Insurance Policy Simulation Model, 2021.

Notes: MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. NA= not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.

^a Includes those without insurance and those with short-term, limited-duration plans.
 ** = less than +/- 0.05%.

TABLE 4
Health Spending for the Nonelderly Population under Current Law and under Nongroup and Employer Reforms, 2022
Health spending (millions of dollars)

Reform	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Household	587,856	579,765	582,780	584,651	529,653	560,801	470,327	500,445
Federal government	467,105	451,742	457,572	461,267	455,432	459,108	455,432	459,108
State government	220,370	220,386	220,400	220,395	220,271	220,318	220,271	220,318
Employers	800,116	799,992	799,996	800,000	714,200	767,957	598,424	655,417
Providers	27,475	27,371	27,381	27,380	27,218	27,289	27,218	27,289
Total, all payers	2,102,923	2,079,257	2,088,128	2,093,692	1,946,774	2,035,473	1,771,672	1,862,576
<i>Change from current law (millions of dollars)</i>								
Household	—	-8,092	-5,077	-3,205	-58,203	-27,055	-117,529	-87,412
Federal government	—	-15,362	-9,533	-5,838	-11,673	-7,997	-11,673	-7,997
State government	—	16	30	25	-99	-52	-99	-52
Employers	—	-124	-120	-116	-85,916	-32,159	-201,692	-144,699
Providers	—	-104	-94	-96	-257	-187	-257	-187
Total, all payers	—	-23,666	-14,795	-9,230	-156,148	-67,450	-331,250	-240,346
Federal tax offset from ESI change	—	NA	NA	NA	16,715	5,242	41,223	29,633
<i>Change from current law (%)</i>								
Household	—	-1.4	-0.9	-0.5	-9.9	-4.6	-20.0	-14.9
Federal government	—	-3.3	-2.0	-1.2	-2.5	-1.7	-2.5	-1.7
State government	—	**	**	**	**	**	**	**
Employers	—	**	**	**	-10.7	-4.0	-25.2	-18.1
Providers	—	-0.4	-0.3	-0.3	-0.9	-0.7	-0.9	-0.7
Total, all payers	—	-1.1	-0.7	-0.4	-7.4	-3.2	-15.8	-11.4

Source: Health Insurance Policy Simulation Model, 2021.

Notes: Dashes indicate the column heading does not apply. NA= not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.
 ** = less than +/- 0.05%.

Notes

- ¹ [Choose Medicare Act](#), S. 1261, 116th Cong. (2019).
- ² See, for example, see [Blumberg and colleagues \(2019\)](#).
- ³ Under current law, Marketplace premium tax credits are tied to the benchmark plan premium in each geographic premium rating area. Subsidized enrollees can enroll in the benchmark plan without paying more than the applicable percentage-of-income cap. Subsidized enrollees choosing higher-premium options must pay the difference between the benchmark premium and their chosen plan's premium; those choosing a plan with a lower premium pay less than their percentage-of-income cap.
- ⁴ For estimates of the effects of reforms that include enhanced nongroup market subsidies combined with a public option, see [Blumberg and colleagues \(2019\)](#).
- ⁵ Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding extension of COVID-19 public health emergency, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.

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About the Authors

John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Michael Simpson is a principal research associate in the Health Policy Center with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

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Public Option and Capped Provider Payment Rate Proposals That Exempt Rural Areas

John Holahan and Michael Simpson

March 2021

In recent years, we have completed extensive analyses of proposals that would introduce a public health insurance option or cap provider payment rates for all insurers, as in Medicare Advantage (Blumberg et al. 2019, 2020; Blumberg, Simpson, and Buettgens 2019). In this and two accompanying papers (Holahan and Simpson 2021a, 2021b), we analyze such reforms that apply to the nongroup health insurance market only and some that would apply both in the nongroup and employer health insurance markets. Here, we explore the coverage and cost impacts of introducing these reforms in urban areas only, leaving rural areas' insurance markets unchanged. This reform is motivated by concern that providers in rural areas, both physicians and hospitals, are under considerable financial stress. It is often difficult to attract physicians to rural areas, and a large number of rural hospitals face threats of closure or shrinkage. Constraints on payment rates could exacerbate these problems. On the other hand, exempting rural areas from payment constraints would mean rural residents and employers pay more for coverage.

We show exempting rural areas in these reforms would not significantly affect aggregate household and employer spending, federal government spending, or overall spending. This is because the number of people living in areas we characterize as rural is relatively small. Rural providers are, by design, better off if exempted from the reforms we examine. However, more rural residents would be uninsured and household and employer spending would generally be higher. Moreover, more federal dollars will flow to rural areas if they are exempted from the reforms.

As noted, we examine public option and capped provider payment rate proposals that would be introduced solely in the nongroup market as well as in both the nongroup and employer markets. The public option would be a government-developed insurance plan that pays professionals (doctors and other health providers), hospitals, and prescription drug manufacturers according to a fee schedule that uses lower rates than those typical of commercial insurers. Discussions of a public option typically center around provider payment rates, specifically, whether they should be set at Medicare rates or some multiple thereof. Savings are greatest when Medicare rates (or lower rates) are used, but that may limit provider participation. Conversely, setting rates too far above Medicare levels could result in very little savings. But providers would be more likely to participate and would see little reduction in revenue.

The public option would require consumers (households and/or employers) to enroll in a new insurance plan to take full advantage of savings. The competition from a public option could result in more aggressive negotiations between private insurers and providers for lower rates, possibly lowering private plan premiums as well. Private insurers that cannot successfully negotiate lower provider payment rates may end up leaving insurance markets.

We also examine reforms that cap provider payment rates for all insurers, as is done in Medicare Advantage. Providers would be required to accept payment rates no higher than established amounts for both in- and out-of-network services. Presumably, the payment rates would be set below those typical of commercial insurers in most markets. Like a public option, capped provider payment rates could also be used in the nongroup market alone or in both nongroup and employer markets. Capping provider payment rates does not exclude the possibility of also having a public option, similar to the way private insurers with capped provider payment rates compete with traditional Medicare in the Medicare Advantage market. Capping rates would allow consumers to reap the full cost savings while enrolling with any insurer, not just the public option. With a capped rate policy, more private insurers are likely to enter and stay in insurance markets because large market share is not needed as leverage for negotiating payment rates with providers.

In this paper, we examine three reforms that would be implemented in just the nongroup market in urban areas. Public option 1 would pay providers at Medicare rates. This option has the deepest cut in payment rates and results in the greatest savings. Public option 2 would pay Medicare rates plus 10 percent for professionals (physicians and other providers) and plus 25 percent for hospitals (or current rates, if the proposed Medicare-like rates would exceed current rates).¹ Public option 3 would pay Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. Of the three nongroup market-only reforms, public option 3 provides the least savings but would be the most acceptable to providers.

We also examine four reforms that would extend the public option or capped rates to both the employer and nongroup markets in urban areas, potentially covering many more lives. Because more people would be affected and payment rates are higher in the employer market than the nongroup market, using Medicare rates could dramatically affect provider revenues (Blumberg et al. 2020). Thus, we assume rates are set somewhat above Medicare levels. In public option 4, payment rates in the

nongroup and employer markets would be set at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals. Public option 5 would also introduce the public option into both the nongroup and employer markets, paying Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. The final two reforms would cap provider payment rates for all insurers. Capped rates 1 would pay Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals. Capped rates 2 would pay Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals.

In each policy option, we assume prescription drug savings would apply in both urban and rural markets. We assume legislation establishing a public option would establish rebates halfway between those for Medicare and Medicaid and would be in effect nationally. Markets for prescription drugs differ from those for hospitals and professionals, and the arguments for exempting rural areas do not apply; under the reforms examined, access to prescription drugs is unlikely to be affected, because drugs are priced nationally. We estimate elsewhere these savings approximate a 30 percent cut relative to commercial payments (Hwang and Kesselheim 2020).

Characteristics of Urban or Rural Areas

Table 1 shows the differences in characteristics of urban and rural rating regions. Rural regions have considerably smaller population size, and many fewer people live in rural areas than urban areas. Thus, policies that exempt rural areas will have smaller effects on federal spending relative to policies that include them. Rural populations are slightly older, less likely to have employer-sponsored insurance, more likely to be covered by Medicaid, and more likely to have considerably lower per capita incomes. In addition, almost all rural areas have concentrated hospital systems, and most have concentrated nongroup insurance markets. Policies that would exempt rural areas would therefore exempt markets with high hospital or insurer concentration, which tend to have higher prices for hospital and professional services than less concentrated markets.

TABLE 1

Characteristics of Rural and Urban Regions, 2022

	Rural	Urban
Population		
Millions under age 65	53	224
Average population of an ACA rating region (thousands)	317	866
Average age	40.8	39.0
Average age of people younger than 65	32.2	31.9
Health insurance coverage among people under 65		
Employer	51%	55%
ACA-compliant nongroup	5%	5%
Medicaid/CHIP	28%	25%
Other public	4%	3%
Uninsured	11%	11%
Short-term, limited duration plan	1%	1%
Average family income among people under 65		
Thousands of dollars	60.3	76.7
As a share of FPL	307%	388%
Hospital/nongroup market concentration		
Share of people under 65 living in concentrated hospital markets ^a	93%	30%
Share of people under 65 living in concentrated hospital and/or ACA nongroup insurance markets ^b	94%	46%

Source: Health Insurance Policy Simulation Model, 2021.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program. FPL = federal poverty level.

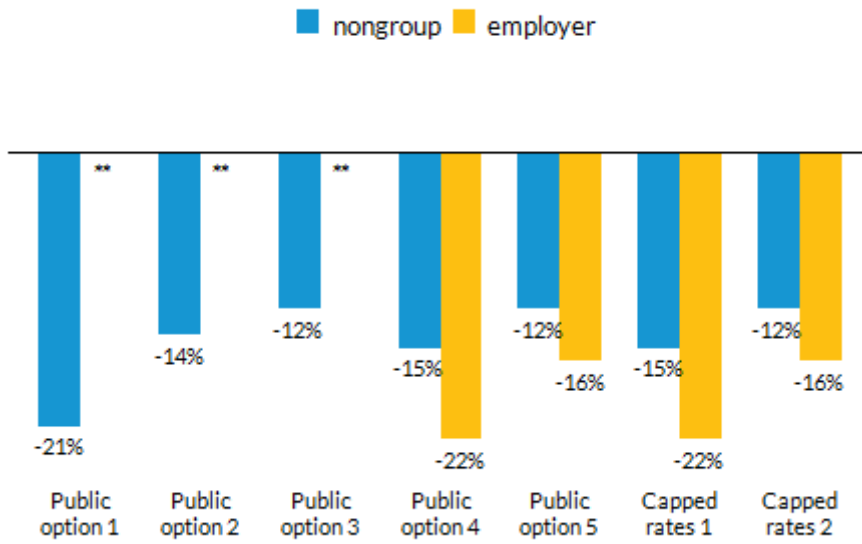
^a Concentrated markets have HHI > 5,000.

^b Concentrated markets have HHI > 5,000 and/or two of fewer insurers in the ACA nongroup market.

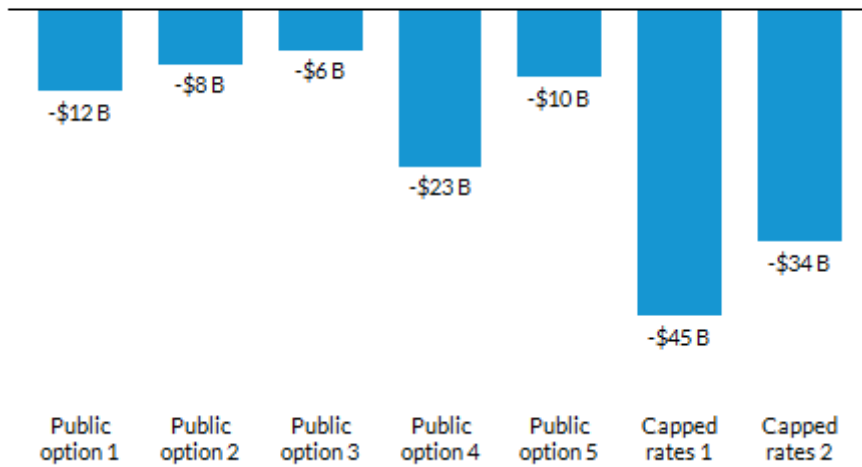
Highlights of Findings

Figure 1 and table 2 summarize our main findings; supplementary tables at the end of the paper show additional details. All estimates assume reforms are fully implemented in 2022. We acknowledge considerable uncertainty surrounding these estimates, which we detail in the methods section. Our primary limitation is the absence of ideal data sources, which forces us to make assumptions and use proxy measures in some areas.

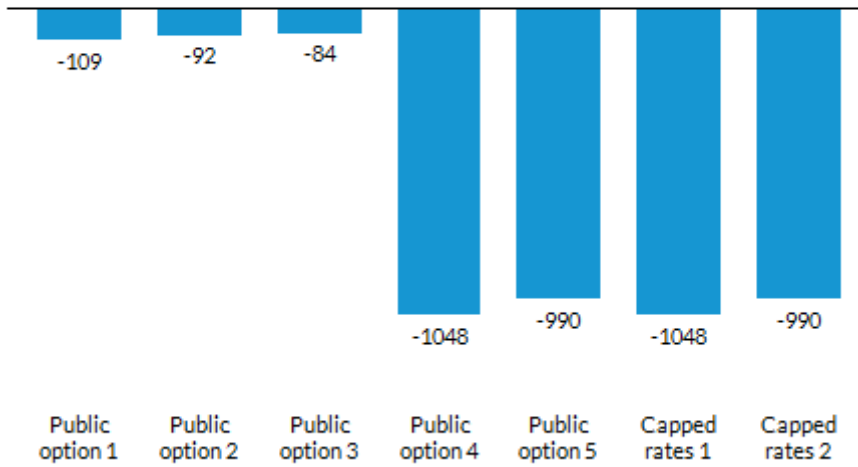
FIGURE 1
Summary of Effects of Reform Options for Urban Areas, 2022
On median premiums



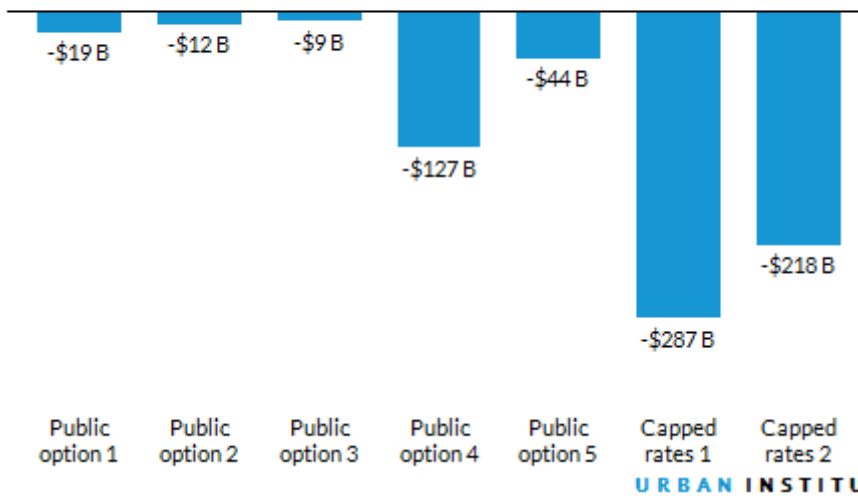
On the federal deficit



On thousands of people uninsured



On health system spending



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Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

- Premium and coverage in the nongroup market.** We estimate a public option in only the nongroup market would lower median premiums by 12 to 21 percent in urban areas. Urban markets tend to be more competitive than rural markets, so premium reductions would be lower than in rural areas, if rural areas were included. The greatest reductions in premiums occur under reforms that have the greatest impact on provider payment rates. We estimate

premiums in rural areas would fall by 7 percent, because we apply increases in prescription drug rebates to rural areas. The coverage effects of public option policies in the nongroup market are very small, because most people in the Marketplace have subsidies. Thus, changes in overall premiums mostly change the subsidy amount, not the premium paid by the household, which is limited to a specified percentage of income. In this paper, we do not consider policies that would expand subsidies to improve coverage.

- **Federal, household, and employer health spending in the nongroup market.** The lower nongroup premiums in the reforms modeled decrease federal spending, primarily on premium tax credits, by \$6 to \$12 billion. Household and employer spending is largely unaffected. Effects on spending are small because the nongroup market is small.
- **Premiums and coverage in the employer market.** A public option or capped provider payment rates tend to lower premiums more in the employer market than in the nongroup market, because employer markets are generally less competitive and pay higher rates to providers. Under reforms that extend a public option to the employer market, we estimate median premiums for participating employers fall by 16 to 22 percent. Reductions in premiums are larger for reforms with greater reductions in provider payment rates. Offering the public option or capped payment rates in the employer market could reduce the number of people uninsured by about 1 million.
- **Employer and household spending.** Extending the public option or capped rates to the employer market has significant effects on employer and aggregate household spending. When the public option is extended to employer markets, employer spending falls by between \$18 and \$69 billion. Employers save more under capped rates in the employer market, from \$130 to \$173 billion. With a public option alone in the employer market, household spending falls by \$19 to \$48 billion; under capped rates in the employer market, household spending falls by \$80 to \$104 billion.
- **The federal deficit.** Federal spending on premium subsidies continues to fall in the nongroup market, but increases in federal tax revenues are much more important. As employers spend less on premiums, economic research indicates they convert the savings into higher wages for their workers. Higher wages are taxable, thus helping reduce the federal deficit. When the reforms are introduced into the employer market, the federal deficit falls by \$10 to \$23 billion under a public option and by between \$34 and \$45 billion under capped rates.
- **National health spending.** National health spending on the nonelderly falls by less than 1 percent if the public option is limited to the nongroup market. If a public option is available to employers as well, spending by all payers could fall by as much as 6 percent, depending on the payment rates used. With capped payment rates, spending by all payers could fall by as much as 14 percent.

TABLE 2

Public Option and Capped Provider Payment Rate Reforms for Urban Areas, 2022

Reform	Availability of public option	Payment policy ^a	Change						
			In median nongroup premiums ^b	In median employer premiums ^c	In number of uninsured	In the federal deficit ^d	In employer spending	In household spending	In health system spending
Public option 1	Nongroup urban markets	Medicare rates	-21%	NA	-109,000	-\$12 B	*	-\$6 B (-1%)	-\$19 B (-1%)
Public option 2	Nongroup urban markets	Medicare rates plus 10% for professionals and hospitals plus 25% for hospitals	-14%	NA	-92,000	-\$8 B	*	-\$4 B (-1%)	-\$12 B (-1%)
Public option 3	Nongroup urban markets	Medicare rates plus 15% for professionals and hospitals plus 60% for hospitals	-12%	NA	-84,000	-\$6 B	*	-\$3 B (-1%)	-\$9 B (**)
Public option 4	Nongroup and employer markets in urban areas; subset of firms choose public option	Medicare rates plus 10% for professionals and hospitals plus 25% for hospitals	-15%	-22%	-1,048,000	-\$23 B	-\$69 B (-9%)	-\$48 B (-8%)	-\$127 B (-6%)
Public option 5	Nongroup and employer markets in urban areas; subset of firms choose public option	Medicare rates plus 15% for professionals and hospitals plus 60% for hospitals	-12%	-16%	-990,000	-\$10 B	-\$18 B (-2%)	-\$19 B (-3%)	-\$44 B (-2%)
Capped rates 1	Nongroup and employer markets in urban areas; all employers pay lower rates	Medicare rates plus 10% for professionals and hospitals plus 25% for hospitals	-15%	-22%	-1,048,000	-\$45 B	-\$173 B (-22%)	-\$104 B (-18%)	-\$287 B (-14%)
Capped rates 2	Nongroup and employer markets in urban areas; all employers pay lower rates	Medicare rates plus 15% for professionals and hospitals plus 60% for hospitals	-12%	-16%	-990,000	-\$34 B	-\$130 B (-16%)	-\$80 B (-14%)	-\$218 B (-10%)

Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

^a Prescription drug prices in each reform scenario are assumed to be halfway between Medicare and Medicaid prices in all (urban and rural) markets.

^b This column shows the change in the median nongroup benchmark premium in urban and mostly urban markets.

^c This column shows the change in median premiums in urban and mostly urban markets among employers providing the public option to their workers in public options 4 and 5. In capped rates 1 and 2, this column shows the change in median premiums for all employers in urban and mostly urban markets.

^d Estimates in this column equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

Projected Impacts of a Public Option and Capped Provider Payment Rates Limited to Urban Markets

In the results below, we present estimated changes in median nongroup and employer premiums, health insurance coverage, and health care spending by households, employers, and the federal government in urban areas under the reforms modeled. All estimates are generated using the Health Insurance Policy Simulation Model (HIPSM; Buettgens and Banthin 2020). We also show the estimated increase in federal income tax revenue that results from employers achieving savings in health insurance costs and passing them on to workers via higher wages, which results in higher tax payments. In addition, we show the impact on the federal deficit, which is a combination of the reduction in federal government spending, primarily from lower spending on Marketplace premium tax credits, and, when reforms include employer-sponsored insurance, the increased income tax revenue.

As noted, all estimates assume reforms are fully phased in and in equilibrium in 2022. This means the supply of services is assumed to expand to meet the increased demand for services. (We also assume services provided are unaffected by decreased provider payments.) In reality, the reforms would more likely require a multiyear phase-in, over which payment rates would decrease toward target levels. How long the phase-in takes will determine the underlying cost savings to households, employers, and the federal government. The slower pace of payment rate reductions, the less potentially disruptive to the health system and the more politically feasible the reform will likely be. The results below are for reforms that exempt rural areas, except for drug savings, which reduces rural premiums by 7 percent.

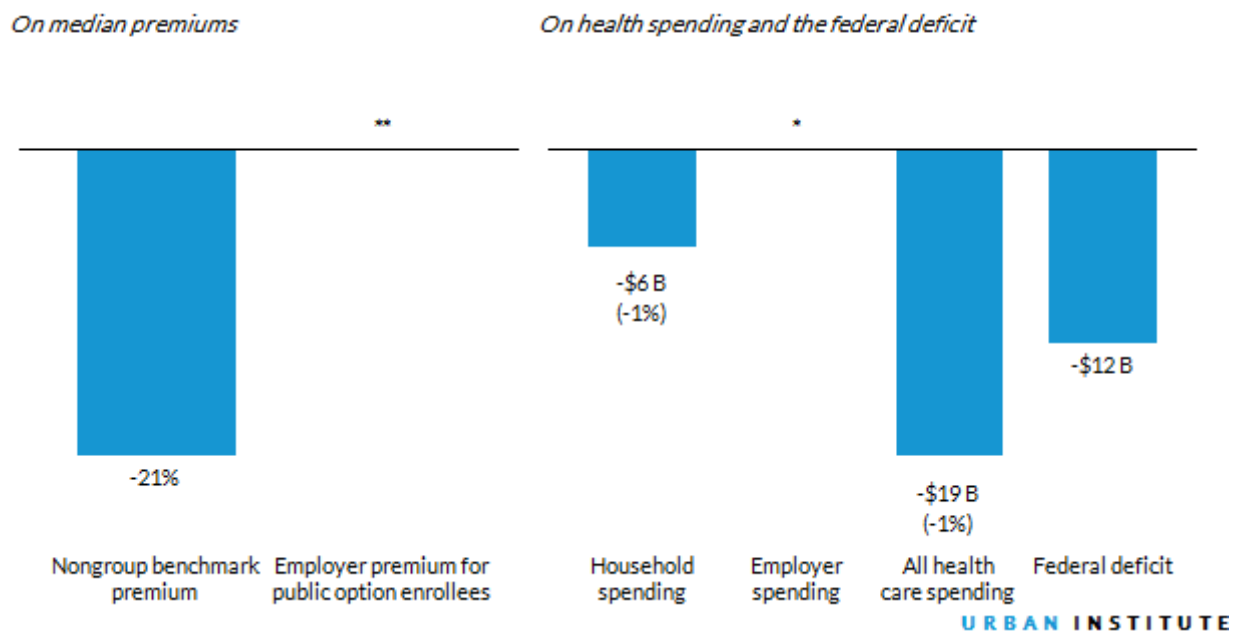
Public Option 1: Medicare Rates in Nongroup Markets

- public option in the private nongroup market in urban areas
- pays Medicare rates for hospitals and professionals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median benchmark premium falls by 21 percent in urban areas because of the lower Medicare payment rates. The number of people uninsured decreases by 109,000, a small effect because only households facing full, unsubsidized nongroup premiums are affected.

Health care spending. Because benchmark nongroup premiums fall in urban markets, Marketplace tax credits also fall, because the credits are tied to those premiums. Federal health spending, primarily on premium tax credits, falls by \$12 billion.² Employer spending is essentially unchanged. Aggregate household spending decreases by \$6 billion, or 1 percent. Because the policy only affects the nongroup market, it affects a small share of the population. Overall spending on the nonelderly falls by \$19 billion, or about 1 percent.

FIGURE 2
Effects of Public Option 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

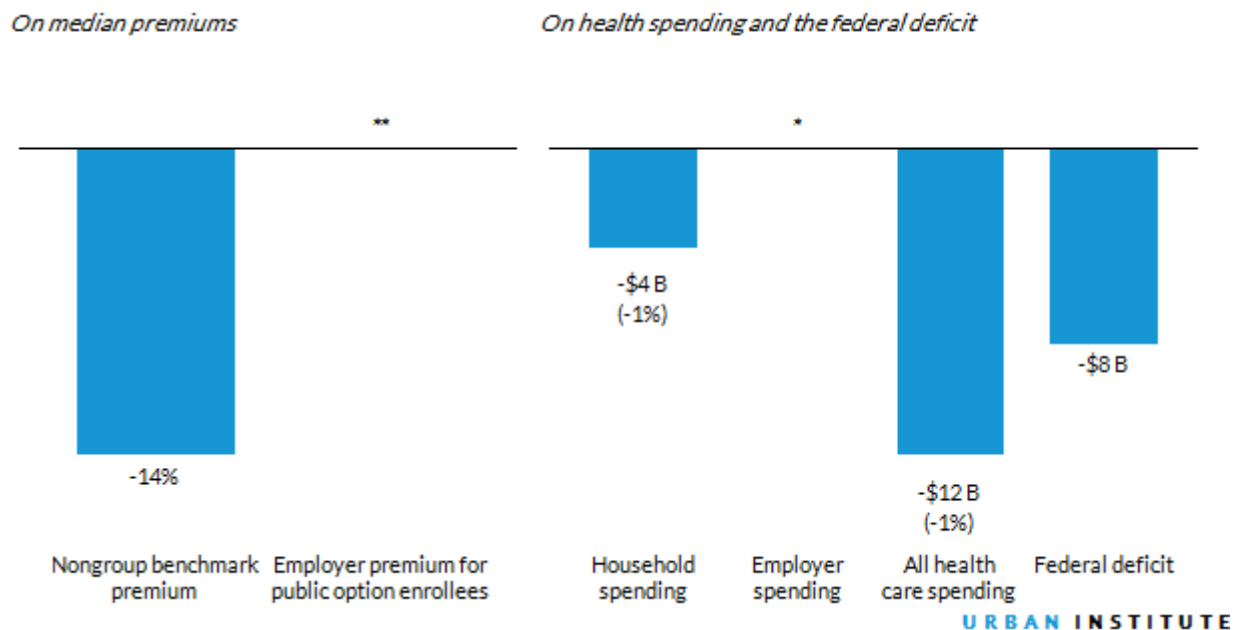
Public Option 2: Medicare Rates with Modest Upward Adjustments

- public option introduced in nongroup markets in urban areas
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median household premiums fall by 14 percent because hospital and physician payment rates are higher than under public option 1. Because premium savings are smaller, the impact on the uninsured population is also smaller; the number of people uninsured declines by 92,000.

Health care spending. Federal spending declines by only \$8 billion, almost all because of the reduction in Marketplace subsidies. Aggregate household spending falls by \$4 billion, or around 1 percent. Employer spending declines very slightly. Overall health care spending falls by \$12 billion, or slightly less than 1 percent.

FIGURE 3
Effects of Public Option 2



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

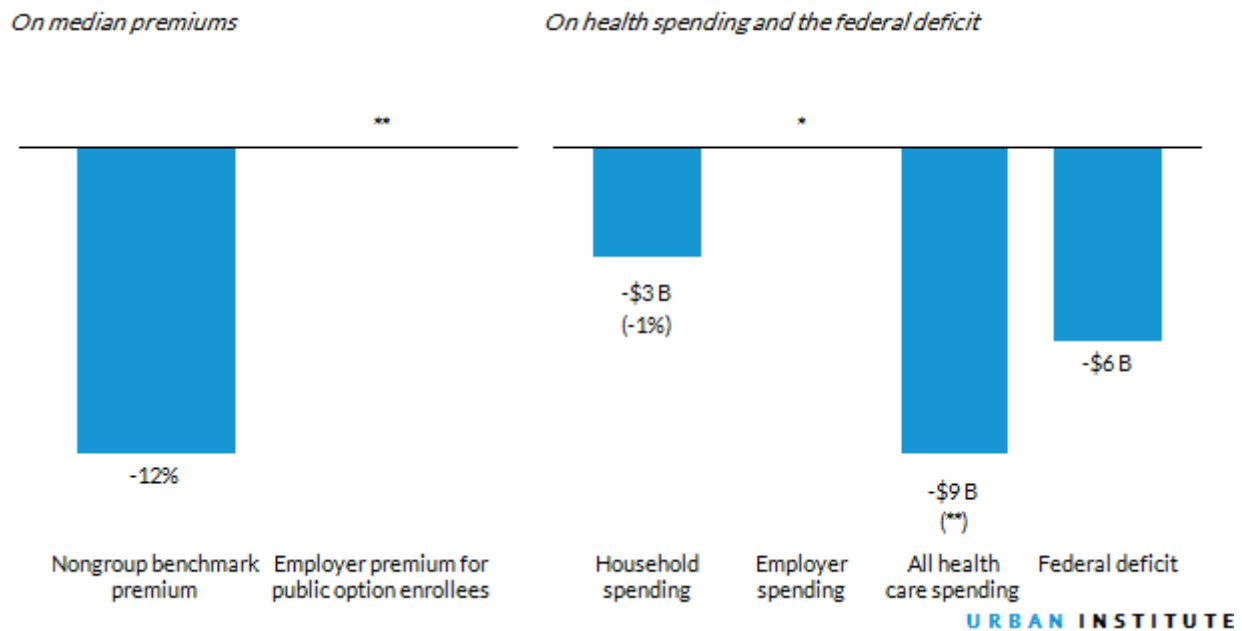
Public Option 3: Medicare Rates with Large Upward Adjustments

- public option in private nongroup insurance markets in urban areas
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums in the nongroup market fall by 12 percent, because the higher payment rates reduce available savings. The number of people uninsured falls by 84,000, less than under public option 2 because of the smaller reduction in premiums.

Health care spending. Federal health care spending falls by \$6 billion, or slightly more than 1 percent, because of lower premium tax credits. Aggregate household spending falls by only \$3 billion, whereas employer spending declines very slightly, because of a small decrease in employer coverage. Overall health care spending falls by \$9 billion, less than 0.5 percent. Setting caps on physician and hospital payments at relatively high rates yields little savings to households, employers, or the federal government. This illustrates that a public option's effects on health care costs depends on how payment rates are set.

FIGURE 4
Effects of Public Option 3



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- \$500 million. ** = less than +/- 0.5%.

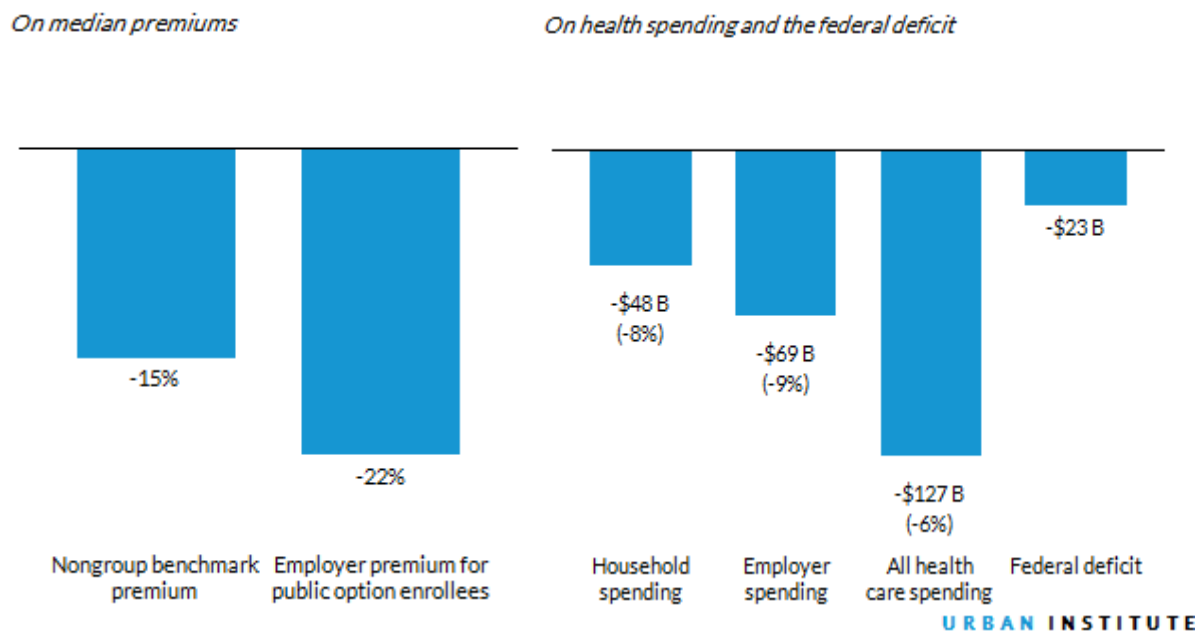
Public Option 4: Payment Rates Modestly above Medicare Levels in Nongroup and Employer Markets

- public option available in the employer and nongroup markets in urban areas; a subset of employers choose the public option
- public option pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median premium for employers choosing the public option falls by 22 percent, whereas the median nongroup premium falls by 15 percent. Premium reductions are larger in the employer market than nongroup market because employer insurance markets tend to be less competitive, and nongroup markets tend to be very competitive in most urban markets. This option reduces the number of people uninsured by 1 million, because almost 1.3 million people gain employer coverage.

Health care spending. Extending the public option to the employer market has dramatically larger effects than limiting it to the nongroup market. Aggregate household spending falls by \$48 billion, or 8 percent. Employer spending falls by \$69 billion, or 9 percent. Spending by the federal government, primarily on premium tax credits, falls by \$10 billion, or 2 percent. Reduced employer spending leads to a \$13 billion increase in tax revenues. The net effect on the federal deficit is \$23 billion reduction. Overall health system spending falls by \$127 billion, or 6 percent.

FIGURE 5
Effects of Public Option 4



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

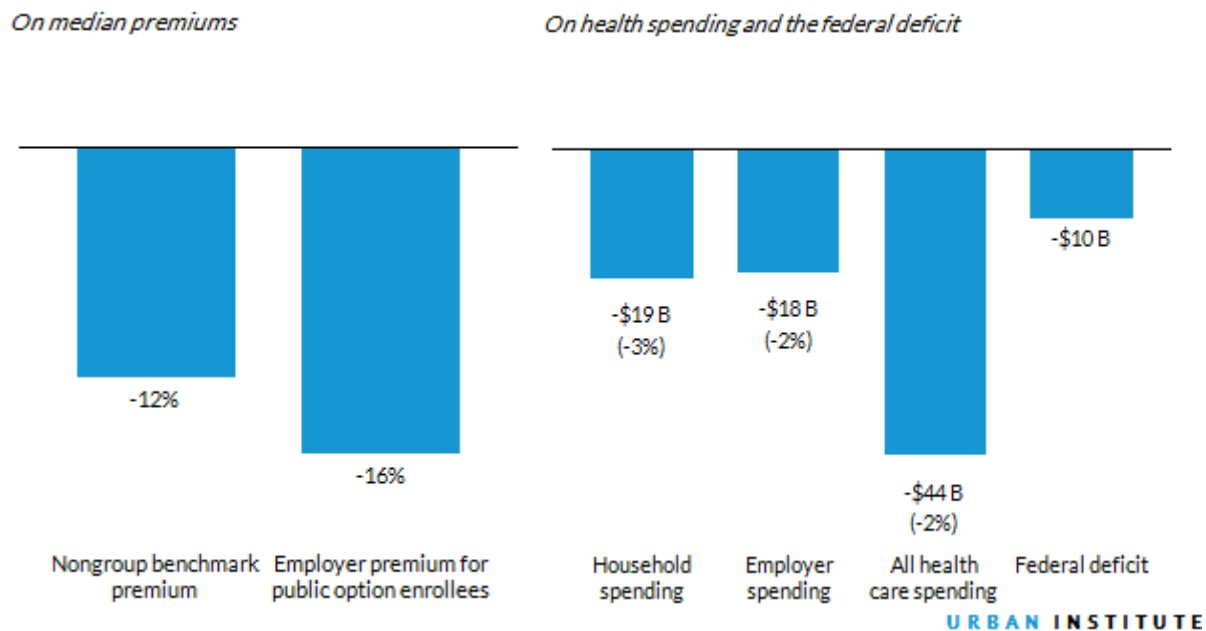
Public Option 5: Payment Rates Considerably above Medicare Levels in Both Employer and Nongroup Markets

- public option available in the employer and nongroup markets in urban areas; a subset of employers choose the public option
- public option pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median employer premium falls by 16 percent, whereas the benchmark nongroup premium falls by 12 percent. The number of people uninsured falls by 1 million, or 3 percent, because 1.2 million people gain employer coverage. This results from employers expanding offers of coverage in response to the availability of the lower-premium public option.

Health care spending. This reform primarily affects employer and household spending. Aggregate household spending falls by \$19 billion, or 3 percent. Employer spending falls by \$18 billion, or 2 percent. Federal spending declines by \$8 billion, or 2 percent, because of reduced premiums in the nongroup market. Federal tax revenues increase by \$2 billion, thereby decreasing the federal deficit by \$10 billion. Overall health system spending falls by \$44 billion, or 2 percent.

FIGURE 6
Effects of Public Option 5



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Capped Rates 1: Payment Rates Capped Somewhat above Medicare Levels in the Employer and Nongroup Markets

- payment rates capped for all insurers in employer and nongroup markets in urban areas
- rates set at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The medium employer premium falls by 22 percent, and the benchmark nongroup premium falls by 15 percent. The number of people uninsured falls by 1 million, or 3 percent, because almost 1.3 million people gain employer coverage.

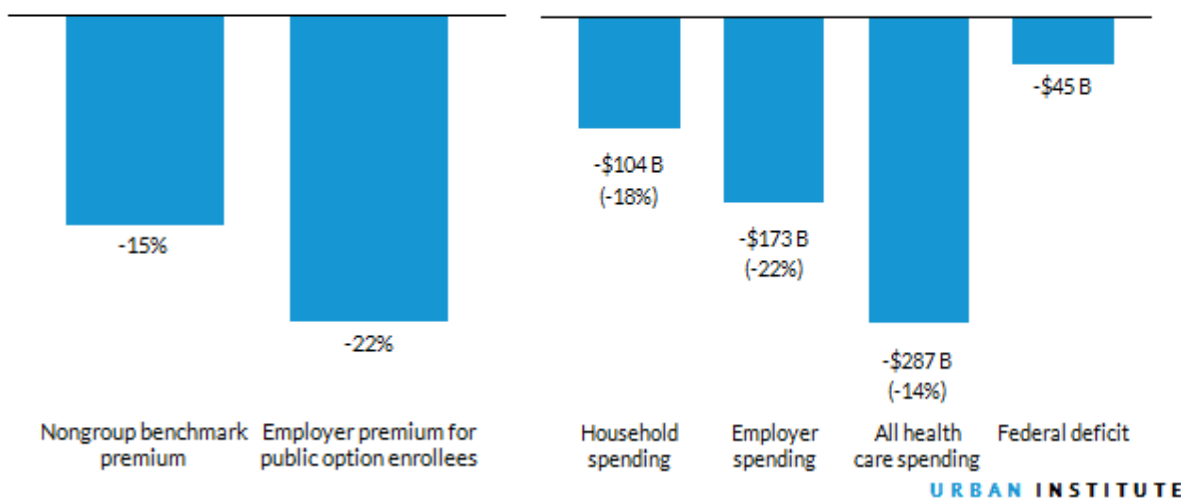
Health care spending. Spending effects are much larger under capped rates because all insurers are affected. Aggregate household spending falls by \$104 billion, or 18 percent. Employer spending falls by \$173 billion, or 22 percent. Federal spending, primarily on tax credits, declines by \$10 billion. Federal tax revenues increase by \$36 billion, thereby reducing the federal deficit by \$45 billion. Overall, health care spending falls by \$287 billion, or 14 percent.

FIGURE 7

Effects of Capped Rates 1

On median premiums

On health spending and the federal deficit



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

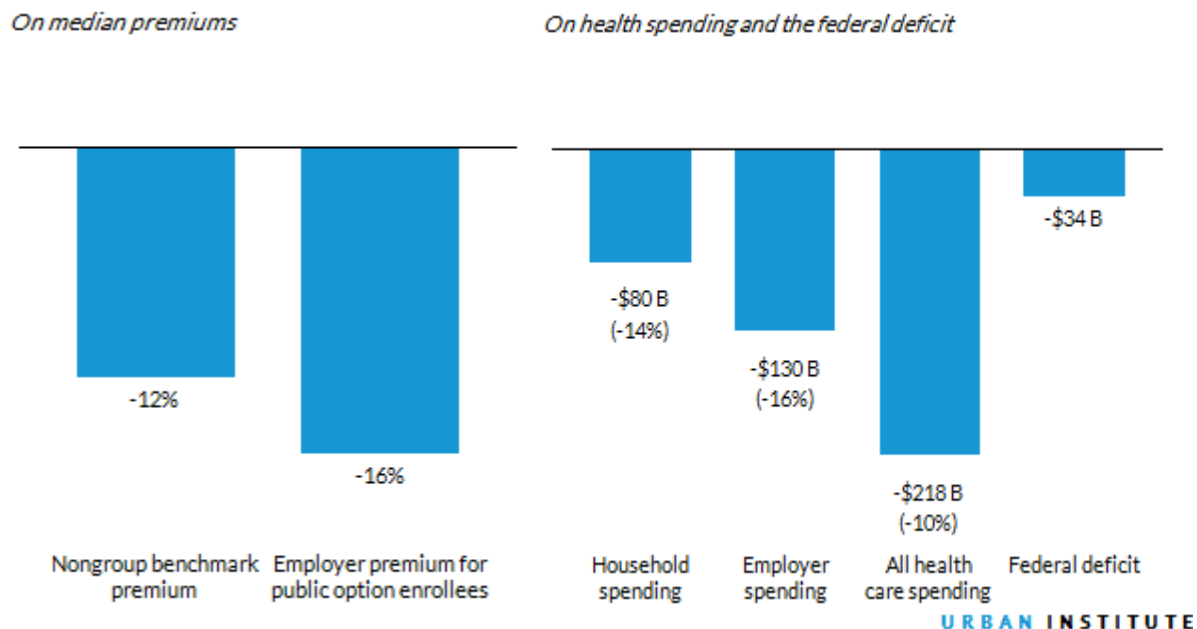
Capped Rates 2: Payment Rates Capped Considerably above Medicare Levels in Employer and Nongroup Markets

- payment rates capped for all insurers in employer and nongroup markets in urban areas
- rates set at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median premium falls by 16 percent in the employer market and by 12 percent in the nongroup market. The number of people uninsured falls by 1 million, or 3 percent. Again, this results from the large increase in employer coverage, because all insurers can lower premiums because of lower provider payment rates.

Health care spending. Health care spending falls by less than under capped rates 1 because payment rates, and thus premiums, are higher. Aggregate household spending falls by \$80 billion, or 14 percent. Employer spending declines by \$130 billion, or 16 percent. Federal government spending falls by \$8 billion, or slightly less than 2 percent. Because of higher wages, federal tax revenues increase by \$27 billion; thus, the federal deficit falls by \$34 billion. Overall health care spending falls by \$218 billion, or more than 10 percent.

FIGURE 8
Effects of Capped Rates 2



Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Impact of Exempting Rural Areas

We estimate the impact of rural exemption from the reforms modeled on rural areas by extending three of our policy options to all regions, instead of limiting them to urban areas, and computing the difference in rural areas. The three reforms, public options 2 and 4 and capped rates 1, would each pay Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals. Through these reforms, we examine the impact on rural areas of exempting them from a public option in the nongroup market (public option 2), a public option in the nongroup and employer markets (public option 4), and capped rates in the nongroup and employer markets (capped rates 2).

TABLE 3
Impacts on Rural Areas of Exempting Rural Areas from Select Reforms

	Public option 2	Public option 4	Capped rates 1
Household spending			
Billions of dollars	1	5	8
Percent of current spending	1	5	7
Employer spending			
Billions of dollars	*	5	8
Percent of current spending	**	3	6
Federal spending			
Billions of dollars	3	3	3
Percent of current spending	2	2	2
State sending (including demand for uncompensated care)			
Billions of dollars	*	*	*
Percent of current spending	**	**	**
Provider spending			
Billions of dollars	*	*	*
Percent of current spending	1	1	1
Total spending, all payers			
Billions of dollars	4	13	19
Percent of current spending	1	3	4
Number of people uninsured^a			
Thousands	18	55	55
Percent difference	**	1	1

Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reforms simulated as fully phased in and in equilibrium in 2022. Federal, state, and provider spending include demand for uncompensated care. Data in this analysis are limited to health care spending among people below 65 not enrolled in Medicare.

^a Includes those without insurance and those with short-term limited-duration plans.

* = less than \$500 million. ** = less than 0.5%.

Under public option 2, aggregate household spending in the nongroup market is \$1 billion higher when rural areas are exempted. Employers are largely unaffected, federal spending is 2 percent higher in rural areas, and overall spending is \$4 billion, or 1 percent, higher than if rural areas were included in this reform. In other words, under rural exemption, households spend more, but more federal dollars enter rural markets. Uninsurance is slightly higher in rural areas because of the exemption as well; with rural areas excluded from the reforms, about 18,000 more people are uninsured.

Under public option 4, which extends the public option to both the nongroup and employer markets, spending by households, employers, and the federal government is higher because of rural exemption; the increases are \$5 billion (5 percent), \$5 billion (3 percent), and \$3 billion (2 percent), respectively. Under rural exemption, overall spending in rural areas under this reform is \$13 billion, or 3 percent, higher. When including rural areas in the reform, about 55,000 more people are uninsured than if such areas are exempted.

Under capped rates 1, spending increases by \$8 billion (7 percent) for households, by \$8 billion (6 percent) for employers, and by \$3 billion (2 percent) for the federal government when rural areas are included in the reform. Overall, under capped rates 1, eliminating the rural exemption increases spending in rural areas by \$19 billion, or 4 percent, and about 55,000 more people are uninsured.

Comparing the data in tables 2 and 3 shows rural exemption adds relatively little to federal or overall spending and reduces uninsurance only slightly. Urban areas are simply much larger and account for most spending. Therefore, rural providers could be protected from payment cuts without significantly changing the coverage and spending effects of a public option or capped provider payment rates.

Discussion

In this analysis, we examine seven public option or capped provider payment rate proposals that would apply only to urban areas, meaning they exempt rural areas from cuts in hospital and professional payment rates. (Rural areas would still benefit from reductions in prescription drug prices.) The reforms examined vary by whether they are limited to the nongroup market, whether the public option is extended to the employer market, or whether reductions in provider payment rates apply to all insurers in the nongroup and employer markets. The reforms' impacts depend on how payment rates are established, specifically, whether they are set at Medicare levels, a relatively small multiple above Medicare rates, or a larger multiple thereof. Exempting rural areas from the reforms is intended to assure rural residents' access to physicians and hospitals and protect rural providers' financial health. At the same time, we show fewer people would have insurance coverage because of the exemption, and households and employers would spend more than if the policies shown did not exempt rural areas.

We estimate public option policies limited to the nongroup market affect coverage very little. They also provide modest savings to the federal government, employers, and households. This is primarily because the nongroup market is relatively small, a large number of urban markets are very competitive, and urban premiums are already fairly low.

Extending the public option to employers reduces the uninsured population by about 1 million and provides more savings to the federal government. Employers would see substantial savings in premiums and, in response, would increase wages. Tax revenues would increase, contributing to a \$10 to \$23 billion reduction in the federal deficit.

The largest spending and coverage effects occur when provider payment rates are capped for all insurers, as under capped rates 1 and 2. All employers benefit, and, in turn, workers' wages increase, thereby increasing federal tax revenues. Consequently, we estimate the federal deficit falls by \$34 to \$45 billion under these reforms.

The effects of the reforms modeled are greater the more payment rates are reduced. Thus, the largest savings come from introducing a public option that pays Medicare rates in the nongroup market, under public option 1. But such severe payment rate cuts may not be politically feasible, especially if they extend to both the nongroup and employer markets. A public option that pays higher rates (e.g., Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals as under public options 3 and 5) may be more feasible. But, such a public option in the employer market would have less of an effect on premiums and thus on federal, household, and employer spending. Capping payment rates to all providers by all insurers in the employer market, even at Medicare plus 15 percent for professionals and plus 60 percent for hospitals as under capped rates 2, would significantly affect government, household, and employer spending on health care, because the policy extends to payments by all insurers.

We also show the effect on rural areas of being exempted from the public option or capped provider payment rates. Because of the exemption, more federal dollars flow into rural areas. On the other hand, the number of people uninsured is slightly higher, as are household and employer spending. The reforms' effects on rural areas vary by their policy designs. Federal spending is higher if rural areas are exempt from the reforms, but how much depends on the policy. But because most federal spending is in urban areas, exempting rural areas only minimally affects the reach of the reforms examined here. And rural areas benefit from less disruption to their health systems.

Methods

Our analysis relies on the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of a broad array of proposed health care policy reforms for the nonelderly (US residents below age 65 not enrolled in Medicare). We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. For example, the current version accounts for each state's Marketplace premiums and enrollment after the 2020 open enrollment period. Enrollment in each state under current law affects how the model simulates policy alternatives.

We begin each simulation with a current-law baseline in 2022 that includes the estimated effects of and a partial recovery from the COVID-19 recession. For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the department planned to extend its public health emergency declaration through calendar year 2021.³ This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates, but it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

We then estimate the effects of implementing each of the seven public option or capped provider payment rate reforms. Each reform affects prescription drug prices in all regions but affects professional

and hospital payment rates in urban rating regions only. The simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employer) in which the public option and/or capped provider payment rates are available. All estimates assume reforms are fully phased in and in equilibrium in 2022.

Because Medicare does not provide benefits to nondisabled nonelderly people, we estimate possible Medicare payment rates for those people. We assume Medicare rates for people with nongroup insurance would equal what payment rates would be if the region had a highly competitive insurance market and a reasonably competitive hospital market, and these rates vary significantly by rating region. We then set payments by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, according to the assumption for each reform, the share of spending for each service type within regions, and if the region is urban or rural. Urban areas see reduced payments for all services and drugs, whereas rural areas see only reduced payments for drugs.

Our approach differs for people with employer-sponsored insurance. We obtained estimates of the ratio of commercial insurer payment rates to Medicare payment rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to estimate costs for people in urban areas with employer-based insurance entering the public option or having provider payments capped. For all reforms modeled, prices for prescription drugs in all areas are set halfway between those paid by Medicare and Medicaid after rebates.

Savings in the nongroup market apply to all enrollees under either a public option or capped provider payment rates. The model implicitly assumes all enrollees are affected by the public option, because we assume the Marketplace benchmark premium would decrease by the percent difference between the public option and baseline premiums. For people with employer-sponsored insurance, only those in firms opting in to the public option see savings. We assume firms that are small, pay lower average wages, and expect significant savings are more likely to choose the public option than large firms, those paying higher wages, and those expecting small savings from the switch. Capped rates 1 and 2 limit all provider payments in urban areas, reducing payments for everyone with employer-sponsored coverage. We discuss additional methodological issues in our earlier report (Blumberg et al. 2020).

Limitations

Uncertainty surrounds our estimates of the impacts of a public option or capped provider payment rates for several reasons: a lack of data on commercial payment rates in the nongroup market, the relevance of claims data to estimate the ratio of commercial payment rates to Medicare rates in the employer market, the need to estimate households' and firms' decisions to participate in the public option, and the need to make assumptions about the savings from regulating prescription drug prices. For each factor, different data can be used and assumptions made. Thus, our results may differ from actual results or those projected in other analyses.

- For the nongroup reform estimates, we lack actual payment rate data. We estimate Medicare payment rates using regression analyses that estimate the impact on premiums of the number of insurers and measures of hospital concentration. We assume markets with a large number of insurers and low hospital concentration have payment rates that approximate Medicare prices and

thus premiums. Markets lacking these characteristics have been shown to have higher premiums. We estimate high premiums in markets with high insurer and hospital concentration will decrease to the levels seen in more competitive markets. But the high premiums we observe in noncompetitive regions could owe to factors other than higher provider payment rates.

- We assume the public option is the benchmark plan. We cannot estimate how many people choose plans that have higher premiums than the benchmark. To the extent individuals enroll in more expensive plans, we may underestimate aggregate household spending in our nongroup reform estimates.
- We use data from FAIR Health, which collects data from a large number of firms. However, the data do not contain all private plans in a state or substate area. Thus, the contributing insurers may not be entirely representative, despite their very large amount of data.
- We use FAIR Health data to represent the distribution of commercial payment levels. FAIR Health data cover plans for 75 percent of the privately insured population in the United States, but they include some Medicare Advantage plans and plans that participate in the nongroup market.
- FAIR Health provided us with data on payments for professional and outpatient facilities representing 47 percent of total professional spending and 42 percent of total outpatient facility spending. However, the services may not fully represent the average ratios of commercial insurer payment rates to Medicare rates. More importantly, FAIR Health does not release substate data on commercial payment rates for inpatient hospital services. Though our estimates include all inpatient services provided in the state, lacking substate information on inpatient care could lead to some error at the substate level.
- We have made assumptions about employer take-up of the public option by firm size, wages, and expected savings. Take-up of the public option is assumed to be higher for small, low-wage firms, and we assume a firm only chooses the public option when resulting savings exceed 20 percent. Our assumptions are somewhat arbitrary and different assumptions would have different results. Our capped rate simulations provide estimates of the extreme case of all employers choosing the public option.
- In our estimates of prescription drug savings, we assume drug pricing rebates from various private payers are the same across the country. If the mix of drugs consumed varies geographically, our rebates may be estimated with error. Medicare's pharmacy benefit manufacturers differ by geography, with some getting better rebates from manufacturers than others. Thus, Medicare rebates could differ across states, but we do not account for this.
- We estimate prescription drug rebates for the reforms modeled would lead to prices halfway between Medicare and Medicaid prices, or 30 percent below commercial insurance prices. These prices seem reasonable because they are less than those currently achieved in Medicaid and considerably less than in other western nations. We may also have underestimated the savings a public option could achieve. However, it has been politically difficult in the US to achieve lower drug prices, so we are cautious in our estimates. The differences or any errors in our savings estimates would be tempered by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

- We assume services provided for the currently insured will be unaffected and care demanded by the newly insured will be provided. We exclude rural areas from the reforms out of concern for access to care in those areas. However, providers in urban areas might therefore cut back on services in response to the payment cuts (Clemens and Gottlieb 2014; White and Yee 2013). If providers reduce services, premium cuts and reductions in spending will be larger than presented here, and issues of care might need to be addressed.
- We designate Affordable Care Act rating regions as urban or rural based on the share of urban counties in the region.⁴ However, HIPSM assigns lower provider reimbursements by public-use microdata areas (PUMAs). Rating regions' and PUMAs' borders often, but not always, align. When a PUMA falls into more than one rating region, we assign it a population-weighted average of the reimbursement savings of the rating regions. PUMAs, whole or fractional (by population), are combined when computing reform effects by rating regions. Because of these assignments, some regions are not fully urban or rural. For presentation, we consider regions that are fully or mostly rural (by population) to be rural, and we consider those fully or mostly urban as urban.

Supplementary Tables

TABLE 4

Rating Region – Level Distribution of Changes in Nongroup and Employer Premiums in Urban Areas under Nongroup and Employer Reforms, 2022
Percent change from current-law premiums

	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Nongroup^a							
<i>Percentile</i>							
10th	-41	-35	-30	-36	-31	-36	-31
25th	-32	-27	-23	-28	-25	-28	-25
50th (median)	-21	-14	-12	-15	-12	-15	-12
75th	-14	-8	-6	-10	-7	-10	-7
90th	-11	-5	-2	-6	-4	-6	-4
All employers^b							
<i>Percentile</i>							
10th	NA	NA	NA	-12	-5	-25	-20
25th	NA	NA	NA	-11	-4	-24	-19
50th (median)	NA	NA	NA	-10	-3	-23	-17
75th	NA	NA	NA	-9	-3	-22	-16
90th	NA	NA	NA	-8	-2	-20	-15
Employers offering public option^b							
<i>Percentile</i>							
10th	NA	NA	NA	-24	-21	-23	-18
25th	NA	NA	NA	-23	-19	-23	-17
50th (median)	NA	NA	NA	-22	-16	-22	-16
75th	NA	NA	NA	-21	-14	-20	-15
90th	NA	NA	NA	-19	-10	-19	-14

Source: Health Insurance Policy Simulation Model, 2021.

Notes: NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (urban and rural) markets.

^a These rows show the change in the median nongroup benchmark premium in urban and mostly urban areas.

^b These rows show the change in the median premiums in urban and mostly urban areas among employers providing the public option to their workers in public options 4 and 5. For capped rates 1 and 2, they show the change in median premiums for all employers.

TABLE 5

Health Insurance Coverage of the Nonelderly Population under Current Law and Nongroup and Employer Reforms in Urban Areas, 2022

Coverage (thousands of people)	Current law						
	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Insured (MEC)	244,113	244,205	244,197	245,161	245,103	245,161	245,103
Employer	149,325	149,272	149,273	150,591	150,531	150,591	150,531
Traditional	149,325	149,272	149,273	81,800	121,138	0	0
Public option	0	0	0	68,791	29,393	150,591	150,531
Private nongroup	14,960	15,036	15,029	14,673	14,678	14,673	14,678
Medicaid/CHIP	71,162	71,233	71,229	71,233	71,229	71,233	71,229
Other public	8,665	8,665	8,665	8,665	8,665	8,665	8,665
Uninsured (no MEC)^a	33,333	33,241	33,250	32,285	32,343	32,285	32,343
Total	277,446	277,446	277,446	277,446	277,446	277,446	277,446
<i>Change from current law (thousands of people)</i>							
Insured (MEC)	109	92	84	1,048	990	1,048	990
Employer	-55	-54	-52	1,265	1,205	1,265	1,205
Traditional	-55	-54	-52	-67,525	-28,187	-149,325	-149,325
Public option	0	0	0	68,791	29,393	150,591	150,531
Private nongroup	85	75	69	-288	-282	-288	-282
Medicaid/CHIP	78	71	67	71	67	71	67
Other public	0	0	0	0	0	0	0
Uninsured (no MEC)^a	-109	-92	-84	-1,048	-990	-1,048	-990
Total	0	0	0	0	0	0	0
<i>Change from current law (%)</i>							
Insured (MEC)	**	**	**	0.4	0.4	0.4	0.4
Employer	**	**	**	0.8	0.8	0.8	0.8
Traditional	0.0	0.0	0.0	-45.2	-18.9	-100.0	-100.0
Public option	NA	NA	NA	NA	NA	NA	NA
Private nongroup	0.6	0.5	0.5	-1.9	-1.9	-1.9	-1.9
Medicaid/CHIP	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other public	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsured (no MEC)^a	-0.3	-0.3	-0.3	-3.1	-3.0	-3.1	-3.0
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Source: Health Insurance Policy Simulation Model, 2021.

Notes: MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. NA = not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.

^a Includes those without insurance and those with short-term, limited-duration plans.

** = less than +/- 0.05%.

TABLE 6

Health Spending for the Nonelderly Population under Current Law and Nongroup and Employer Reforms in Urban Areas, 2022
Health spending (millions of dollars)

Reform	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Household	587,856	581,432	583,517	584,611	539,661	569,182	484,126	507,376
Federal government	467,105	454,978	459,187	461,414	457,268	459,494	457,268	459,494
State government	220,370	220,374	220,398	220,407	220,312	220,356	220,312	220,356
Employers	800,116	800,019	800,011	800,009	731,095	782,269	626,753	670,582
Providers	27,475	27,395	27,419	27,441	27,316	27,386	27,316	27,386
Total, all payers	2,102,923	2,084,197	2,090,532	2,093,882	1,975,652	2,058,687	1,815,774	1,885,195
<i>Change from current law (millions of dollars)</i>								
Household	—	-6,425	-4,339	-3,245	-48,195	-18,675	-103,730	-80,480
Federal government	—	-12,127	-7,918	-5,691	-9,837	-7,610	-9,837	-7,610
State government	—	4	27	37	-58	-14	-58	-14
Employers	—	-97	-105	-107	-69,021	-17,847	-173,363	-129,534
Providers	—	-80	-56	-34	-160	-90	-160	-90
Total, all payers	—	-18,725	-12,391	-9,041	-127,271	-44,236	-287,149	-217,728
Federal tax offset from ESI change	—	NA	NA	NA	13,206	2,330	35,540	26,548
<i>Change from current law (%)</i>								
Household	—	-1.1	-0.7	-0.6	-8.2	-3.2	-17.6	-13.7
Federal government	—	-2.6	-1.7	-1.2	-2.1	-1.6	-2.1	-1.6
State government	—	**	**	**	**	**	**	**
Employers	—	**	**	**	-8.6	-2.2	-21.7	-16.2
Providers	—	-0.3	-0.2	-0.1	-0.6	-0.3	-0.6	-0.3
Total, all payers	—	-0.9	-0.6	-0.4	-6.1	-2.1	-13.7	-10.4

Source: Health Insurance Policy Simulation Model, 2021.

Notes: ESI = employer-sponsored insurance. Dashes indicate the column heading does not apply. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.
 ** = less than +/- 0.05%.

Notes

- ¹ Rates are capped at current rates in all reforms considered.
- ² In reforms limited to the nongroup market, the change in federal spending equals the change in the federal deficit.
- ³ Norris Cochran (acting secretary, US Department of Health and Human Services), letter to state governors regarding extension of COVID-19 public health emergency, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.
- ⁴ Counties are designated urban or rural using data from the University of Iowa's RUPRI Center for Rural Health Policy Analysis, available at <https://rupri.public-health.uiowa.edu/publications/policybriefs/2014/premiums/>.

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MAR, 16, 2021

Overview of the American Rescue Plan Act of 2021

Manatt Health

On March 11, 2021, President Biden signed an approximately \$1.9 trillion COVID-19 relief bill—the American Rescue Plan Act of 2021 (<https://www.congress.gov/bill/117th-congress/house-bill/1319/text>) (“the American Rescue Plan”). The American Rescue Plan includes myriad health care provisions, focused primarily in two areas: first, it provides funding the Biden Administration requested to carry out its COVID-19 response plans; second, it enacts significant but largely temporary coverage policies.

Although House and Senate Democrats collaborated to draft the legislative package that passed the House late last month, the Senate ultimately made several key changes to the bill, which required the House to vote again. The Senate’s targeted changes include the following:

- Ensuring that anyone who receives unemployment insurance in 2021 is eligible for maximum cost-sharing subsidies to purchase coverage on the Marketplace;
- Increasing Consolidated Omnibus Budget Reconciliation Act (COBRA) subsidies from 85 percent to 100 percent of premiums;
- Delaying the effective date of the Medicaid drug rebate cap rescission by one year;
- Reestablishing an imputed rural floor for the Medicare hospital area wage index for hospitals in all-urban states;

- Adding \$8.5 billion in Provider Relief Fund funding for rural providers; and
- Modifying the state and local relief funds to create more specific parameters regarding recipients' use of the funding, modifying the ways in which the federal government may distribute the funding including by introducing phased-in distributions, and establishing a new state infrastructure fund.

The legislation also includes major economic stimulus and anti-poverty measures, including enhanced federal unemployment insurance, child tax credits, and stimulus checks for Americans who make under \$80,000 per year. The final bill does not include the House-passed increase in the minimum wage to \$15 per hour because the Senate Parliamentarian ruled that the provision could not be passed via reconciliation.

Although all health care coverage provisions of the bill are temporary, many will have a lasting impact. Some of the American Rescue Plan policies, such as temporarily making Marketplace subsidies more generous and available to more Americans, will lay the groundwork for future policy discussions. Other policies, such as incentivizing the remaining states to expand Medicaid, could permanently alter the coverage landscape. Below is a high-level summary of the key provisions of the bill:

- **Marketplace.** Temporary enhancements to the advance premium tax credits (APTC) available for individual insurance coverage purchased on the Marketplace for plan years 2021 and 2022, including enhanced benefits for individuals who receive unemployment insurance for 2021, as well as funding for State-Based Marketplaces (SBMs).

Table 1. Proposed Premium Percentages by Household Income

Household Income (% of the FPL)	Original 2021 Premium Percentage	Proposed Temporary Premium Percentage, 2021-2022
Up to 150%	2.07%-4.14%	0%
150%-200%	4.14%-6.52%	0%-2%
200%-250%	6.52%-8.33%	2%-4%
250%-300%	8.33%-9.83%	4%-6%
300%-400%	9.83%	6%-8.5%
Over 400%	No subsidies	8.5%

- **COBRA.** Temporary, enhanced premium assistance to make COBRA coverage more affordable for people who lose employer-sponsored coverage. The subsidy begins April 1, 2021 and extends through September 30, 2021.

- **Medicaid.** Provisions to increase coverage and access, including enhanced federal matching funds for states that newly expand Medicaid, a state option to extend the period of time to 12 months for which postpartum individuals are eligible for Medicaid/the Children's Health Insurance Program (CHIP), and expanded coverage of vaccines and COVID-19 treatment. The bill also imposes new rebate obligations under the Medicaid Drug Rebate Program (MDRP) and abolishes the cap on Medicaid rebates.
- **Medicare.** Requires the Centers for Medicare & Medicaid Services (CMS) to re-establish a rural floor for the Medicare hospital area wage index for hospitals in all-urban states.
- **COVID-19 Vaccine, Testing, and Tracing Funds.** Funds for the Biden Administration to carry out its National Strategy for the COVID-19 Response and Pandemic Preparedness (<https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf>).
- **Provider Relief Funds.** Adds \$8.5 billion to the Provider Relief Fund, specifically for rural Medicare- and/or Medicaid- enrolled providers.
- **Nursing Facilities.** Adds \$700 million in fiscal relief funds—\$500 million for state nursing strike teams and \$200 million for infection control support.
- **State and Locality Relief Funding.** \$350 billion in fiscal relief funds—\$230 billion for states, Tribal governments and territories, and \$130 billion for counties, cities, and local governments.
- **Other Funds for Health Care Initiatives.** Funding to support mental health and substance use disorder (SUD) programs, nursing facilities, and other public health initiatives such as community health centers, the Title X family planning program, and workforce initiatives.

Notably, Congressional Democrats are already in the early stages of developing a second reconciliation package that could include a wide range of additional health care priorities.

See below for additional information:

- ***The American Rescue Plan: An Overview of Private Insurance Provisions*** (<https://www.shvs.org/resource/the-american-rescue-plan-an-overview-of-private-insurance-provisions/>) Webinar.
- ***The American Rescue Plan: An Overview of Medicaid Provisions and State/Local Relief*** (<https://www.shvs.org/resource/the-american-rescue-plan-an-overview-of-medicaid-provisions-and-state-local-relief/>) Webinar.

Updated March 15, 2021

American Rescue Plan Act Will Help Millions and Bolster the Economy

By CBPP Staff

The American Rescue Plan Act, which Congress has passed and President Biden is expected to sign on March 12, will provide needed help to tens of millions of people, reduce high levels of hardship, help school districts address student learning loss, and bolster the economy.

The economy remains weak, the jobs recovery has lost momentum, and there are 9.5 million fewer jobs than in February of 2020. Black and Latino unemployment is 9.9 percent and 8.5 percent, respectively, well above the white unemployment rate of 5.6 percent — which itself is too high. The economy won't return to its full potential until 2025, the Congressional Budget Office projects; the number of people employed won't return to pre-pandemic levels until 2024; and unemployment won't fall below 4 percent until 2026.¹

Hardship remains extraordinary; it's particularly acute among Black, Latino, and Indigenous people and immigrants; and households with children also have been particularly hard hit.² Nearly 81 million adults (35 percent of all adults) reported between February 17 and March 1 that their household found it somewhat or very difficult to cover usual expenses in the past seven days, and that figure rises to 41 percent for adults living with children. Some 22 million adults (11 percent) said their household sometimes or often didn't have enough to eat in the past seven days, rising to 14 percent among adults in households with children. An estimated 13.5 million adults in rental housing (19 percent of adult renters) said they were not caught up on rent, rising to 28 percent among adult renters with children.

The American Rescue Plan Act can dramatically reduce hardship and begin to set the stage for a stronger and more equitable recovery. Its key provisions to meet these goals include:

- [Expanded and extended unemployment benefits](#);

¹ Joel Friedman, "Budget Resolution Marks Important Step Toward Urgently Needed COVID Relief," Center on Budget and Policy Priorities, February 3, 2021, <https://www.cbpp.org/blog/budget-resolution-marks-important-step-toward-urgently-needed-covid-relief>.

² Center on Budget and Policy Priorities, "Tracking the COVID-19 Recession's Effects on Food, Housing, and Employment Hardships," updated March 10, 2021, <https://www.cbpp.org/research/poverty-and-inequality/tracking-the-covid-19-recessions-effects-on-food-housing-and-employment-hardships>.

- [Expansions in the Child Tax Credit and Earned Income Tax Credit](#);
- [Continuation of key food assistance provisions now in place and new investments in WIC](#);
- [Expansions in health coverage](#);
- [Increased housing assistance](#);
- [Fiscal aid for states, territories, tribes, and localities](#);
- [Funding for K-12 schools](#); and
- [Emergency funds to help families facing hardship](#).

The Act includes other provisions as well, including a new round of stimulus payments, public health investments, paid leave provisions, additional child care funding, and aid to businesses. These are not covered in this paper.

This legislation will help millions of people, but the nation would need fewer stopgap measures during hard times if we had permanent policies to ensure universal health coverage, adequate jobless benefits, and supports for households struggling to make ends meet. Charting a course for an equitable recovery will require turning to these long-term, underlying investment deficits and policy gaps.

Unemployment Benefits

The American Rescue Plan Act will extend critical unemployment benefits that are helping jobless workers pay their bills and care for their families.³

Not only are there now 9.5 million fewer jobs than in February of 2020, but a disproportionate number of job losses over the past year are in industries that pay low wages. (See Figure 1.) Since the steep job losses of last spring, workers of color and those without a bachelor’s degree have endured a far slower jobs recovery than white workers and college graduates. The lowest-paying industries accounted for 31 percent of all jobs in February of 2020, but 55 percent of jobs lost since then.

The December relief package reinstated a federal unemployment benefit increase, provided more weeks of benefits so that jobless workers wouldn’t lose them while the nation struggled with COVID-19 and its economic fallout, and continued the Pandemic Unemployment Assistance (PUA) program, which expands benefit eligibility to more jobless workers. These provisions are slated to expire in mid-March, and the American Rescue Plan Act will extend them through September 6. The early September cutoff, however, is problematic compared to the end-of-September date in President Biden’s plan. Unemployment, particularly among workers of color and workers without a college degree, will likely remain elevated in the fall; extending benefits through September better aligns with a time when — unlike August — Congress will be in session and focused on budget matters (with the fiscal year ending on September 30) and thus well positioned to extend benefits if

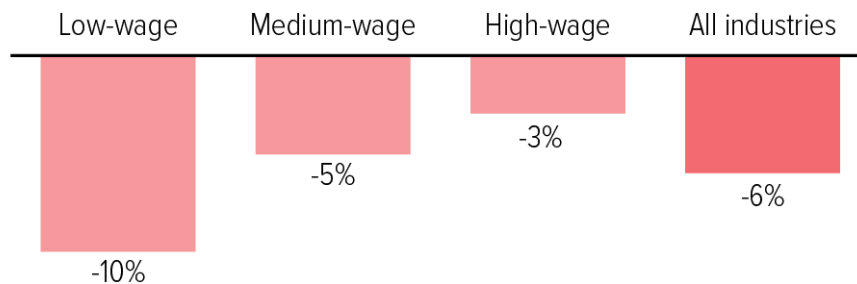
³ Chad Stone, “COVID Relief Package Includes Important Unemployment Benefit Extensions, But Duration Should Be Extended,” Center on Budget and Policy Priorities, February 9, 2021, <https://www.cbpp.org/blog/covid-relief-package-includes-important-unemployment-benefit-extensions-but-duration-should-be>.

necessary. The early September timing makes a benefit lapse, which would hurt families and disrupt states’ ability to administer jobless programs, likelier.

FIGURE 1

Job Losses Largest in Low-Wage Industries

Percent change in number of jobs, February 2020 to February 2021



Note: Industries were ranked by average wages in February 2020 and divided into three groups containing roughly the same number of jobs.

Source: CBPP calculations of Bureau of Labor Statistics data

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Tax Credits

The American Rescue Plan Act will make the full Child Tax Credit available to 27 million children in families with low or no income, increase the size of the Child Tax Credit, and provide an expanded Earned Income Tax Credit (EITC) for far more low-paid adults without minor children at home — driving a historic reduction in child poverty and providing timely income support for millions of people.⁴ (See Appendix Tables 1-3 for state-by-state data.)

Together, the Child Tax Credit and EITC now lift more children above the poverty line (5.5 million) than any other program. The American Rescue Plan Act will make the full Child Tax Credit available to children in families with low or no earnings, raise the maximum credit from \$2,000 to \$3,000 per child and \$3,600 for children under age 6, and extend the credit to 17-year-olds. The increase in the maximum amount will begin to phase out for heads of households making \$112,500 and married couples making \$150,000. The Act will lift 4.1 million additional children above the poverty line — cutting the remaining number of children in poverty by more than 40 percent — and lift 1.1 million children above half the poverty line (referred to as “deep poverty”). Among the children that the Child Tax Credit expansion will lift above the poverty line, some 1.2 million are Black and 1.7 million are Latino.⁵

⁴ Chuck Marr *et al.*, “House COVID Relief Bill Includes Critical Expansions of Child Tax Credit and EITC,” Center on Budget and Policy Priorities, updated March 2, 2021, <https://www.cbpp.org/research/federal-tax/house-covid-relief-bill-includes-critical-expansions-of-child-tax-credit-and>.

⁵ Racial and ethnic categories do not overlap. Unless otherwise noted, figures for each racial group such as Black or Asian American do not include individuals who identify as multiracial or of Latino ethnicity. Latino includes all people of Hispanic, Latino, or Spanish origin regardless of race. Data are not available for people living in the territories. Figures for children identified as American Indian or Alaska Native (AIAN) are particularly sensitive to definition. Among the roughly 2.0 million children identified as AIAN alone or in combination, regardless of Latino ethnicity,

The American Rescue Plan Act also will raise the EITC for low-paid working adults who are not raising children at home and now get only a tiny credit. It will raise the maximum EITC for these so-called “childless workers” from about \$540 to about \$1,500, raise the income cap for them to qualify from about \$16,000 to at least \$21,000, and expand the age range of those eligible to include younger adults aged 19-24 who aren’t full-time students and those 65 and over. That will provide timely income support to over 17 million people who work for low pay, including the 5.8 million childless workers aged 19-65 (excluding full-time students aged 19-23) who are now the lone group that the federal tax code taxes into, or deeper into, poverty because the payroll taxes (and in some cases, income taxes) they owe exceed any EITC they receive.

These expansions will help push against racial disparities. Currently about *half* of all Black and Latino children get only a partial Child Tax Credit or no credit at all because their families’ incomes are too low to qualify for the full credit. This design flaw in the current Child Tax Credit comes on top of long-standing employment discrimination, unequal opportunity in education and housing, and other factors that leave more Black and Latino households struggling to make ends meet. Similarly, the 5.8 million childless workers who are taxed into, or deeper into, poverty are disproportionately people of color: about 26 percent are Latino and 18 percent are Black, compared to 19 percent and 12 percent of the population, respectively.

In two historic firsts, the American Rescue Plan Act will also extend a federal supplement to help Puerto Rico expand its local EITC and will correct a long-standing limitation by which only families with three or more children in the Commonwealth can claim the Child Tax Credit. This will be the first time Puerto Rico receives federal EITC dollars since the program’s inception nearly half a century ago, and the first time that families with one and two children may claim the Child Tax Credit since it was established in the late 1990s. Both credits will provide a crucial boost to hundreds of thousands of families in Puerto Rico, whose poverty rates of 43 percent overall and 57 percent for children are among the highest in the country.

Food Assistance

The American Rescue Plan Act will extend and expand nutrition assistance to help address today’s extraordinarily high levels of hunger and hardship.⁶

The number of households struggling to put enough food on the table spiked last spring due to COVID-19, remained nearly three times its pre-pandemic levels over the summer, and rose even higher in late 2020. Food hardship has disproportionately affected households with children, especially Black and Latino households. Between 6 and 10 million children live in a household in which the children didn’t eat enough in the last seven days because they couldn’t afford enough food, compared to 1.1 million children in December of 2019. The current figure includes 27 percent of children in Black households and 22 percent of children in Latino households, compared to 9 percent in white households.

about 180,000 will be lifted above the poverty line by the American Rescue Plan Act’s Child Tax Credit expansion. (If we apply the non-overlapping categories this report uses for other groups, only 684,000 children are considered AIAN alone, not Latino; 70,000 of them will be lifted above the poverty line by the Act’s Child Tax Credit expansion.

⁶ “Tracking the COVID-19 Recession’s Effects on Food, Housing, and Employment Hardships,” *op. cit.*

The American Rescue Plan Act will extend, through September, a 15 percent increase in SNAP benefits from December’s relief package that is slated to expire in June — likely before the economy has recovered and while food insecurity remains high. (See Appendix Table 4 for state-by-state impacts.) It will allow states to continue, through the summer and through the end of the COVID-19 public health emergency, the Pandemic EBT (P-EBT) program, which provides grocery benefits to replace meals that children miss when they do not attend school or child care in person. Extending this benefit through the summer is important, providing a bridge to help families until school reopens, hopefully fully in-person, for the next school year.

The Act also will provide funds to modernize the WIC nutrition program for low-income women, infants, and children, support innovative service delivery, conduct robust outreach, and temporarily raise the amount of fruit and vegetables that participants can get. These steps will improve a critical program that has been proven to boost health and cognitive outcomes for children but served fewer individuals in fiscal year 2020 than the prior year despite the surge in food hardship during the pandemic. And it will add \$1 billion to the capped block grants for food assistance that Puerto Rico, American Samoa, and the Northern Mariana Islands receive instead of SNAP, enabling them to better meet their residents’ food assistance needs over the next several years.

Health

The American Rescue Plan Act will make comprehensive health coverage more affordable and accessible for millions of people during the current crisis.⁷

Comprehensive health coverage is important under any circumstances because it improves people’s access to care, financial security, and health outcomes. But preserving and extending coverage is even more important now, during COVID-19 and its economic fallout, because it will shield families from financial hardship and support public health efforts, easing people’s access to testing, treatment, and vaccines. Those who have low incomes or are uninsured, in particular, have faced unprecedented challenges. The relief measures that policymakers enacted over the last year in response to COVID-19 and its fallout did not extend health coverage or make it more affordable.

To make marketplace coverage more affordable, the Act eliminates or vastly reduces premiums for many people with low or moderate incomes who enroll in plans through the Affordable Care Act (ACA) marketplaces and provides new help to people with somewhat higher incomes who face high premiums. (See Figure 2.) This provision lowers premiums for most current marketplace enrollees and will expand coverage to 1.3 million people who would otherwise be uninsured.⁸ In addition, the Act improves affordability and decreases the number of uninsured people by:

⁷ Sarah Lueck, “Bigger Tax Credits, More Medicaid Expansion Would Make Health Coverage More Accessible and Affordable,” Center on Budget and Policy Priorities, February 10, 2021, <https://www.cbpp.org/blog/bigger-tax-credits-more-medicaid-expansion-would-make-health-coverage-more-accessible-and>; Tara Straw *et al.*, “Health Provisions in House Relief Bill Would Improve Access to Health Coverage During COVID Crisis,” Center on Budget and Policy Priorities, updated February 19, 2021, <https://www.cbpp.org/research/health/health-provisions-in-house-relief-bill-would-improve-access-to-health-coverage>.

⁸ Congressional Budget Office, “Reconciliation Instructions of the House Committee on Ways and Means,” Cost Estimate, February 15, 2021, <https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf>.

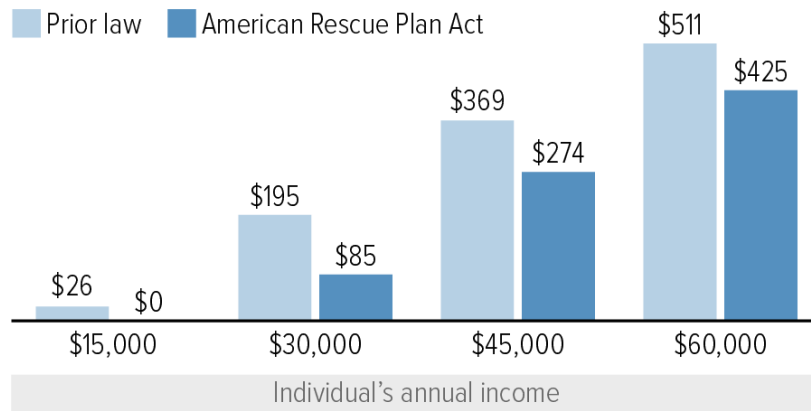
- protecting marketplace enrollees, especially those whose income fluctuated last year, from having to repay large portions of their federal premium tax credits;
- making it easier for those getting unemployment benefits to afford coverage; and
- assisting people who recently lost their job and want to continue their current coverage to afford so-called “COBRA” coverage through September.

In addition, the Act will increase financial incentives for the 14 states that have not implemented the ACA’s Medicaid expansion to do so, which would provide critical coverage to nearly 4 million uninsured people (if all states adopted the expansion). And it will strengthen Medicaid coverage in other ways — for instance, with higher federal matching funds to help more seniors and people with disabilities get services in the community instead of nursing homes, a new state option to extend Medicaid or Children’s Health Insurance Program coverage to 12 months after childbirth for postpartum people, and an option to cover uninsured people for testing, vaccines, and treatment of COVID-19.

FIGURE 2

The American Rescue Plan Act Will Make Marketplace Coverage More Affordable

Monthly premium for benchmark marketplace coverage for a 45-year-old, based on national average premium



Note: These premiums are applicable in all states except for those with different poverty level standards than the national standard (Alaska and Hawai'i) and those states that subsidize marketplace premiums beyond the federal subsidy (California, Massachusetts, New York, and Vermont).

Source: CBPP calculations based on American Rescue Plan Act

Housing

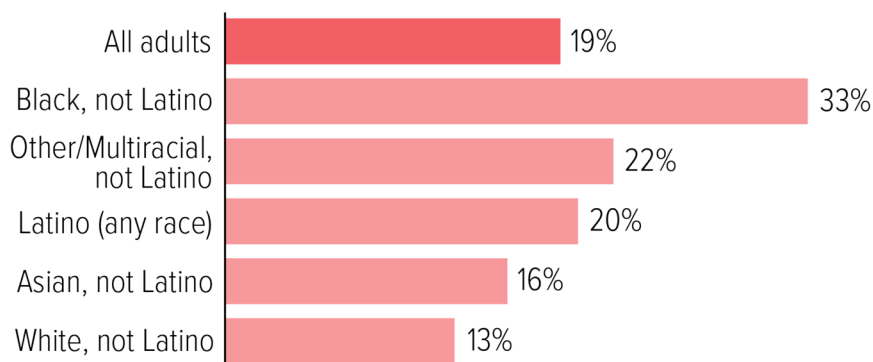
The American Rescue Plan Act includes critical housing assistance for millions who are struggling to pay rent and avoid eviction, and badly needed funds for communities to address homelessness during the pandemic.⁹

As noted, some 13.5 million adults — nearly 1 in 5 adult renters — report that they are not caught up on their rent, and renters likely already owe tens of billions in back rent and will need more help paying rent in the coming months. (See Figure 3.) More than 5 million renters say they have lost employment income and expect to be evicted soon. Struggling renters are disproportionately households with children and people of color, particularly people who are Black or Latino. Communities are struggling to provide safe, non-congregate shelter and housing options to the more than half-million people experiencing homelessness. Evictions and homelessness may exacerbate the spread of COVID-19 and cause severe hardship.

FIGURE 3

Nearly 1 in 5 Renters Not Caught Up on Rent During Pandemic, With Renters of Color Facing Greatest Hardship

Share of adult renters saying their household is not caught up on rent



Note: Other/Multiracial, not Latino = people identifying as American Indian, Alaska Native, Native Hawaiian or Pacific Islander, or more than one race. Chart excludes renters who did not respond to the question.

Source: CBPP analysis of Census Bureau Household Pulse Survey tables for February 17 - March 1, 2021

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The American Rescue Plan Act provides critical relief to reduce evictions and other housing-related hardship. This relief will supplement \$25 billion in rental assistance aid in December's relief package (which will likely help only a fraction of those behind on rent) as well as the Biden Administration's action to extend a Centers for Disease Control and Prevention order prohibiting

⁹ Douglas Rice and Ann Oliva, "Housing Assistance in House COVID Bill Would Prevent Millions of Evictions, Help People Experiencing Homelessness," Center on Budget and Policy Priorities, February 8, 2021, <https://www.cbpp.org/research/housing/housing-assistance-in-house-covid-bill-would-prevent-millions-of-evictions-help>.

most evictions through the end of March. The Act builds upon these efforts by providing \$21.6 billion in emergency rental assistance for low-income renters who have lost income or are experiencing other hardship and risk losing their housing; \$5 billion for Housing Choice Vouchers for people recovering from homelessness and for renters at greatest risk of homelessness; \$5 billion for homelessness assistance through the HOME Investment Partnerships Program; \$750 million in housing aid for tribal nations and Native Hawaiians; \$139 million for rural housing assistance; \$100 million for housing counseling services for renters and homeowners; and \$20 million to support fair housing activities. It also provides \$10 billion to help homeowners who are experiencing financial hardship due to COVID-19 maintain their mortgage, tax, and utility payments and avoid foreclosure and displacement.

State Fiscal Aid

The pandemic has imposed massive additional costs on state and local governments to fight the virus, deliver services despite public-health-related restrictions, and help struggling people and businesses. These substantial, unexpected costs will continue in the months ahead even if the pandemic is ultimately contained. Many millions of people, particularly low-income people and people of color, are struggling with hunger, have large unpaid rent bills, face mental health challenges as a result of the pandemic, or are enduring other forms of extreme hardship.¹⁰ Millions of children have effectively lost a year of schooling. Households, as well as millions of struggling small businesses, will require unprecedented levels of support to make it through the pandemic and to recover from the harm done. While other forms of federal support provide important direct assistance, states and local governments will also need to deliver a wide range of localized supports and services and to sustain them over a long period of time.

Meanwhile, while the pandemic's hit on state revenues has been less than feared, revenues in most states remain below pre-pandemic projections, and some states have experienced severe revenue losses.¹¹ Most cities and counties have received no direct federal aid to date, and revenue sources they depend upon — including hotel and restaurant charges, parking fees, and business license fees — have been hit particularly hard. Tribal nations are especially dependent on tourism and have seen their revenues collapse.¹²

The American Rescue Plan Act provides \$350 billion to help states, localities, tribal governments, and territories cover these unexpected costs and offset the pandemic's impact their revenues. They can also use the funding to help pay for long overdue investments in broadband (a need particularly exposed by the pandemic) and for clean water and sewer infrastructure projects, as well as to provide “premium pay” to essential public workers. In addition, the Act provides a separate \$10 billion to states, territories, and tribal nations for capital projects. To help ensure the funds are spent

¹⁰ “Tracking the COVID-19 Recession’s Effects on Food, Housing, and Employment Hardships,” *op. cit.*

¹¹ Michael Leachman and Elizabeth McNichol, “Despite Improved State Fiscal Conditions, Serious Challenges Remain, Including for Localities, Tribal Nations, and Territories,” Center on Budget and Policy Priorities, February 26, 2021, <https://www.cbpp.org/research/state-budget-and-tax/despite-improved-state-fiscal-conditions-serious-challenges-remain>.

¹² Joshua Marshall, “Tribal Nations More Vulnerable to COVID-19 Impacts, Need Additional Fiscal Aid,” Center on Budget and Policy Priorities, August 5, 2020, <https://www.cbpp.org/blog/tribal-nations-more-vulnerable-to-covid-19-impacts-need-additional-fiscal-aid>.

as intended, the Act requires that any state adopting tax cuts that lose revenue on net lose an equivalent amount in federal aid.

Of the \$350 billion in aid, states will get \$195.3 billion. Each state will receive \$500 million plus its share of the remainder based on its share of the nation's jobless workers; Treasury Secretary Janet Yellen is authorized to withhold up to half of a state's aid for up to 12 months based on her assessment of the state's unemployment rate. Municipalities and counties will get \$130.2 billion (\$65.1 billion each) — with a municipality's allocations based largely on its population and poverty, and county allocations based on each county's share of the nation's population. Half the aid for cities and counties will be distributed within 60 days of the bill's enactment, while the other half will be distributed one year after the first. Tribal nations will receive \$20 billion, and territories will get \$4.5 billion.

Schools

The American Rescue Plan Act includes \$123 billion in new, mostly very flexible funds for school districts, which they will be able to spend through the 2023-24 school year to address the pandemic and its effects on student learning. This is the largest-ever one-time federal investment in K-12 education, but entirely appropriate in light of school funding needs.¹³

Historically, K-12 schooling has been funded overwhelmingly by states and localities; they currently provide 92 percent of funding, with the federal government providing the rest. COVID-19, however, forced states to cut funding and created enormous financial and educational challenges that states and localities will be hard pressed to meet over the next several years without federal assistance. K-12 funding comprises about 26 percent of state budgets and states will find it very hard to fully shield that funding while meeting their balanced-budget requirements. Even before COVID-19, schools endured years of inadequate and inequitable funding. Some 15 to 20 states were still providing less funding for K-12 schools when the pandemic hit than before the Great Recession of a decade ago in per-pupil, inflation-adjusted terms. When COVID-19 hit, schools were employing 77,000 fewer teachers and other workers while educating 1.5 million more children.

The CARES Act of March 2020 provided \$13.2 billion for K-12 education and December's package provided another \$54 billion, but schools will need far more to pay for distance learning, safe in-person instruction, caring for students' physical and mental health, and, most significantly, making up for learning loss. Schools need to close the "digital divide," so all students and teachers have access to devices and connectivity. They need to safely operate in-person schools, which will require plexiglass shields, hand sanitizer, more custodial staff, and more buses and drivers to maintain social distancing. A quarter of schools have no full- or part-time nurse, and most schools lack counselling support to help students navigate the mental-health challenges of returning to school. Many schools will need to add staff and/or portable classrooms to reduce class size to meet social distancing guidelines.

But beyond the costs of operating remotely and in person, the American Rescue Plan Act's funds will enable school districts to make critical investments to address the widespread learning loss that

¹³ Nicholas Johnson and Victoria Jackson, "House Bill to Implement Biden COVID-Relief Plan Includes Much-Needed K-12 Funding," Center on Budget and Policy Priorities, February 9, 2021, <https://www.cbpp.org/research/state-budget-and-tax/house-bill-to-implement-biden-covid-relief-plan-includes-much-needed>.

the pandemic and remote learning have caused. Students on average will likely lose nine months of learning by the end of the 2020-21 school year, McKinsey & Company estimates, and students of color may well lose a full year on average. With resources, schools can lengthen school days and the school year and invest in high-quality tutoring to help students — over the course of the next couple of years — recover what they have lost. The costs of addressing all these needs could easily top \$100 billion over the next few years, based on estimates from the Learning Policy Institute and McKinsey.¹⁴ Along with the \$123 billion, the Act includes “maintenance of equity” provisions that require states to avert funding cuts to schools and school districts with high numbers of poor children.

Emergency Funds

The American Rescue Plan Act includes \$1 billion for a Pandemic Emergency Assistance fund to enable states, tribes, and territories to help families with the lowest incomes cover their additional pandemic-driven expenses and avert eviction and other real hardships.¹⁵

Hardship is particularly high among families with children, raising serious concerns about the long-term consequences for children’s health and academic outcomes. More than 4 in 10 children live in households that are having trouble covering usual expenses, and 4 in 10 children in rental housing live in a household that either isn’t getting enough to eat or isn’t caught up on rent.

States (along with tribes and territories) could use the new fund to provide households with non-recurrent, short-term benefits — that is, benefits that: (1) address a specific crisis or episode of need; (2) don’t meet recurring or ongoing needs; and (3) don’t extend beyond four months. States could direct funds to the families that most need them, and states need not limit payments to families receiving TANF cash assistance. Indeed, in states in which few families get TANF, states could reach more needy families by targeting a broader set of them (such as SNAP families with children). States also could use the funds, for instance, to help families that don’t get emergency housing assistance pay their back rent and avoid eviction, or help families fleeing domestic violence cover their moving costs and initial rental payments.

¹⁴ Emma Dorn *et al.*, “COVID-19 and Learning Loss — Disparities Grow and Students Need Help,” McKinsey & Company, December 8, 2020, <https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid-19-and-learning-loss-disparities-grow-and-students-need-help>; Michael Griffith, “What Will It Take to Stabilize Schools in the Time of COVID-19?” Learning Policy Institute, May 7, 2020, <https://learningpolicyinstitute.org/blog/what-will-it-take-stabilize-schools-time-covid-19>.

¹⁵ LaDonna Pavetti, “Pandemic Emergency Fund Would Help Families With Lowest Incomes,” Center on Budget and Policy Priorities, February 10, 2021, <https://www.cbpp.org/blog/pandemic-emergency-fund-would-help-families-with-lowest-incomes>.

Appendix

APPENDIX TABLE 1

Estimated Number of Children Who Will Benefit From American Rescue Plan Act Child Tax Credit Expansion, by State

State	Children under 17 left out of the full \$2,000 Child Tax Credit who will benefit from expansion	Children under 18 lifted above the poverty line by expansion	Children under 18 lifted above or closer to the poverty line by expansion	Children under 18 who will benefit from expansion	Share of children under 18 who will benefit from expansion
Total U.S.	27,000,000	4,140,000	9,894,000	65,694,000	90%
Alabama	479,000	80,000	162,000	1,021,000	94%
Alaska	52,000	12,000	21,000	167,000	91%
Arizona	690,000	112,000	238,000	1,508,000	93%
Arkansas	324,000	48,000	94,000	661,000	94%
California	3,527,000	553,000	1,689,000	7,865,000	88%
Colorado	345,000	57,000	132,000	1,109,000	89%
Connecticut	199,000	29,000	79,000	608,000	83%
Delaware	67,000	10,000	24,000	183,000	90%
District of Columbia	52,000	8,000	25,000	94,000	76%
Florida	1,733,000	272,000	698,000	3,837,000	92%
Georgia	1,042,000	171,000	354,000	2,274,000	91%
Hawai'i	92,000	14,000	43,000	278,000	92%
Idaho	154,000	17,000	37,000	410,000	94%
Illinois	986,000	153,000	338,000	2,543,000	89%
Indiana	556,000	80,000	175,000	1,453,000	93%
Iowa	198,000	25,000	48,000	669,000	93%
Kansas	219,000	29,000	57,000	652,000	93%
Kentucky	421,000	69,000	143,000	931,000	93%
Louisiana	529,000	94,000	188,000	1,028,000	94%
Maine	75,000	10,000	21,000	229,000	91%
Maryland	353,000	52,000	158,000	1,125,000	85%
Massachusetts	355,000	55,000	161,000	1,105,000	81%
Michigan	810,000	117,000	249,000	1,970,000	92%
Minnesota	321,000	44,000	85,000	1,126,000	88%
Mississippi	350,000	57,000	116,000	677,000	96%
Missouri	505,000	73,000	153,000	1,262,000	92%
Montana	78,000	10,000	21,000	210,000	93%
Nebraska	141,000	18,000	36,000	434,000	93%
Nevada	272,000	40,000	86,000	634,000	94%

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Estimated Number of Children Who Will Benefit From American Rescue Plan Act Child Tax Credit Expansion, by State

State	Children under 17 left out of the full \$2,000 Child Tax Credit who will benefit from expansion	Children under 18 lifted above the poverty line by expansion	Children under 18 lifted above or closer to the poverty line by expansion	Children under 18 who will benefit from expansion	Share of children under 18 who will benefit from expansion
New Hampshire	52,000	8,000	20,000	222,000	87%
New Jersey	560,000	89,000	257,000	1,608,000	82%
New Mexico	244,000	32,000	71,000	454,000	95%
New York	1,546,000	242,000	680,000	3,564,000	87%
North Carolina	924,000	137,000	307,000	2,088,000	92%
North Dakota	40,000	4,000	10,000	157,000	92%
Ohio	948,000	132,000	278,000	2,372,000	92%
Oklahoma	398,000	63,000	113,000	895,000	94%
Oregon	292,000	40,000	92,000	779,000	90%
Pennsylvania	892,000	140,000	311,000	2,368,000	90%
Rhode Island	67,000	8,000	23,000	185,000	91%
South Carolina	475,000	68,000	151,000	1,025,000	94%
South Dakota	67,000	10,000	19,000	197,000	93%
Tennessee	633,000	95,000	212,000	1,394,000	93%
Texas	3,091,000	503,000	1,079,000	6,696,000	92%
Utah	235,000	32,000	69,000	860,000	94%
Vermont	30,000	4,000	8,000	105,000	91%
Virginia	530,000	85,000	249,000	1,591,000	86%
Washington	478,000	66,000	159,000	1,437,000	88%
West Virginia	169,000	23,000	50,000	346,000	94%
Wisconsin	368,000	46,000	94,000	1,159,000	92%
Wyoming	35,000	3,000	11,000	128,000	95%

Notes: Based on economy as of 2016-2018 using tax year 2020 tax rules and incomes adjusted for inflation to 2020 dollars. Children left out receive less than full \$2,000 per child because their parents lack earnings or have earnings that are too low.

Source: For children left out of the full \$2,000 Child Tax Credit, Tax Policy Center national estimate allocated by state based on CBPP analysis of American Community Survey (ACS) data for 2016-2018. For remaining columns, preliminary CBPP analysis of the March 2019 Current Population Survey (national estimate) allocated by state based on CBPP analysis of ACS data for 2016-2018. Poverty calculations also use U.S. Census Bureau Supplemental Poverty Measure research files for the ACS.

APPENDIX TABLE 2

Estimated Children Under 17 Left Out of the Full \$2,000 Child Tax Credit, by State and by Race/Ethnicity

State	Total	White	Black	Latino	Asian	Another race or multiple races
Total U.S.	27,000,000	8,781,000	5,716,000	9,910,000	814,000	1,779,000
Alabama	479,000	180,000	219,000	55,000	N/A	22,000
Alaska	52,000	15,000	N/A	N/A	N/A	26,000
Arizona	690,000	154,000	39,000	404,000	8,000	84,000
Arkansas	324,000	158,000	87,000	55,000	N/A	22,000
California	3,527,000	450,000	226,000	2,484,000	222,000	145,000
Colorado	345,000	121,000	19,000	176,000	8,000	22,000
Connecticut	199,000	53,000	37,000	92,000	N/A	11,000
Delaware	67,000	19,000	26,000	17,000	N/A	N/A
District of Columbia	52,000	N/A	42,000	N/A	N/A	N/A
Florida	1,733,000	467,000	498,000	658,000	26,000	84,000
Georgia	1,042,000	274,000	470,000	221,000	21,000	56,000
Hawai'i	92,000	N/A	N/A	20,000	15,000	47,000
Idaho	154,000	96,000	N/A	46,000	N/A	10,000
Illinois	986,000	298,000	263,000	355,000	26,000	44,000
Indiana	556,000	307,000	107,000	95,000	11,000	36,000
Iowa	198,000	121,000	24,000	32,000	N/A	17,000
Kansas	219,000	107,000	23,000	65,000	N/A	20,000
Kentucky	421,000	292,000	59,000	37,000	N/A	27,000
Louisiana	529,000	160,000	294,000	42,000	N/A	28,000
Maine	75,000	62,000	N/A	N/A	N/A	6,000
Maryland	353,000	82,000	148,000	85,000	13,000	24,000
Massachusetts	355,000	118,000	50,000	144,000	21,000	22,000
Michigan	810,000	408,000	230,000	97,000	16,000	59,000
Minnesota	321,000	133,000	73,000	56,000	23,000	36,000
Mississippi	350,000	104,000	213,000	17,000	N/A	15,000
Missouri	505,000	299,000	112,000	46,000	N/A	43,000
Montana	78,000	51,000	N/A	N/A	N/A	21,000
Nebraska	141,000	66,000	13,000	46,000	N/A	11,000
Nevada	272,000	53,000	42,000	143,000	N/A	23,000
New Hampshire	52,000	40,000	N/A	N/A	N/A	N/A
New Jersey	560,000	144,000	121,000	251,000	23,000	21,000
New Mexico	244,000	33,000	N/A	165,000	N/A	42,000
New York	1,546,000	470,000	314,000	570,000	123,000	68,000
North Carolina	924,000	300,000	299,000	241,000	18,000	66,000

APPENDIX TABLE 2

Estimated Children Under 17 Left Out of the Full \$2,000 Child Tax Credit, by State and by Race/Ethnicity

State	Total	White	Black	Latino	Asian	Another race or multiple races
North Dakota	40,000	20,000	N/A	N/A	N/A	12,000
Ohio	948,000	512,000	247,000	91,000	N/A	87,000
Oklahoma	398,000	153,000	52,000	100,000	N/A	90,000
Oregon	292,000	146,000	N/A	103,000	N/A	25,000
Pennsylvania	892,000	428,000	195,000	190,000	24,000	53,000
Rhode Island	67,000	23,000	N/A	30,000	N/A	N/A
South Carolina	475,000	156,000	220,000	65,000	N/A	29,000
South Dakota	67,000	28,000	N/A	N/A	N/A	29,000
Tennessee	633,000	313,000	187,000	93,000	N/A	33,000
Texas	3,091,000	478,000	432,000	2,042,000	60,000	79,000
Utah	235,000	131,000	N/A	75,000	N/A	19,000
Vermont	30,000	26,000	N/A	N/A	N/A	N/A
Virginia	530,000	194,000	178,000	103,000	17,000	39,000
Washington	478,000	191,000	32,000	174,000	20,000	61,000
West Virginia	169,000	144,000	N/A	N/A	N/A	12,000
Wisconsin	368,000	172,000	73,000	76,000	13,000	34,000
Wyoming	35,000	22,000	N/A	N/A	N/A	N/A

Notes: Figures are rounded to the nearest 1,000 and may not sum to totals due to rounding. N/A indicates reliable data are not available due to small sample size. Based on economy as of 2016-2018 using tax year 2020 tax rules and incomes adjusted for inflation to 2020 dollars. Children left out receive less than full \$2,000 per child because their parents lack earnings or have earnings that are too low. Racial and ethnic categories do not overlap. Figures for each racial group such as Black, white, or Asian do not include individuals who identify as multiracial or people of Latino ethnicity. Latino includes all people of Hispanic, Latino, or Spanish origin regardless of race.

Source: Tax Policy Center national estimate allocated by state and by race or ethnicity based on CBPP analysis of American Community Survey (ACS) data for 2016-2018.

APPENDIX TABLE 3

Estimated Number of Workers Without Children Who Will Benefit From American Rescue Plan Act EITC Expansion, by State and by Race/Ethnicity

State	Total	White	Black	Latino	Asian	Another race or multiple races
Total U.S.	17,271,000	10,365,000	2,843,000	2,775,000	678,000	610,000
Alabama	287,000	169,000	98,000	N/A	N/A	N/A
Alaska	41,000	22,000	N/A	N/A	N/A	12,000
Arizona	379,000	212,000	23,000	110,000	9,000	26,000
Arkansas	183,000	129,000	37,000	N/A	N/A	N/A
California	1,840,000	707,000	144,000	698,000	216,000	76,000
Colorado	298,000	212,000	15,000	54,000	7,000	10,000
Connecticut	154,000	94,000	22,000	28,000	N/A	N/A
Delaware	48,000	28,000	14,000	N/A	N/A	N/A
District of Columbia	33,000	9,000	18,000	N/A	N/A	N/A
Florida	1,303,000	674,000	228,000	345,000	25,000	30,000
Georgia	569,000	280,000	227,000	34,000	15,000	13,000
Hawai'i	69,000	18,000	N/A	7,000	21,000	21,000
Idaho	109,000	92,000	N/A	12,000	N/A	N/A
Illinois	616,000	373,000	121,000	85,000	24,000	13,000
Indiana	382,000	295,000	50,000	19,000	N/A	11,000
Iowa	181,000	159,000	9,000	N/A	N/A	N/A
Kansas	168,000	127,000	17,000	15,000	N/A	N/A
Kentucky	271,000	222,000	32,000	8,000	N/A	N/A
Louisiana	296,000	149,000	125,000	12,000	4,000	N/A
Maine	93,000	87,000	N/A	N/A	N/A	N/A
Maryland	255,000	124,000	89,000	21,000	13,000	7,000
Massachusetts	292,000	208,000	24,000	36,000	16,000	8,000
Michigan	600,000	437,000	105,000	28,000	12,000	19,000
Minnesota	288,000	228,000	22,000	14,000	11,000	13,000
Mississippi	176,000	85,000	82,000	N/A	N/A	N/A
Missouri	360,000	277,000	54,000	14,000	6,000	N/A
Montana	84,000	73,000	N/A	N/A	N/A	N/A
Nebraska	104,000	82,000	N/A	N/A	N/A	N/A
Nevada	168,000	84,000	21,000	41,000	13,000	10,000
New Hampshire	70,000	65,000	N/A	N/A	N/A	N/A
New Jersey	354,000	179,000	69,000	75,000	22,000	9,000
New Mexico	134,000	53,000	N/A	61,000	N/A	14,000

APPENDIX TABLE 3

Estimated Number of Workers Without Children Who Will Benefit From American Rescue Plan Act EITC Expansion, by State and by Race/Ethnicity

State	Total	White	Black	Latino	Asian	Another race or multiple races
New York	910,000	490,000	152,000	172,000	71,000	25,000
North Carolina	601,000	361,000	173,000	34,000	12,000	21,000
North Dakota	41,000	31,000	N/A	N/A	N/A	N/A
Ohio	691,000	512,000	126,000	25,000	10,000	19,000
Oklahoma	236,000	153,000	27,000	19,000	N/A	34,000
Oregon	263,000	207,000	N/A	28,000	9,000	13,000
Pennsylvania	697,000	514,000	98,000	53,000	17,000	14,000
Rhode Island	48,000	35,000	N/A	N/A	N/A	N/A
South Carolina	315,000	178,000	113,000	12,000	N/A	8,000
South Dakota	53,000	40,000	N/A	N/A	N/A	9,000
Tennessee	395,000	284,000	85,000	13,000	N/A	N/A
Texas	1,396,000	572,000	221,000	528,000	45,000	30,000
Utah	138,000	109,000	N/A	19,000	N/A	N/A
Vermont	40,000	37,000	N/A	N/A	N/A	N/A
Virginia	417,000	246,000	111,000	27,000	18,000	14,000
Washington	358,000	252,000	19,000	39,000	20,000	27,000
West Virginia	110,000	98,000	8,000	N/A	N/A	N/A
Wisconsin	320,000	260,000	30,000	15,000	N/A	10,000
Wyoming	38,000	33,000	N/A	N/A	N/A	N/A

Note: Figures are rounded to the nearest 1,000 and may not sum to totals due to rounding. N/A indicates reliable data are not available due to small sample size. Based on economy as of 2016-2018 adjusted for inflation. Workers without children who would benefit from the House EITC expansion are those aged 19 and over (excluding full-time students 19-24). Racial and ethnic categories do not overlap. Figures for each racial group such as Black, white, or Asian do not include individuals who identify as multiracial or people of Latino ethnicity. Latino includes all people of Hispanic, Latino, or Spanish origin regardless of race.

Source: CBPP analysis of the March 2019 Current Population Survey (national estimate) allocated by state and by race or ethnicity based on CBPP analysis of American Community Survey (ACS) data for 2016-2018.

APPENDIX TABLE 4

Estimated Increase in SNAP Benefits, by State, From Extension of 15 Percent Increase in Maximum Benefit for July through September 2021

Under a 15% increase in SNAP maximum benefit						
State	Number of SNAP participants ^a (thousands)	Average monthly benefit increase per person	Estimated total monthly benefit increase statewide (millions)	Estimated total 3-month benefit increase statewide (millions)	Share of increase going to participants in households with income below 50 percent of federal poverty level	Share of increase going to participants who are in households with children
Alabama	794	\$29	\$23	\$69	42%	72%
Alaska	83	\$35	\$3	\$9	46%	67%
Arizona	816	\$27	\$22	\$66	45%	69%
Arkansas	360	\$28	\$10	\$30	40%	74%
California	4,245	\$28	\$118	\$355	50%	66%
Colorado	508	\$27	\$14	\$41	37%	66%
Connecticut	360	\$28	\$10	\$30	31%	55%
Delaware	119	\$27	\$3	\$10	38%	66%
District of Columbia	137	\$29	\$4	\$12	54%	54%
Florida	3,510	\$28	\$98	\$293	32%	60%
Georgia	1,726	\$27	\$47	\$141	44%	73%
Guam	43	\$36	\$2	\$5	38%	78%
Hawai'i	185	\$52	\$10	\$29	37%	60%
Idaho	135	\$26	\$4	\$11	34%	74%
Illinois	1,878	\$29	\$55	\$165	38%	67%
Indiana	638	\$28	\$18	\$54	41%	74%
Iowa	295	\$28	\$8	\$25	31%	69%
Kansas	199	\$27	\$5	\$16	34%	72%
Kentucky	592	\$28	\$17	\$50	44%	71%
Louisiana	976	\$30	\$29	\$87	48%	73%
Maine	154	\$28	\$4	\$13	20%	55%
Maryland	760	\$29	\$22	\$66	39%	62%
Massachusetts	879	\$28	\$25	\$75	29%	53%
Michigan	1,264	\$24	\$31	\$92	33%	61%
Minnesota	453	\$25	\$11	\$34	34%	64%
Mississippi	423	\$29	\$12	\$36	42%	73%
Missouri	697	\$28	\$19	\$58	38%	71%
Montana	103	\$27	\$3	\$8	37%	65%

APPENDIX TABLE 4

Estimated Increase in SNAP Benefits, by State, From Extension of 15 Percent Increase in Maximum Benefit for July through September 2021

Under a 15% increase in SNAP maximum benefit						
State	Number of SNAP participants ^a (thousands)	Average monthly benefit increase per person	Estimated total monthly benefit increase statewide (millions)	Estimated total 3-month benefit increase statewide (millions)	Share of increase going to participants in households with income below 50 percent of federal poverty level	Share of increase going to participants who are in households with children
Nebraska	156	\$27	\$4	\$13	37%	72%
Nevada	478	\$28	\$14	\$41	40%	62%
New Hampshire	70	\$27	\$2	\$6	17%	64%
New Jersey	776	\$28	\$22	\$65	25%	64%
New Mexico	493	\$24	\$12	\$35	41%	67%
New York	2,720	\$30	\$81	\$242	28%	54%
North Carolina	1,430	\$28	\$40	\$119	40%	70%
North Dakota	50	\$28	\$1	\$4	38%	68%
Ohio	1,465	\$28	\$41	\$122	39%	65%
Oklahoma	616	\$26	\$16	\$47	48%	71%
Oregon	686	\$28	\$19	\$58	33%	52%
Pennsylvania	1,810	\$25	\$46	\$138	25%	61%
Rhode Island	138	\$27	\$4	\$11	27%	54%
South Carolina	605	\$28	\$17	\$50	47%	75%
South Dakota	77	\$27	\$2	\$6	42%	70%
Tennessee	882	\$28	\$24	\$73	46%	71%
Texas	3,674	\$28	\$102	\$307	42%	79%
Utah	164	\$27	\$4	\$13	40%	77%
Vermont	68	\$26	\$2	\$5	21%	54%
Virginia	758	\$28	\$21	\$63	41%	69%
Virgin Islands	23	\$36	\$1	\$2	50%	66%
Washington	930	\$27	\$25	\$76	37%	55%
West Virginia	303	\$28	\$8	\$25	38%	59%
Wisconsin	725	\$27	\$20	\$59	31%	65%
Wyoming	26	\$31	\$1	\$2	39%	73%
United States	41,447	\$28	\$1,160	\$3,479	38%	66%

^a USDA used November 2020 administrative data, with adjustments for some states where November data differed substantially from September and October.

Estimated Increase in SNAP Benefits, by State, From Extension of 15 Percent Increase in Maximum Benefit for July through September 2021

Under a 15% increase in SNAP maximum benefit						
State	Number of SNAP participants ^a (thousands)	Average monthly benefit increase per person	Estimated total monthly benefit increase statewide (millions)	Estimated total 3-month benefit increase statewide (millions)	Share of increase going to participants in households with income below 50 percent of federal poverty level	Share of increase going to participants who are in households with children

Source: USDA, "Fact Sheet: Biden-Harris Administration's Actions to Reduce Food Insecurity Amid the COVID-19 Crisis," March 3, 2021, <https://www.fns.usda.gov/news-item/usda-003721>.

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The Affordable Care Act's Insurance Marketplace Subsidies Were Associated With Reduced Financial Burden For US Adults

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ABSTRACT Research suggests that the Affordable Care Act (ACA) Medicaid expansions improved financial protection for the poor. However, evidence is limited on whether subsidies offered through the ACA Marketplaces, the law's other major coverage expansion, were associated with reduced financial burden. Using national survey data from the period 2008–17, we examined changes in household health care spending among low-income adults eligible for both Marketplace premium subsidies and cost-sharing reductions (139–250 percent of the federal poverty level) and middle-income adults eligible only for premium subsidies (251–400 percent of the federal poverty level), using high-income adults ineligible for subsidies (greater than 400 percent of the federal poverty level) as controls. Among low-income adults, Marketplace subsidy implementation was associated with 17 percent lower out-of-pocket spending and 30 percent lower probability of catastrophic health expenditures. In contrast, middle-income adults did not experience reduced financial burden by either measure. These findings highlight the successes and limitations of Marketplace subsidies as debate continues over the ACA's future.

A decade after the Affordable Care Act (ACA) was passed, health care expenditures continue to be a leading cause of financial hardship for US families and pose a major barrier to accessing medical care. In 2019 one in four US adults reported that their household had trouble paying medical bills in the past year, and 51 percent reported that a household member had delayed needed care because of its cost.¹ This financial burden affects both uninsured and insured patients: 45 percent of uninsured adults and 25 percent of insured adults ages 18–64 report difficulty paying medical bills.² The share of uninsured working-age adults declined from 20 percent in 2010 to 12 percent in 2018, but the percentage of underinsured adults increased from 16 percent to 23 percent.³

A central goal of the ACA was to protect patients from high and increasing medical costs by expanding insurance coverage through Medicaid and by reforming the nongroup private health insurance market.^{4–8} For people ineligible for Medicaid and unable to obtain affordable insurance through their employer, the ACA established state-based health insurance Marketplaces through which they could purchase subsidized coverage. In these Marketplaces, people earning up to 400 percent of the federal poverty level (\$48,240 for an individual and \$98,400 for a family of four, as of January 2017)⁹ are eligible to receive premium subsidies to reduce the cost of purchasing private insurance. Those earning up to 250 percent of the federal poverty level (\$30,150 for an individual and \$61,500 for a family of four) are also eligible for cost-sharing

reduction subsidies to lower out-of-pocket spending.¹⁰

Evidence is limited as to how the ACA's Marketplace subsidies have affected people's health care spending. A prior study found no evidence of changes in out-of-pocket spending among previously uninsured adults who became eligible for Marketplace subsidies, but that study had access to data from only the first year of Marketplace implementation.¹¹ Other studies demonstrated that adults who became eligible for Marketplace subsidies were less likely to delay or forgo medical care because of cost after ACA implementation^{12,13} but did not quantitatively measure their out-of-pocket spending or changes in that spending. A clearer understanding of what the Marketplace subsidies have achieved, and over a longer period since their implementation, is needed to inform whether and how the subsidies should be modified through future policy reforms.

In this study we used nationally representative data and two robust study designs—a difference-in-differences approach and an event study analysis—to examine how the introduction of Marketplace subsidies affected out-of-pocket spending and the probability of experiencing catastrophic health expenditures for working-age US adults in the first four years after ACA implementation.

Study Data And Methods

DATA SOURCE AND STUDY POPULATION We analyzed data from the Medical Expenditure Panel Survey (MEPS), a nationally representative survey of health care use and spending for the US civilian noninstitutionalized population, covering the period from January 1, 2008, to December 31, 2017.¹⁴ The MEPS Household Component (MEPS-HC) collects data on out-of-pocket spending, health insurance coverage (including whether private insurance was employer-sponsored or purchased on the ACA Marketplaces), income, and demographics from about 15,000 households per year, interviewing each household five times over the course of a two-year period and enrolling new households annually. Information from respondents is supplemented with data from medical providers and pharmacies. Although no individual respondent is followed for more than two years, each year's survey participants are weighted to generate nationally representative estimates, allowing for the analysis of national trends during the ten-year study period (see Methods 1 in the online appendix for more details).¹⁵

Our study population included US adults ages 26–64. We excluded young adults ages 19–25, who became eligible to remain on their parents'

insurance plans in September 2010 through the ACA's Dependent Coverage Provision.¹⁶ Because the first Marketplace plans took effect January 1, 2014, we defined the pre- and post-ACA periods as 2008–13 and 2014–17, respectively. We also excluded people earning up to 138 percent of the federal poverty level, who became eligible for Medicaid in many states under the ACA Medicaid expansions. People earning more than 138 percent of the federal poverty level were stratified into three income groups: low-income people (139–250 percent of the federal poverty level, eligible for cost-sharing reductions and premium subsidies), middle-income people (251–400 percent of the federal poverty level, eligible only for premium subsidies), and high-income people (more than 400 percent of the federal poverty level, ineligible for subsidies). See appendix exhibit A1 for a detailed flowchart.¹⁵

DEFINITIONS OF HEALTH CARE SPENDING We evaluated two outcomes: out-of-pocket health care spending at the individual level and whether the person's family experienced catastrophic health expenditures. We defined health care spending as spending due to inpatient stays, outpatient visits, emergency department visits, prescription drugs, and home health visits. We defined catastrophic health expenditures as family combined out-of-pocket spending exceeding 10 percent of family income, which is a threshold widely used in prior studies to define unaffordable expenditures and underinsurance.^{17–21} We used the Current Population Survey definition of a family—people living together and related by birth, marriage, or adoption²²—which is used by the Census Bureau to determine poverty thresholds.²³

All expenditures were adjusted for inflation using the Centers for Medicare and Medicaid Services Personal Health Care Index,²⁴ and incomes were adjusted using the Consumer Price Index.^{25,26}

STATISTICAL ANALYSIS We examined the association between Marketplace subsidy implementation and health care spending using two study designs: a difference-in-differences analysis and an event study analysis. Both methods are robust approaches comparing the change in an outcome for a treatment group after an intervention with the change in the outcome for a control group during the same period. These approaches account for background changes in the outcome over time, yielding an estimate of the change related specifically to the policy implementation.^{27,28}

We compared two policy-affected groups (low-income people eligible for cost-sharing reductions and premium subsidies) and middle-income

people eligible only for premium subsidies) against one control group (high-income people ineligible for subsidies). We adjusted for age, sex, race/ethnicity, marital status, self-reported health status, census region, unemployment, and family size to control for observed differences between groups, as well as year fixed effects to control for secular trends in all the regression models. Survey weights, strata, and clusters provided by MEPS were used to account for the complex survey design, and cluster-robust standard errors were employed to account for correlation within each sampling unit.

We fit separate multivariable ordinary least squares regression models to out-of-pocket spending (a continuous outcome) and catastrophic health expenditures (a binary outcome). We used an ordinary least squares regression model for the binary outcome as well (that is, a linear probability model) because it allows for better interpretation of the coefficients of the interaction terms than a logistic regression model.^{29–32}

For the difference-in-differences analysis, we regressed each outcome on a binary indicator for the post-ACA period, a three-level categorical variable for income group, and the interaction term between these two regressors. The coefficient of the interaction between time period and income group represented the difference-in-differences estimate of the effect of Marketplace subsidy implementation on our outcomes. (Although people in our control group were also affected by the implementation of the ACA Marketplaces, they were not eligible for Marketplace subsidies.) We formally tested the parallel trends assumption underlying the difference-in-differences analysis (see Methods 2 in the appendix for details).¹⁵

For the event study analysis, we fit a similar regression model to the difference-in-differences analysis but replaced the binary time period indicator with a categorical variable for the year, which allowed us to estimate changes in each spending outcome over time while controlling for fixed differences between income groups and national trends over time. To maintain a sufficient sample size for stable estimates, we used two-year time intervals for the event study analysis. We again regressed each spending outcome on the interaction terms between income group and time period, using the period immediately before ACA implementation (2012–13) and the high-income group as reference categories. The coefficients of the interaction between time period and income group represented the event study estimates of the effect of the Marketplace subsidies on our outcomes.

SENSITIVITY ANALYSES We conducted several

Our study supplies new evidence at a time of growing public dissatisfaction about financial hardship due to health care costs.

sensitivity analyses (see Methods 3 in the appendix for details).¹⁵ First, instead of the Current Population Survey definition of *family*, we reanalyzed the data using the MEPS definition of *family*, which includes nonmarried partners, foster children, and in-laws, and the health insurance unit, a subfamily unit consisting of an adult and family members typically eligible for coverage under the same plan (namely, spouse and dependent children).

Second, to address the possibility of income measurement error in MEPS, we excluded people with incomes near each of the various income thresholds for Marketplace subsidy eligibility, meaning that the low-, middle-, and high-income groups were redefined as 175–240 percent, 260–390 percent, and more than 410 percent of the federal poverty level, respectively.

Third, to investigate further whether our observed changes were attributable to Marketplace subsidies, we excluded adults who were covered by public insurance (Medicaid, Medicare, Veterans Health Administration, or Tricare), as well as those covered by employer-sponsored insurance, at any point during the calendar year.

Fourth, we reanalyzed the data using narrower income bins—139–150 percent, 151–200 percent, 201–250 percent, 251–400 percent, and more than 400 percent (reference group) of the federal poverty level—to better understand how the financial protection benefits of Marketplace subsidies were distributed across income levels.

Fifth, we also adjusted for the presence of chronic health conditions.

Sixth, to examine the sensitivity of our findings to model specification, we used a two-part model to analyze out-of-pocket spending, and we used a logistic regression model to analyze catastrophic health expenditures instead of a linear regression model.

Finally, we used two alternative definitions of catastrophic health expenditures from the literature: out-of-pocket plus premium spending ex-

There remains a critical need for reforms that address the health care affordability crisis for low- and middle-income people.

ceeding 19.5 percent of family income, a definition used in a previous study,¹⁷ and out-of-pocket plus premium spending exceeding 40 percent of family income less expenditures for food and housing, a threshold established by the World Health Organization.³³

All analyses were conducted using Stata, version 16.1. Ethical approval was obtained from the University of California Los Angeles Institutional Review Board.

LIMITATIONS Our study had several limitations. First, because of the simultaneous nationwide implementation of the ACA, no perfect control group exists to study the impact of Marketplace implementation. In particular, our high-income control group was not eligible for Marketplace subsidies but was affected by many of the other reforms included in the ACA Marketplaces, such as community rating requirements and standardization of insurance plans. Therefore, our estimates should be interpreted as reflecting the impact of the Marketplace subsidies only, as opposed to the impact of the ACA Marketplaces more broadly.

Second, because the MEPS-HC data did not permit us to follow people who gained Marketplace coverage longitudinally (because of a small sample size and the fact that no respondent is followed for longer than two years), we instead studied people in the income ranges targeted by the Marketplace subsidies. As a result, only a relatively small proportion of our study population actually purchased a Marketplace insurance plan. The observed decreases in spending may thus be attributable not only to the Marketplace subsidies but also to other ACA provisions that disproportionately benefited low-income people and people with high out-of-pocket spending, including some degree of Medicaid enrollment in our low-income group.

Third, MEPS-HC did not collect data on unpaid

bills or medical debt until 2014, so we were unable to assess the effect of Marketplace subsidies on these aspects of financial hardship. This potentially underestimated both true rates of catastrophic health expenditures and changes in financial protection.

Study Results

Our analysis included 127,942 survey respondents (flowchart shown in appendix exhibit A1),¹⁵ representing approximately 133 million US adults per year after survey weighting. Compared with the high-income group, the two lower-income groups were younger and more likely to be non-White, to report being in fair or poor health, and to be uninsured pre-ACA (exhibit 1). From pre- to post-ACA, the uninsurance rate decreased by nearly one-third in the low-income group and by nearly one-quarter in the middle- and high-income groups, and private coverage trended upward in all three groups. Finally, coverage purchased through the Marketplaces constituted about 7 percent, 5 percent, and 3 percent of the low-, middle-, and high-income groups, respectively, post-ACA.

Using standard approaches, we found no evidence of nonparallel trends in the outcome variables among the three income groups in the pre-ACA period, supporting the validity of the difference-in-differences analysis (see Methods 2 and appendix exhibit A2).¹⁵ Similarly, our event study analysis found no evidence that our outcomes were diverging among income groups in the pre-ACA period, supporting the validity of this approach (appendix exhibit A3).¹⁵

OUT-OF-POCKET SPENDING Among low-income working-age adults eligible for both cost-sharing reductions and premium subsidies, our difference-in-differences analysis showed that Marketplace subsidy implementation was associated with 17.2 percent lower out-of-pocket spending (absolute change, $-\$109$ per year; $p < 0.001$) (exhibit 2). Our event study analysis further demonstrated that among low-income adults, out-of-pocket spending trended downward in years 1–2 of Marketplace subsidy implementation (2014–15) and achieved a statistically significant decrease of 23.2 percent (absolute change, $-\$139$ per year; $p = 0.002$) in years 3–4 (2016–17), relative to the two years prior to ACA implementation (2012–13) (exhibit 3 and appendix exhibit A3).¹⁵

We found no evidence that out-of-pocket spending changed after Marketplace subsidy implementation among middle-income adults eligible for only premium subsidies in either the difference-in-differences analysis or the event study analysis (exhibit 3 and appendix ex-

EXHIBIT 1

Characteristics	Low income		Middle income		High income	
	Pre-ACA (n = 23,379) ^a	Post-ACA (n = 14,467) ^b	Pre-ACA (n = 21,954) ^a	Post-ACA (n = 13,729) ^b	Pre-ACA (n = 32,391)	Post-ACA (n = 22,022) ^b
US weighted population per year	29,540,525	28,241,456	34,250,823	33,063,612	67,069,213	74,542,941
Age, mean years (SD)	43.1** (11.7)	43.3 (12.1)	43.8** (10.5)	43.9 (10.7)	46.6 (9.1)	46.3 (8.9)
Female (%)	52.0**	52.2	50.2**	50.4	49.2	48.9
Race/ethnicity (%)						
Non-Hispanic White	57.0**	51.5**	67.8**	61.3**	76.3	71.7**
Hispanic	22.3**	25.5**	14.4**	18.0**	8.0	9.9**
Non-Hispanic Black	14.0**	15.3**	11.3**	12.7**	7.6	8.1**
Asian	4.6**	4.8**	4.8**	5.3**	6.3	7.8**
Other/multiple	2.1**	3.0**	1.8**	2.7**	1.9	2.4**
Marital status (%)						
Married	54.7**	51.2**	61.5**	60.1**	73.5	72.9**
Divorced, separated, widowed	22.1**	21.4**	18.5**	17.1**	12.2	11.4**
Never married	23.3**	27.4**	20.0**	22.8**	14.3	15.7**
Census region (%)						
Northeast	15.8**	14.5	17.0**	15.7	20.7	20.6
Midwest	21.1**	19.6	23.9**	23.3	21.6	21.2
South	39.5**	41.1	36.5**	39.4	34.1	33.7
West	23.7**	24.9	22.6**	21.6	23.7	24.5
Employed (%)	78.8**	80.0	86.6**	87.0	90.2	91.6**
Family income in 2017 dollars, mean (SD)	40,219** (17,023)	39,944 (16,968)	64,161** (21,451)	65,207 (22,374)	133,309 (54,786)	137,189** (57,291)
Family size, mean (SD)	3.1** (1.8)	3.2 (1.8)	3.0** (1.5)	3.1** (1.5)	2.7 (1.0)	2.7 (1.0)
Self-reported health (%)						
Excellent/very good/good	83.6**	84.2	89.1**	88.9	93.3	93.7
Fair/poor	16.1**	15.6	10.7**	10.8	6.6	6.2
Unknown	0.2**	0.3	0.2**	0.2	0.1	0.1
Insurance coverage (%) ^c						
Any private ^d	51.6**	53.5**	76.1**	77.2	89.3	89.9
Marketplace	— ^e	6.5	— ^e	4.6	— ^e	2.8
Private employer sponsored	47.4**	44.1**	71.4**	69.9	84.5	83.6
Uninsured	35.1**	24.9**	18.7**	14.5**	8.5	6.4**

SOURCE Authors' analysis of data from the Medical Expenditure Panel Survey—Household Component, 2008–17. **NOTES** N = 127,942, weighted N = 132,855,540 per year. Low income is 139–250% of the federal poverty level; middle income, 251–400%; and high income, more than 400%. All values shown are weighted to be nationally representative. SD is standard deviation. ^aSignificance results in this column are for difference from high-income group in the pre-ACA period, using t-test for continuous variables and chi-square test for categorical variables. ^bSignificance results in this column are for difference from pre-ACA in the same income group. ^cReflects insurance coverage sources in December of each study year. ^dIncludes private insurance coverage obtained through an employer, on the ACA Marketplaces, or through other sources. ^eNot applicable. **p < 0.05

hibit A3).¹⁵

CATASTROPHIC HEALTH EXPENDITURES Among low-income adults, our difference-in-differences analysis found that Marketplace subsidy implementation was associated with a 29.6 percent lower likelihood of catastrophic health expenditures (absolute change, –2.4 percentage points; *p* < 0.001) (exhibit 2). Our event study analysis demonstrated that this was driven by a 30.6 percent decrease in likelihood of catastrophic health expenditures (absolute change, –2.2 percentage points; *p* = 0.01) in years 3–4 (2016–17) of Marketplace subsidy implementation, relative to the two years prior to implementation (2012–13) (exhibit 4 and appendix exhibit A3).¹⁵

Among middle-income adults, our difference-

in-differences analysis demonstrated that Marketplace subsidy implementation was associated with a marginally significant 20.0 percent decrease in the likelihood of catastrophic health expenditures (absolute change, –0.8 percentage points; *p* = 0.04) (exhibit 2). In contrast, our event study analysis did not find evidence of such an association (exhibit 4 and appendix exhibit A3).¹⁵

SENSITIVITY ANALYSES Our findings were qualitatively unaffected by using alternative definitions of family, alternative sample definitions (exclusion of adults near income eligibility thresholds, adults with public insurance, or adults with employer-sponsored insurance), alternative model specifications (adjustment for

chronic conditions, a two-part model for out-of-pocket spending, or a logistic regression model for catastrophic health expenditures), or alternative definitions of catastrophic health expenditures. Notably, the first stage of our two-part model found that Marketplace subsidy implementation was associated with no change in the likelihood of having any out-of-pocket spending, meaning that our overall findings were explained by changes in mean spending among people with nonzero spending. In a sensitivity analysis using narrower income bins, we observed a consistent monotonic relationship between lower income and greater decreases in spending associated with the implementation of Marketplace subsidies, with the exception of the lowest-income group (139–150 percent of the federal poverty level), which had a substantially smaller sample size. See appendix exhibits A4–A10 for the results of the sensitivity analyses.¹⁵

Discussion

In the first four years of implementation, the ACA Marketplace subsidies were associated with significant improvements in financial protection for low-income adults, as indicated by reductions in out-of-pocket spending and reduced likelihood of experiencing catastrophic expenditures. These reductions were substantial in magnitude, ranging from a 17.2 percent decrease in out-of-pocket spending to a 29.6 percent decrease in the likelihood of catastrophic health expenditures. We did not, however, consistently observe similar improvements in financial protection for middle-income people eligible only for premium subsidies. These findings contribute to ongoing policy debates about how best to address the financial burden of health care costs for patients and families and suggest that ACA Marketplace subsidies are achieving a primary objective: reducing the financial burden experienced by low-income people.

Our study supplies new evidence at a time of growing public dissatisfaction about financial hardship due to health care costs in the United States. A decade after the passage of the ACA, health insurance premiums and out-of-pocket spending continue to be major concerns for patients and are consistently ranked as a top financial stressor for US households. In a 2019 survey, 80 percent of Americans said that they personally worried a “great deal” or a “fair amount” about the availability of affordable health care.³⁴ As health care costs continue to increase, patients are also responsible for a growing share of expenses. For example, the percentage of privately insured people with out-of-pocket spend-

EXHIBIT 2

Difference-in-differences (DID) analysis of out-of-pocket spending and the likelihood of catastrophic health expenditures among adults ages 26–64 who were eligible for Affordable Care Act (ACA) Marketplace subsidies, by income level

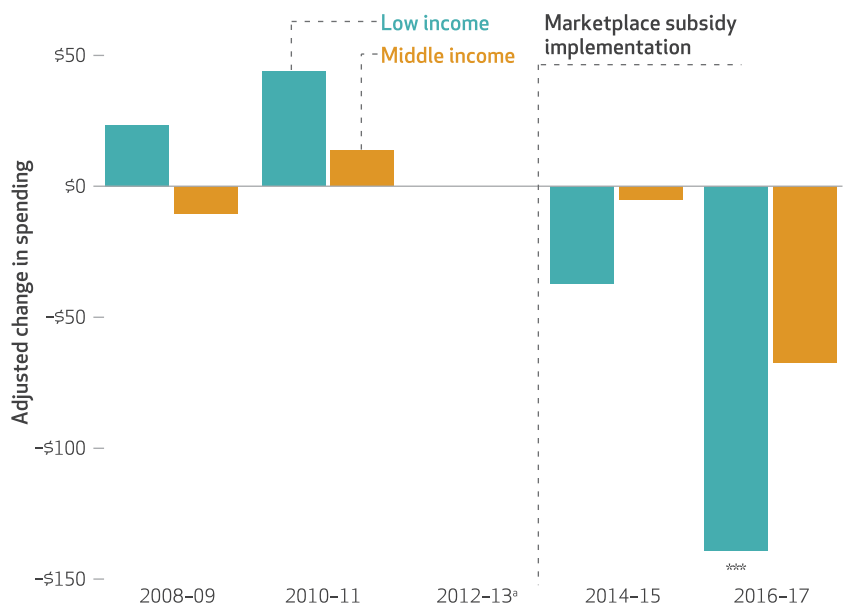
Income group	Mean pre-ACA level	Adjusted DID change
OUT-OF-POCKET SPENDING		
Low income	\$635	−\$109****
Middle income	709	−\$38
High income	882	ref
LIKELIHOOD OF CATASTROPHIC HEALTH EXPENDITURES		
Low income	8.1%	−2.4 ^a ****
Middle income	4.0	−0.8 ^a **
High income	1.1	ref

SOURCE Authors’ analysis of Medical Expenditure Panel Survey data, 2008–17. **NOTES** Sample size (absolute and weighted) are in the exhibit 1 notes. Income levels are defined in the exhibit 1 notes. Out-of-pocket spending is summed over each person. Catastrophic health expenditures are defined as combined family out-of-pocket spending exceeding 10% of family income. Regression analyses were performed using the individual as the unit of analysis. ^aPercentage points. ** $p < 0.05$ **** $p < 0.001$

ing greater than \$1,000 has increased steadily over time,³⁵ and the proportion enrolled in high-deductible health plans nearly doubled to 46 percent between 2010 and 2018.³⁶ This finan-

EXHIBIT 3

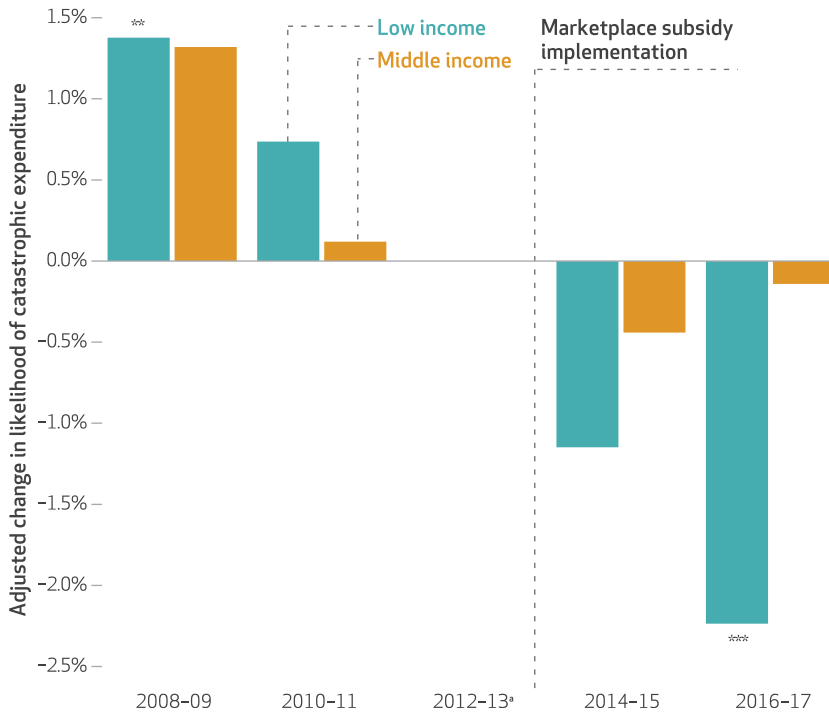
Adjusted changes in out-of-pocket health care spending among low- and middle-income US adults ages 26–64 associated with implementation of the Affordable Care Act (ACA) Marketplace subsidies



SOURCE Authors’ analysis of data from the Medical Expenditure Panel Survey–Household Component, 2008–17. **NOTES** Low income is family income 139–250% of the federal poverty level and thus eligible for cost-sharing reductions and premium subsidies. Middle income is family income 251–400% of the federal poverty level and thus eligible only for premium subsidies. The dotted line indicates the implementation of ACA Marketplace subsidies. ^aChanges shown are relative to 2012–13 levels. *** $p < 0.01$

EXHIBIT 4

Adjusted changes in the likelihood of catastrophic health expenditures among low- and middle-income US adults ages 26–64 associated with implementation of the Affordable Care Act (ACA) Marketplace subsidies



SOURCE Authors' analysis of data from the Medical Expenditure Panel Survey—Household Component, 2008–17. **NOTES** Income levels are defined in the notes to exhibit 3. Catastrophic health expenditures are defined as out-of-pocket spending exceeding 10 percent of family income. The dotted line indicates the implementation of ACA Marketplace subsidies. *Changes shown are relative to 2012–13 levels. ** $p < 0.05$ *** $p < 0.01$

cial burden, of which we explore a key aspect in this study, has negative consequences for patients' ability to obtain and adhere to care and is associated with poor health outcomes.³⁷

POTENTIAL DRIVERS OF REDUCED FINANCIAL BURDEN At least two potential reasons exist for the association between the implementation of Marketplace subsidies and improved financial protection for low-income people. First, 7 percent of low-income people in our study purchased Marketplace coverage post-ACA, which is required by law to cover hospital and ambulatory care and to cap enrollees' annual out-of-pocket spending.⁴ Thus, people transitioning from being uninsured or underinsured to having Marketplace coverage likely experienced reduced out-of-pocket spending. Second, improved access to primary and preventive care through the ACA⁵ may have improved the management of chronic conditions, thereby reducing complications and costs for low-income people with multiple comorbidities.³⁸ However, further investigation is still needed to better understand the effects of Marketplace subsidies on financial

burden among low-income people, as these effects did not increase in magnitude when we limited our analysis to the subgroups most likely to be affected by the subsidies.

In contrast to low-income people, middle-income people eligible only for premium subsidies did not experience a significant change in out-of-pocket spending or the likelihood of catastrophic expenditures. There are two possible reasons for this, aside from cost-sharing subsidies not being offered to this group. First, compared with low-income people, middle-income people experienced smaller insurance coverage gains after ACA implementation. Second, because of their less generous ACA subsidies, middle-income people may have been more likely to purchase less comprehensive bronze-tier or high-deductible health plans on the Marketplaces, exposing them to higher out-of-pocket spending. For example, during the 2018 Marketplace open enrollment period, people with incomes of 100–250 percent of the federal poverty level selected silver or gold plans over bronze plans 82 percent to 18 percent, whereas those earning 251–400 percent of the federal poverty level selected bronze plans over silver or gold plans 51 percent to 49 percent.³⁹ Marketplace reforms that could improve affordability and financial risk protection for middle-income people include increasing the size of premium subsidies, as California did in 2020;⁴⁰ reindexing premium subsidies to the cost of gold rather than silver plans, as was proposed during the 2020 presidential campaign;⁴¹ or offering middle-income people cost-sharing reductions similar to those available to low-income people.

PERSISTENT CHALLENGES Finally, we also found that despite gains under the ACA, 6 percent of low-income people continue to experience catastrophic health expenditures each year. These people may be residually uninsured or underinsured because of the variable implementation of the Marketplaces across states, lack of awareness of program eligibility, or plan-specific factors such as out-of-network or balance billing. Alternatively, they may be part of the growing group of people with employer-sponsored insurance that inadequately protects against catastrophic health expenditures.³ Finally, high out-of-pocket spending limits even after cost-sharing subsidies might also be contributing to persistent catastrophic health expenditures. For example, the federal out-of-pocket limit for Marketplace enrollees with incomes of 200–250 percent of the federal poverty level in 2017 was \$5,700 for single coverage and \$11,400 for family coverage,⁴² whereas a family of four in that income range in 2017 earned only \$49,200–\$61,500.⁹ Altogether, although Marketplace subsidies

have improved financial security for some, there remains a critical need for reforms that address the health care affordability crisis for low- and middle-income people in the US.

Conclusion

Using nationally representative data, we found that implementation of the ACA Marketplace subsidies was associated with significant reduc-

tions in out-of-pocket spending and the likelihood of catastrophic expenditures among low-income US adults. Amid efforts to undermine the ACA Marketplaces, including halting of cost-sharing subsidy payments to insurers⁴³ and elimination of the individual mandate,⁴⁴ our findings provide evidence that the Marketplace subsidies are advancing one of their central objectives: reducing the financial burden of health care for working-age people in the US. ■

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this document do not represent the views of the Department of Veterans Affairs or the United States government. The authors thank Laura Wherry for her feedback on study design and statistical analysis.

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The Healthcare Industry Is Evolving Rapidly

What Will It Look Like in the Next Five to 10 Years?



Healthcare is constantly changing. Advances in technology, population shifts and illness trends affect everything from the demand for care to its delivery and costs. The COVID-19 pandemic is quickly reshaping and restructuring healthcare in a variety of ways that are likely to have long-lasting implications.

While payers, providers and organizations continue to address the impact of the virus today, they are also planning for the future of healthcare. Over the next five to 10 years, we expect the industry will continue to evolve on several fronts, including [access to and the delivery of care](#), [financing and payment arrangements](#), [patient care and engagement](#) and [population health](#). This publication covers those areas, based on our predictions, and concludes with advice on [preparing for the future of healthcare](#).





Access and delivery

The COVID-19 pandemic has accelerated use of telehealth services. Consequently, both patients and providers are now more accepting than ever before of virtual care delivery. (See [Segal's insight](#) on digital health trends). The rise of telehealth is also broadening access to care for underserved populations and driving efficiencies.

The traditional doctor-patient relationship is being disrupted

The coupling of virtual technologies with remote medicine disrupts the idea that having a regular relationship with a local primary care provider is necessary to manage chronic illness and improve health and well-being. Younger generations prefer interacting with the health system in the same way they purchase other goods and services — virtually and on demand. Expectations are high for on-demand access to information on services, costs, quality and satisfaction.

Access to more information could empower consumers to be more engaged in their healthcare.

Much of traditional primary care and chronic care management is likely to be enhanced by virtual delivery

Telehealth will evolve from being a complement to physician office visits to becoming a substantial source of primary care, some specialty care and certainly behavioral healthcare. In some cases, office visits will be by referral and telehealth encounters will be integrated into a larger delivery system or practice. Virtual-first models will become more common as health plans seek to better manage non-urgent issues and provide more convenient options and broader access for individuals.

Providers have advocated to be paid similarly for virtual visits for the same level of care as an in-person visit, eliminating the cost efficiencies promised by telemedicine.

Access to specialists is expected to increase via virtual technology

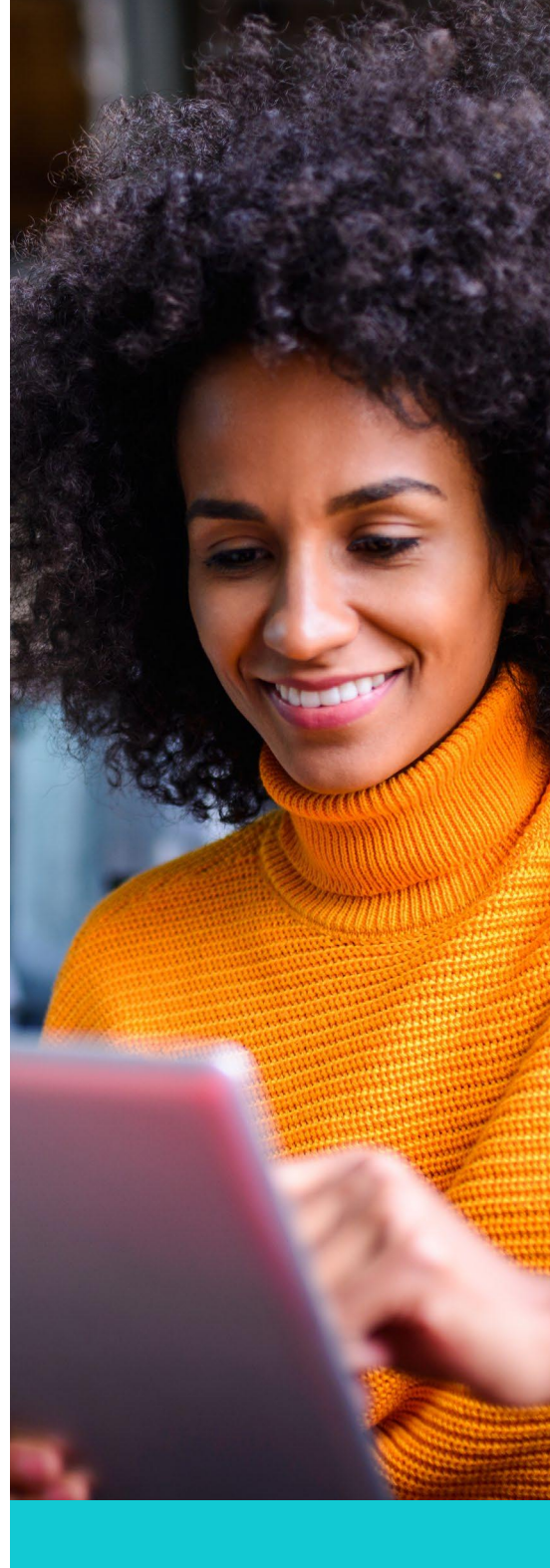
Those in traditionally underserved geographic regions will benefit through improved access and intervention by experts in their field and subspecialists. The model is especially viable for behavioral health and overcoming barriers to treatment, such as stigma and confidentiality. Wider use of remote monitoring technology will enable specialists to provide more collaborative and data-driven care to improve outcomes.

Access to primary care services and chronic care management is projected to accelerate

The “retailization” of medicine at pharmacies and big-box stores, as well as new partnerships and arrangements with and by payers, is expected to improve convenience and access to care for those in underserved geographic areas. Access to medications will expand to include more delivery options, on-site kiosks and retail storefronts.

Consolidation of health systems and providers will further drive independent providers out of the market

Mobile technologies along with automated intelligent operational and clinical technologies will drive additional mergers and acquisitions in the healthcare industry. Advances in remote medicine will increase competition beyond traditional geographic borders. Independent physician practices are rapidly disappearing. Regional health plans and medical carriers will push a more integrated solution that will attempt to reverse the trends for plan sponsors to contract with stand-alone specialty carve-out services. As the digital landscape continues to grow and become more competitive, expect swift and massive consolidations as many vendors work to embed themselves into different health plans and PBMs under their “digital formularies.”





Financing and payments

Healthcare costs will continue their upward trajectory, but increased competition among providers, price transparency and the move to value-based care will attempt to drive efficiencies in the system and help stakeholders better manage costs.

The conflict between broad access and affordability is likely to come to a head

Affordability among plan participants continues to be a top concern. As a result, plan sponsors will be forced to choose among more restricted provider networks and drug formularies to avoid increasing out-of-pocket costs for their workers. A growing number of plan sponsors are already adding narrow networks and closed formularies as an election option for participants or as a full-replacement coverage strategy.

Hospitals' contracted rates with insurers are expected to become somewhat more uniform

In 2021, hospitals must begin publishing shoppable rates for certain services. This could lead to more direct-to-consumer advertising and appeals from hospital systems to patients.

In addition, the [transparency rule](#), parts of which are set to begin taking effect January 1, 2022, will make it much easier for patients to compare costs among providers. The rule requires group health plans and insurers to disclose negotiated provider rates, drug pricing and cost-sharing information. As a result, we expect high-cost outlier hospitals will face new pressures to bring their pricing down to market levels or risk being removed from the insurer's broad networks. (Our [February 16, 2021 webinar](#) discussed the transparency rule and its implications for plan sponsors.)

Bundled payments and value-based care may become the norm

Bundled payments, which are included in the transparency rule, will make it easier to appear cost competitive (see above) because they are more straightforward for patients to understand. They are also a shift away from inflationary fee-for-service pricing. Incentives to overtreat will be lessened under bundled-payment contracts.

In addition, bundled payments will encourage more efficient delivery of care, such as using telemedicine for follow-up visits rather than requiring in-office care.

Providers are likely to compete directly with insurers

As health systems continue to grow in depth and breadth, absorbing physicians and other providers into their systems, some will become insurance providers themselves and take on risk for the total costs of caring for individuals. In exchange, they will require patients to be captive to their health system, leading to a reduction in choice and out-of-network care options. The result will pit health systems against health insurers, with both competing directly for patients' premium dollars.

Prescription drug pricing is expected to remain murky

The political pressures for reducing prescription drug prices will continue to gain momentum. Regulations controlling prescription drug costs, such as the elimination of rebates in the Medicare Part D program in favor of point-of-service discounts, will lead to increased pricing transparency. International pricing standards for certain Medicare Part B drugs may be linked to shifts in payment standards.

We should expect that any changes in public policy will be used by private payers to generate cost savings. Private payers will continue to push for more transparent drug-pricing contracts and will trade deeper discounts for exclusivity.





Patient care and engagement

With the application of new technologies and new treatments, patient care is ever-changing. Digital care offers new ways to engage patients and provides opportunities for individuals to take a more active role in their healthcare. Furthermore, higher out-of-pocket expense liabilities from high-deductible plans will force plan participants to be more prudent consumers of elective services.

Care protocols are likely to become more patient centric and cost efficient

Driven by the pandemic, clinical protocols were adjusted to mitigate and reduce exposure to the virus, particularly among high-risk populations. This will have a lasting impact on standards of care and the practice of medicine. Protocols will continue to evolve to deliver care more efficiently and safely. Clinical trials will become more decentralized, making it easier for patients to participate and leading to less costly and invasive interventions that can get to market faster. A patient-centered care model will take priority, emphasizing the partnership among practitioners, patients, their families and caregivers to align decisions with patient needs and preferences.

Digital transformation of disease and chronic condition management are anticipated to improve outcomes

Programs and services to manage chronic disease through digital applications or direct patient engagement will grow and support improved program adherence. New technologies will enable providers to prevent and detect disease earlier and intervene with low-touch care. Earlier and more cost-effective interventions, including remote monitoring and virtual check-ins, show promise to reduce disease spending.

Many payer programs are shifting from a generalist model to focusing on the members who have the most catastrophic costs. As programs offer a suite of digital options for disease management, traditional telephonic coaching programs will become less common.

Attention will also shift from managing individual diseases to focusing on overall health and well-being that addresses underlying behavioral causes and uses a team-based management approach. However, it must be noted that current engagement rates in digital disease management programs are low and more work needs to be done to improve and sustain higher engagement rates.

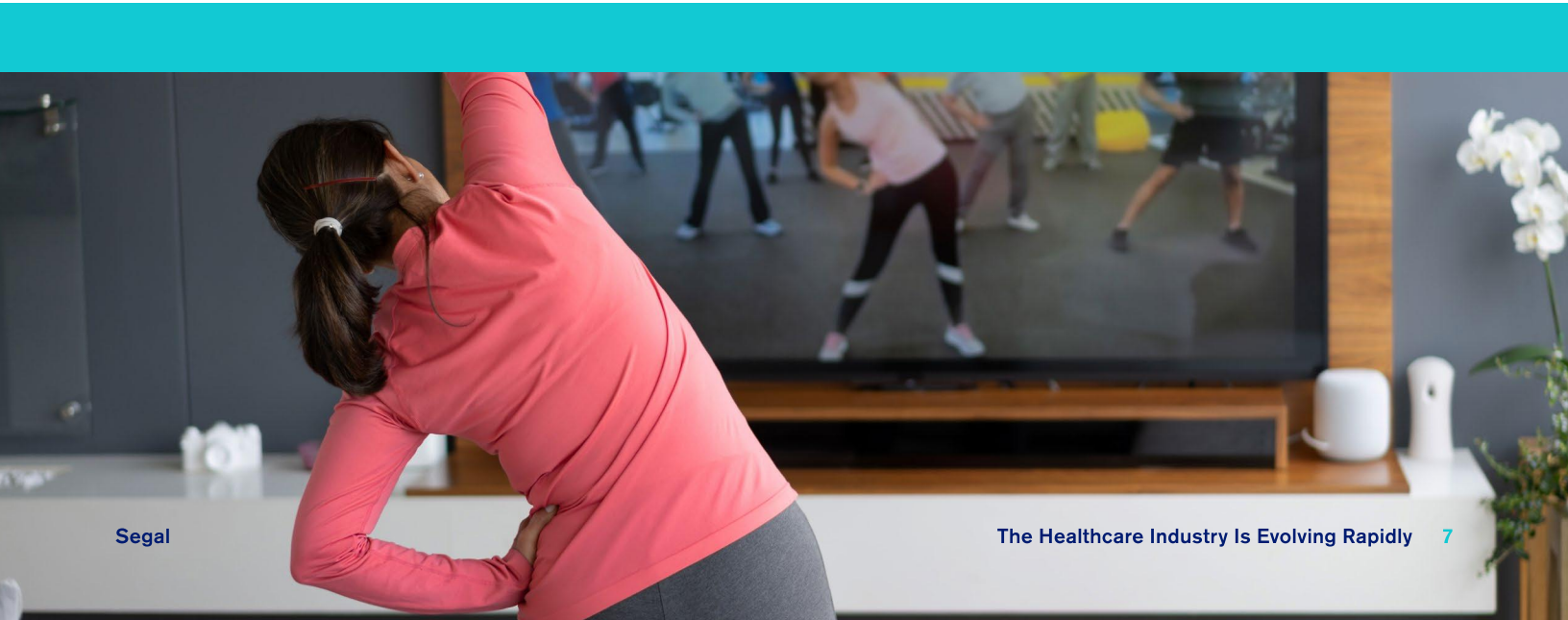
A word about healthcare consumerism

The typical economic principles of supply and demand have proven to be elusive in the healthcare industry. Transparency of fees are unlikely to change things in the near term. Because the healthcare system is intimidating and complicated for most patients, rational demand for treatments don't respond to traditional incentives.

Technology and innovation will likely reshape prescription drug development

The pharmaceutical industry will continue to develop treatments for rare and extremely rare diseases and conditions. Curative in nature (rather than palliative), the treatments are being developed to prevent long-term medical costs, excessive care delivery and high mortality.

Continued consolidation in the industry is expected and can potentially create issues with competition. For diseases that have many available medications produced by multiple drug manufacturers, there will be intense competition for market share on PBM formularies. This will help slow ever-rising drug prices through price discounts and rebates. As newer, more effective medications are developed, more expensive treatments may become obsolete.



Population health

Addressing the long-term effects of the pandemic on population health and behavior will be a high priority for policymakers in the coming years. In addition, policymakers, providers and plan sponsors will take a renewed interest in social determinants of health and make better use of big data and new technologies to guide predictive modeling and program design.

The pandemic is expected to have long-term effects on physical and mental health

The social, emotional and financial turbulence of 2020 will have a lasting impact on physical health, mental well-being and substance use disorders (SUD) for years to come. Since the beginning of the pandemic, demand for anti-anxiety/antidepressants and sleep-disorder prescriptions have increased and SUD have grown. Researchers are only beginning to understand the long-term effects of COVID-19. For many patients, severe fatigue, cognitive issues and heart problems are lingering long after they were expected to recover. Access to virtual solutions integrating behavioral and physical health issues will become the norm as ongoing support is needed to address the long-term effects of the virus.

The impact of the pandemic on the supply of healthcare providers remains uncertain. Will we see a decline in the supply of nurses, doctors, therapists and other healthcare professionals or will the pandemic increase the flow of students who want to join the healthcare services industry? The answer to this question could have a tremendous impact on future access issues.

Social determinants of health are expected to receive more attention

Emerging research identifies a direct correlation between social determinants of health — where people live, work, learn and play — and the high utilization of potentially avoidable acute care services. More health plans will offer social-determinant index scoring and predictive modeling using data to project future costs. Insights to addressing the root cause of preventable maladies have the potential to reverse the increase in the prevalence rates of disease among future generations.

Partnerships with vendors and government programs will grow to address issues like transportation and food insecurities within a region and within workforce populations. As the next generations enter the workforce, they will continue to evaluate potential employers based on societal contributions and overall individual well-being.



Data is likely to drive program design

Expanded use of data analytics to identify populations for targeted prevention, screening and treatment will help organizations better target programs to address workers' immediate and long-term concerns. Wellness planning that encompasses physical, emotional, financial and social well-being will become the standard.

New technology, including wearables and AI-powered tools, will track and monitor individual health and connect users with appropriate support programs and counseling. Broader use of these tools and other new technologies will demand increased scrutiny of usage guidelines and safeguards to ensure privacy and security.



Preparing for the future of healthcare

The pandemic is providing the healthcare industry and its many stakeholders with an opportunity to reshape the health system. As plan sponsors prepare for the future, the focus will be on leveraging digital health technologies to:

- Improve access to care
- Increase cost transparency
- Partnering with providers to ensure cost-effective, high-quality care that's affordable
- Enhance patient care, health equity and well-being to drive advances in population health

The growth in enrollment in both Medicare and Medicaid in the last decade (partly driven by the ACA and partly driven by the pandemic's impact on employment) will play a growing role in all facets of the healthcare system. Publicly funded health plan enrollment levels are approaching private employer-based plan enrollment. This trend will put even more pressure on private health plan sponsors. Healthcare providers will look to private healthcare payers to replace revenue lost on less generous public health systems. The challenges to make healthcare more efficient and cost-effective for private health plan sponsors remain complex and varied.

Health plan sponsors will need to continue to take an active role to understand these industry trends and to closely manage their health benefits programs. Whether it's improving contracts, revising plan designs or modernizing their prevention and utilization-management programs, plan sponsors have work to do to get the most out of the benefit dollars they spend.

Questions? Contact us.

To discuss the implications of the trends discussed here for your health plan, contact the authors:



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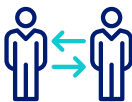
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American Rescue Plan Act: Health Coverage Provisions Explained

by Edwin Park and Sabrina Corlette

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARP) Act of 2021 (H.R. 1319). The wide-ranging, critically needed COVID-19 relief legislation includes a number of key provisions that strengthen both public and private health insurance coverage. Some of the new provisions build on actions Congress previously took in earlier COVID relief packages including the Families First Coronavirus Response Act (116-127).¹

Among its Medicaid and the Children's Health Insurance Program (CHIP) provisions, the American Rescue Plan encourages states to finally take up the Medicaid expansion by offering even more favorable financial incentives than those already in place and allows states to provide longer postpartum health coverage for new mothers. Among its private insurance provisions, the American Rescue Plan provides full premium subsidies for COBRA coverage, substantially increases subsidies for the purchase of health plans offered through the Affordable Care Act's marketplaces, and targets additional marketplace subsidies to those receiving unemployment benefits.

This issue brief explains the American Rescue Plan's Medicaid, CHIP and private insurance provisions.



Medicaid and CHIP Provisions in the American Rescue Plan

The American Rescue Plan includes a number of provisions expanding and strengthening the Medicaid and CHIP programs. Some of these provisions are dependent on state action to fulfill their promise. These include financial incentives to spur more states to adopt the Medicaid expansion; a new state option to provide extended postpartum coverage to help address the maternal mortality crisis; extend through Medicaid coverage of COVID-19 vaccines and treatments for uninsured people; and provide enhanced federal financial support for home- and community-based services for those with long-term service and support needs. The new law will also require state Medicaid and CHIP programs to cover vaccines and treatments, with vaccines and their administration fully funded by the federal government, and help state Medicaid programs better address rising drug costs.

New or Enhanced Medicaid and CHIP Opportunities for States

- **Additional Federal Funding to States that Newly Adopt the Medicaid Expansion**

There are currently 12 states that have still not adopted the Affordable Care Act's Medicaid expansion: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming. According to the Kaiser Family Foundation (KFF), if all of these states expanded Medicaid, more than 4.3 million uninsured adults would become newly eligible.²

States already have an extremely generous, permanent federal matching rate of 90 percent for the expansion population on the table, and the American Rescue Plan provides a significant, additional fiscal incentive for the remaining states to newly cover these adults. States that newly expand Medicaid receive an additional five percentage point increase in their regular federal Medicaid matching rate (FMAP) for two years, no matter when they newly expand.³ This increase is in addition to the temporary 6.2 percentage point FMAP increase enacted as part of the Families First COVID-19 relief legislation (P.L. 116-127) that is available through the duration of the COVID-19 public

health emergency.⁴ The matching rate for the expansion remains unchanged: the federal government continues to pay for 90 percent of Medicaid expansion costs; both the American Rescue Plan and Families First matching rate increases apply to the rest of the Medicaid program covering children, some parents, people with disabilities and seniors.

The 5-percentage point increase does not apply to other Medicaid spending that is not subject to the regular FMAP such as administrative costs as well as to Disproportionate Share Hospital (DSH) spending. It also does not affect the federal matching rate under CHIP or matching rates under Title IV programs. The 5-percentage point increase is not taken into account when applying federal funding caps for the territories.

KFF has issued estimates of how much current non-expansion states would receive in additional federal Medicaid funding under this provision if they newly adopt the expansion starting in federal fiscal year 2022, how much states would spend for their share of the cost of the expansion in the first two years, and the resulting net impact on state spending. These estimates find that the FMAP increase in the ARP is expected to more than offset expansion costs in all of the non-expansion states in the two-year period. In sum, if all 12 non-expansion states expand in 2022, states would receive a net overall gain of \$9.6 billion.⁵

- **New Medicaid and CHIP Option for States to Extend Postpartum Coverage for 12 Months**

The American Rescue Plan offers states a new “state plan” option to provide pregnancy-related Medicaid and CHIP coverage for one year after the end of pregnancy, extending coverage well beyond the current cutoff of 60 days. Previously, states could only receive federal matching funds to extend postpartum coverage beyond 60 days through a Section 1115 waiver, and though six states have applied to the Centers for Medicare and Medicaid Services (CMS), none have yet received approval.



States that opt to extend postpartum coverage through the new state plan option must do so for both Medicaid and CHIP (if they cover pregnant women through CHIP as six states do) and must provide full Medicaid benefits. States can take up this option starting in the first calendar year quarter one year after enactment, which is April 1, 2022. The option, however, is temporary and will be available to states for five years unless Congress acts to extend it at a later time. (The original House-passed version of the American Rescue Plan would have made this option available for seven years.)

This new option is an important step in responding to the alarming maternal mortality crisis in the U.S., which disproportionately affects women of color. When Medicaid and CHIP coverage ends at 60 days postpartum, many women are at risk of becoming uninsured and missing out on critical access to care that can prevent pregnancy-related deaths.⁶ The Congressional Budget Office (CBO), for example, estimates that about 45 percent of women covered by Medicaid on the basis of pregnancy now become uninsured after the end of the 60-day postpartum coverage period.⁷ Many states appear interested in the option but it will be critical that the states with high rates of maternal mortality adopt the option as soon as it takes effect.

- **Expansion of the State Medicaid Option for Coverage of COVID-19 Testing for the Uninsured to Include Coverage for COVID-19 Vaccines and Treatment**

The Families First legislation included a Medicaid option for states to cover COVID-19 testing for the uninsured through the duration of the public health emergency.⁸ The federal government picks up 100 percent of the cost. The American Rescue Plan expands this fully federally-funded option to cover COVID-19 vaccines and their administration, and treatment, including prescription drugs, and treatment for conditions that complicate COVID-19 treatment.

- **Additional Federal Medicaid Support for Home- and Community-Based services (HCBS)**

The American Rescue Plan provides states the option of receiving a 10 percentage point increase in their

Medicaid matching rate for home- and community-based services furnished to Medicaid beneficiaries with long-term service and support (LTSS) needs. (An earlier version of the provision included in the original House-passed bill would have provided a 7.35 percentage point increase.) This increase would be on top of the 6.2 percentage point Families First FMAP increase available for the duration of the public health emergency but the resulting matching rate cannot exceed 95 percent. This option for an increased matching rate for HCBS services is available for one year starting April 1, 2021. In addition, the federal funding caps for the territories would not apply to this HCBS matching rate increase.

HCBS services eligible for the matching rate increase include home health, personal care, HCBS services provided through several types of Medicaid waivers, case management, rehabilitative care, services provided through PACE programs (Programs of All-Inclusive Care for the Elderly), and other services specified by the Secretary of Health and Human Services. As a condition of the increase, states are required to use this additional federal funding to implement, or supplement the implementation of, activities that enhance, expand or strengthen home- and community-based services. States are also required to use the increased federal funding to supplement, not supplant their level of HCBS spending as of April 1, 2021.

- **Increased Federal Support for Certain Indian Health and Native Hawaiian Health Providers.**

The American Rescue Plan Act temporarily applies for two years the 100 percent FMAP available to Indian Health Service (IHS) providers for furnishing care to Medicaid beneficiaries to services furnished by Urban Indian Health Programs. Such providers are grantees of the IHS and serve IHS-eligible patients on Medicaid, but they are not formally part of the IHS and as a result, payments to these providers do not otherwise receive the 100 percent FMAP that other IHS providers do. The provision would also provide for two years a 100 percent FMAP for services furnished by Native Hawaiian Health centers. The funding becomes available at the start of the first fiscal year quarter after date of enactment, which is April 1, 2021.



- **Other Federal Opportunities for States**

The law also gives states the option to provide community-based mobile crisis intervention services to individuals experiencing mental health or substance use disorder crises for five years (with an 85 percent FMAP for the first three years). It also appropriates \$250 million to states so they can establish and implement “strike” teams to help respond to COVID-19 in nursing homes. Finally, the American Rescue Plan clarifies that during the public health emergency when the Families First FMAP increase is in effect, states’ DSH allotments will be recalculated to ensure that total DSH payments remain at the same levels that would have been paid in the absence of the FMAP increase.

New Medicaid and CHIP Requirements

- **Required Medicaid and CHIP Coverage of COVID-19 Vaccines and Treatment without Cost-Sharing with Full Federal Funding for Vaccines**

The Families First COVID-19 legislation required Medicaid and CHIP coverage of COVID-19 testing without cost-sharing. The American Rescue Plan builds on that earlier provision to explicitly require Medicaid and CHIP coverage of COVID-19 vaccines, treatment (including prescription drugs), and treatment of conditions that complicate COVID-19 treatment, without the imposition of cost-sharing charges.⁹ (The Families First legislation indirectly required states to cover COVID-19 testing and treatment without cost-sharing in Medicaid as part of its maintenance-of-effort requirement, but that provision did not apply to separate state CHIP programs.)

These requirements apply through the end of the first calendar year quarter that starts one year after the end of the COVID-19 public health emergency. (In contrast, the original Families First requirement related to Medicaid coverage of testing and treatment without cost-sharing extended only through the end of the fiscal year quarter in which the public health emergency ends.) In addition, the federal matching rate for COVID-19 vaccines and their administration is also increased to 100 percent. The 100 percent matching rate increase would be exempted from the territorial funding caps and in the case of CHIP, states’ CHIP allotments would be adjusted to reflect this 100 percent matching rate. Finally, the package clarifies that any drugs used for COVID-19 treatment are subject to the

Medicaid Drug Rebate Program, which would lower their cost for state Medicaid programs.

- **Increased Medicaid Drug Rebates for Manufacturers that Have Imposed Excessive Price Increases**

The American Rescue Plan eliminates a cap on total drug rebates that manufacturers must pay state Medicaid programs under the highly effective Medicaid Drug Rebate Program (MDRP) starting January 1, 2024.¹⁰ (An earlier version of the provision originally passed by the House would have been effective one year earlier on January 1, 2023.)

One key element of the MDRP is its inflation-related rebate, under which manufacturers must pay additional rebates for both brand-name and generic drugs if their prices rise faster than general inflation. The intent of the inflation-related rebate is to discourage manufacturers from raising their prices excessively. However, under current law, total Medicaid drug rebates on both brand-name and generic drugs cannot exceed 100 percent of the Average Manufacturer Price. The cap effectively allows some drug manufacturers that have imposed very large price increases over time to not pay rebates equal to the full difference between their price increases and inflation, as the inflation-related rebate generally requires. CBO estimates that in 2019, this rebate cap allowed drug manufacturers to avoid paying more than \$3 billion in rebates that they would otherwise have been required to pay to the federal government and the states.¹¹

Because the cap has effectively weakened the ability of the Medicaid Drug Rebate Program to discourage manufacturers from instituting excessive annual price increases, elimination of the cap has been recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC).¹² It has also enjoyed significant bipartisan support.¹³

The provision will likely produce about \$20 billion in total federal and state prescription drug savings over the next 10 years, of which about \$6.5 billion in savings would accrue to the states.¹⁴ (No updated CBO estimates for this provision, however, are yet available.) These savings will provide significant help to state Medicaid programs in addressing their rising drug costs over time.



Private Health Insurance Provisions in the American Rescue Plan

The American Rescue Plan includes several policy changes to improve the affordability of private health insurance coverage and coverage access including:

- Subsidies to defray the cost of COBRA premiums for those who have lost employer-sponsored insurance
- Enhanced premium tax credits for individuals who enroll through the health insurance marketplaces
- Tax relief for individuals who received excess marketplace premium tax credits in 2020
- Free marketplace health insurance for individuals who receive unemployment insurance benefits in 2021
- \$20 million in grants to states to modernize and update health insurance marketplace systems, programs, or technology

These changes are designed to expand the availability of affordable coverage options to individuals who have lost job-based coverage, are currently uninsured, or who are struggling to maintain their premium payments for marketplace coverage due to the pandemic. The COBRA subsidies will be available through September 2021, while the enhanced marketplace premium tax credits will be available in 2021 and 2022.

Subsidies for COBRA Premiums

Individuals who lose their job-based insurance because of a layoff or other qualifying event are able to continue their coverage under a federal law called the Consolidated Omnibus Budget Reconciliation Act or COBRA. Generally, such individuals have up to 60 days after their qualifying event to enroll, and are required to pay both their share and the employer's share of their plan premium, plus an administrative fee of up to 2 percent. Individuals may maintain their COBRA coverage for up to 18 months, so long as they continue paying the full premium. For most individuals, but particularly for anyone who has lost their job, these premium costs can be prohibitive. KFF estimates that the average annual premium for self-only employer-based coverage in 2020 was \$7,470; for a family plan, premiums averaged \$21,342.¹⁵

Under the American Rescue Plan, the government would subsidize 100 percent of COBRA premiums through

September 30, 2021 for COBRA enrollees. Further, the law would allow individuals who missed the 60-day enrollment window for COBRA prior to the availability of subsidies to go back and enroll. For example, if someone was laid off from their job in August of 2020 but found the premiums too high to enroll at the time, he or she could come back and enroll for up to 60 days after being notified of the availability of the subsidies under the American Rescue Plan. Such individuals would not have to pay premiums back to the date they were originally eligible to enroll in COBRA, but coverage for any medical claims would only apply from their date of enrollment.

The ability to maintain employer group coverage offers several benefits. First, individuals can continue with their same doctors and avoid any disruption in treatment. Second, individuals who switch plans mid-year generally face a new deductible and out-of-pocket limit, but enrolling in COBRA allows any amounts the enrollee already paid towards the deductible or out-of-pocket limit under the group plan to be carried forward. Third, employer-based plans often come with broader provider networks and lower cost-sharing than marketplace plans, although marketplace enrollees with household income between 100 and 250 percent of the federal poverty level (FPL) (between \$26,200-\$65,500 for a family of four) may qualify for a lower cost-sharing plan.

However, for some individuals, enrolling in COBRA, even when subsidized at 100 percent, may not be the best option. As explained in more detail below, individuals who receive unemployment insurance benefits in 2021 may qualify for a free marketplace plan with extremely low cost-sharing. The American Rescue Plan's subsidies for COBRA premiums will expire on September 30th, and many enrollees will likely not be able to afford COBRA premiums past that date. Under current rules, individuals who lose COBRA coverage due to failure to pay premiums do not qualify for a special enrollment period (SEP) in the marketplace. The Biden Administration and state-based marketplaces could establish such a SEP via administrative action, to reduce potential coverage losses, but they have not yet done so.



Enhanced Marketplace Premium Tax Credits

The Affordable Care Act provides advance premium tax credits (PTCs) to qualified individuals and families that enroll in coverage through the health insurance marketplaces. These PTCs are available to people with modified adjusted gross income between 100 and 400 percent of the FPL (between \$26,200 and \$104,800 for a family of four), who are lawfully present in the U.S. and do not qualify for other affordable minimum coverage such as Medicaid, Medicare, or an employer plan. The ACA provides the tax credits such that an individual or family's premium contribution is capped based on a percentage of their income. That specified percentage varies, with lower-income families required to pay the lowest percent of income towards premiums. Specifically, absent enactment of the American Rescue Plan, families with incomes between 100-150 percent of FPL would be required to pay between 2.07 and 4.14 percent of their household income towards their plan premium. Families with household income between 300 and 400 percent FPL would pay 9.83 percent of their income towards their plan premium. Families with household income over 400 percent of the federal poverty level receive no PTCs and must bear the full cost of the plan premium. In 2021, the average, unsubsidized premium for the lowest-cost Silver-level plan on the marketplace is \$5,232.¹⁶

The American Rescue Plan increases the PTCs available for marketplace enrollees by reducing the percentage of income that individuals and families are expected to contribute towards premiums, for plan years 2021 and 2022. Under the new premium schedule, families with incomes between 100 and 150 percent FPL would have their premium contribution reduced to \$0, though they would still face cost-sharing. Families with incomes over 400 FPL would have their premium contribution capped at 8.5 percent FPL. See Table 1.

With the enhanced PTCs, people enrolled in the ACA marketplaces in 2021 and 2022 could experience significant reductions in premiums. For example, a 64-year-old earning an income of \$19,300 (150 percent FPL) would have their net premium reduced from \$800 to \$0; a 64-year-old earning \$58,000 (450 percent FPL) would have their premiums reduced from \$12,900 per year to \$4,950. CBO estimates that this provision will reduce the number of uninsured by 1.3 million people.¹⁷ In addition, KFF estimates that approximately 8 million people either currently buy unsubsidized individual market plans or must pay full-price for ACA coverage, including 3.4 million people with incomes too high to qualify for subsidies.¹⁸ These individuals will have a substantial reduction in their premium obligations under the American Rescue Plan. Additionally, individuals with incomes under 150 percent FPL who enroll in a Silver-level plan can qualify for cost-sharing reductions that increase their plan's actuarial value to 94 percent, at a \$0 premium. Many more people at higher income levels will be able to find Bronze-level plans with a \$0 premium.¹⁹

The federally facilitated marketplace (FFM) and state-based marketplaces face a considerable operational challenge to update their eligibility and enrollment systems to account for the enhanced subsidies. It may be some time—weeks or perhaps even months—between when the American Rescue Plan is signed into law and when an individual or family will be able to access the enhanced PTCs. Marketplace officials will need to provide clear and actionable information to consumers about when and how they can obtain the premium relief provided under the new law.

Table 1. Maximum Income Contribution Percentage by Household Income for Premium Tax Credits in 2021

Income Range (Percent of Federal Poverty Level)	Range of Maximum Income Distribution (Percent of Income)	
	Under Current Law *	Under Section 9661
100-133%	2.07	0
133-150%	3.10 – 4.14	0
150-200%	4.14 – 6.52	0 – 2.0
200-250%	6.52 – 8.33	2.0 – 4.0
250-300%	8.33 – 9.83	4.0 – 6.0
300-400%	9.83	6.0 – 8.5
400+%	–	8.5

Source: Congressional Budget Office.

* See irs.gov/pub/irs-drop/rp-20-36.pdf.



Premium Tax Credits: Reconciliation Relief for 2020

Under the ACA, when an individual seeks to enroll in marketplace coverage with a premium tax credit, the marketplace estimates the amount of PTC to allocate based on a projection of the individual's annual income and household size for the coming year. The PTCs are then advanced to the enrollee on a monthly basis. If an individual's actual income for the year is greater than what they projected, they could owe some or all of the excess PTCs back to the federal government in their annual tax filing, in a process called "reconciliation."

The American Rescue Plan removes the requirement that individuals pay back excess PTCs for tax year 2020. The law's authors recognized that, due to the pandemic, many individuals had disruptions in employment and income sources that made it difficult to predict their income for the year. They also recognized that for many families, economic challenges make it unusually difficult for them to face an unexpected tax bill. Indeed, CBO has estimated that this provision alone will save families \$6.3 billion. For individuals who filed their 2020 tax returns and paid excess 2020 PTCs prior to passage of the American Rescue Plan, the IRS will need to determine how best to refund those payments.

Extra Subsidies for the Unemployed

The American Rescue Plan would increase the amount of PTCs available for individuals receiving unemployment insurance benefits in 2021. Such individuals would qualify for PTCs as if they have incomes of no more than 133 percent of FPL (or \$34,846 for a family for four). In practice, this means that if they enroll in a plan equal to or less expensive than a benchmark Silver-level plan, they would qualify for PTCs that cover 100 percent of their premium payment. Furthermore, if they enroll in Silver-level coverage, these individuals would also qualify for cost-sharing reductions as if they have incomes at 133 percent FPL, meaning they could enroll in a plan with a 94 percent actuarial value.

This provision also provides help for some individuals under 100 percent FPL who live in states that have not yet expanded Medicaid. Although currently these individuals do not qualify for PTCs via the marketplaces, under the American Rescue Plan, any such individual who receives unemployment benefits in 2021 may qualify for PTCs to cover the full cost of their premium in 2021, so long as they enroll in a marketplace plan equal to or less expensive than a benchmark Silver-level plan.

Health Insurance Marketplace Modernization

The enhanced premium tax credits provided under the American Rescue Plan could help millions of individuals and families obtain affordable insurance or switch to a more generous, lower-cost plan. However, these changes will require the health insurance marketplaces to implement a number of updates to their eligibility and enrollment systems as well as to provide consistent and clear communications with current and potential enrollees. These are all changes that states that run their own marketplaces did not plan or budget for.

The American Rescue Plan would provide \$20 million in grants to the 20 state-based marketplaces to "modernize or update" any "system, program, or technology" to ensure it is compliant with "all applicable requirements." These grant funds could be used by states that operate their own eligibility and enrollment platforms to update those platforms to provide the enhanced PTCs and transmit the necessary data to the enrollee's health plan. The funds could potentially also be used to expand and improve outreach and assistance for consumers about the coverage opportunities that the American Rescue Plan has made available.



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Health Provisions in American Rescue Plan Act Improve Access to Health Coverage During COVID Crisis

MARCH 11, 2021 | BY TARA STRAW, SARAH LUECK, HANNAH KATCH, JUDITH SOLOMON, MATT BROADDUS AND GIDEON LUKENS

The American Rescue Plan Act includes several vital provisions that would make comprehensive coverage more affordable and accessible for millions of people. The COVID-19 relief law enhances for two years premium tax credits available through the health insurance marketplaces, boosts financial incentives for additional states to rapidly expand Medicaid, and takes other steps to improve access to health coverage during the health and economic crisis.

Consistent with a proposal President Biden outlined in January, the Act eliminates premiums for many low-income people who are already eligible for plans in the Affordable Care Act (ACA) marketplaces and vastly reduces premiums for others. It extends new help with premiums to people with somewhat higher incomes who face high premium burdens. And it protects marketplace enrollees who experienced income fluctuations last year from large repayments of their premium tax credits to the federal government. Additional provisions will bring down insurance costs for specific populations, such as those who receive unemployment benefits and those who lose their jobs but want to temporarily maintain their job-based health insurance.

The law also offers a strong incentive for the 14 states that have not yet implemented the ACA's Medicaid expansion to quickly do so by providing increased federal funds to states that newly expand. If the remaining states expanded Medicaid, nearly 4 million uninsured low-income adults, including about 640,000 essential or front-line workers, could gain coverage. Those who could gain coverage also include over 2 million people now in the so-called coverage gap — that is, people whose incomes are below the poverty line, and thus ineligible for premium tax credits for marketplace coverage, but who are ineligible for Medicaid under their state's rules.

Improving premium tax credits and further expanding Medicaid, in particular, will provide much-needed assistance to people who need help obtaining or affording health coverage. Comprehensive health coverage is important under any circumstances because it improves people's access to care, financial security, and health outcomes when they get sick. But preserving and extending coverage is even more important in the COVID crisis because it shields families from financial hardship and supports public health efforts, easing people's access to testing, treatment, and vaccines.

"Improving premium tax credits and further expanding Medicaid, in particular, will provide much-needed assistance to people who need help obtaining or affording health coverage."

Premium Tax Credit Improvements Provide Significant Financial Help

The American Rescue Plan Act boosts premium tax credits for 2021 and 2022, eliminating or reducing premiums for millions of current marketplace enrollees to ensure that no marketplace enrollee spends more than 8.5 percent of their income on premiums, irrespective of their income. This reduces the previous 9.83 percent limit for people with income of 300 to 400 percent of the poverty line and newly establishes a premium cap for marketplace enrollees with higher incomes. Under the law, people with income below 150 percent of the poverty line (about \$19,000 for a single person and \$39,000 for a family of four) will pay no premiums for a benchmark plan, after accounting for premium tax credits, and other families will pay a capped share of income toward health coverage.

These improvements to premium tax credits help a broad group: almost everyone enrolled in marketplace coverage, except for higher-income people whose premiums are already less than 8.5 percent of their incomes. (See Appendix tables 1 and 2.) The Urban Institute estimated that similar improvements would lead about 4.5 million people to gain coverage.^[1]



Increasing Subsidies for Low- and Moderate-Income People Is Key to Increasing Coverage

People with incomes up to 400 percent of the poverty line (about \$51,000 for a single person and \$105,000 for a family of four) are already eligible for premium tax credits that help them afford marketplace coverage. But data suggest that low- and moderate-income people still face the greatest challenges affording coverage and care.^[2]

The premium tax credit has made insurance more affordable for many people, yet the uninsured rate for lower-income people eligible for the most generous subsidies remains high: 14.1 percent of people with incomes between 138 and 250 percent of the poverty line are uninsured, compared to 3.1 percent for people with incomes above 500 percent of the poverty line. Uninsured people at all income levels cite cost as the greatest barrier to coverage, so making financial assistance more adequate is key to appreciably reducing uninsured rates and improving access to care.^[3] For example in Massachusetts — which has the lowest uninsured rate in the country for people with incomes between 138 and 250 percent of the poverty line — sizable state subsidies on top of those the ACA offers greatly reduce premiums for people with income below 300 percent of the poverty line. People with income between 138 and 150 percent of the poverty line are guaranteed a plan with zero net premium (after accounting for premium tax credits), compared to monthly premiums of \$50 and \$66 for a benchmark plan in other states.

The American Rescue Plan Act significantly reduces premiums for people who are currently eligible for help by increasing their premium tax credits. For example:

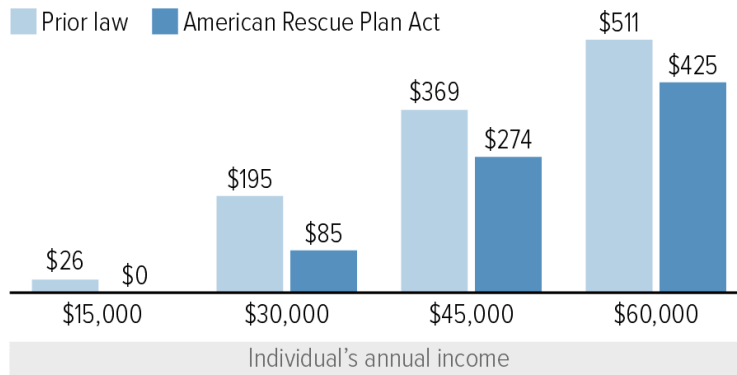
- A single individual making \$18,000 will pay zero net premium rather than \$54 per month (3.6 percent of income) and will qualify for the most generous subsidies for deductibles and other cost-sharing amounts.
- A single individual making \$30,000 will pay \$85 rather than \$195 per month in premiums (3.4 instead of 7.8 percent of income) and qualify for a plan with reduced deductibles and other cost-sharing amounts. (See Figure 1.) Or, with the bigger subsidy, the same person could opt to buy a gold plan with lower cost-sharing charges for \$115 per month.
- A family of four making \$50,000 will pay \$67 rather than \$252 per month in premiums for benchmark coverage (1.6 instead of 6.0 percent of their income) and qualify for generous cost-sharing reductions.^[4]
- A family of four making \$75,000 will pay \$340 rather than \$588 per month in premiums for benchmark coverage (5.4 instead of 9.4 percent of their income). A typical family could purchase a gold plan with lower deductibles and other cost sharing for about \$440 per month (roughly 7 percent of income).^[5]



FIGURE 1

The American Rescue Plan Act Will Make Marketplace Coverage More Affordable

Monthly premium for benchmark marketplace coverage for a 45-year-old, based on national average premium



Note: These premiums are applicable in all states except for those with different poverty level standards than the national standard (Alaska and Hawai'i) and those states that subsidize marketplace premiums beyond the federal subsidy (California, Massachusetts, New York, and Vermont).

Source: CBPP calculations based on American Rescue Plan Act

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Extending Premium Tax Credits Helps Older People and Those Living in High-Cost Areas

About 2.6 million people with income over 400 percent of the poverty line are uninsured.^[6] Extending premium tax credits to people in this group who can't afford the full cost of coverage will help many of them and ensure that middle-income people who purchase individual market coverage pay premiums no higher than 8.5 percent of their income.

Creating an income cap of 8.5 percent on premiums will be especially important to middle-income people, older people, and people who live in areas with high premiums.^[7] The cap targets the most assistance to people with high premium burdens. For example, marketplace benchmark coverage for a 40-year-old in Charleston, West Virginia earning \$55,000 a year (431 percent of the poverty line) costs about \$731 per month, more than 1.5 times the national average. Under the Act, this person will get a monthly premium discount of \$341, bringing their premium down to \$390 per month.^[8] In lower-cost states, a person of the same age with the same income won't receive a premium tax credit because their premium is already below 8.5 percent of their income. And the premium tax credit enhancement will automatically phase out at higher income levels because premiums are generally less than 8.5 percent of income for high-income people.

Providing premium tax credits to limit premium liability to no more than 8.5 percent of income helps other people who might otherwise have trouble affording coverage. For example:

- A typical 60-year-old making \$60,000 will see their premiums cut by more than half, or \$535 per month. Instead of paying \$960 per month in premiums for benchmark coverage, or 19 percent of income, the consumer will pay \$425, or 8.5 percent of income.
- A typical family of four with income of \$110,000 will see their premiums cut almost in half, by \$666 per month. Instead of paying \$1,445 per month in premiums for benchmark coverage, or nearly 16 percent of their income, the family will pay \$779, or 8.5 percent of their income, with the premium tax credit making up the difference.

Related Marketplace Policies Will Help Families Recover From COVID's Coverage Impacts

Several other policies in the American Rescue Plan Act will provide meaningful help to people struggling to afford health coverage as they face economic hardship and uncertainty.

Under the ACA, people receive premium tax credits in advance to pay for coverage based on their projected annual income. But if they have a change in circumstance during the year, their year-end income might be higher than they predicted and they must repay some or all of the excess premium tax credit they received. In 2020, many low- and moderate-income people had fluctuating incomes that made projecting income especially difficult and meant that some people had higher incomes than they had projected. For example, some people lost their jobs early in the year but later got new ones with higher earnings than they had expected, while others worked additional hours or received bonus pay as essential workers. The Act exempts low- and moderate-income families from having to repay the excess premium tax credit they received in 2020. This protects people from having very high repayments this spring, during a time of continued economic uncertainty.

In addition, the Act offers subsidies to people who have recently lost their jobs. It enhances premium tax credits for people who receive unemployment benefits in 2021 by setting their marketplace eligibility at a projected income that guarantees they get the most generous premium tax credit and cost-sharing help if they enroll in an ACA marketplace plan, irrespective of their actual year-end income. This will help many people who are financially vulnerable and work in non-telework occupations that are more susceptible to loss of earnings during the pandemic, particularly single earners, people of color, and people with minimal savings to cushion the income loss.^[9]

The Act also provides federal funding to cover the entire cost of people's premiums for "COBRA" coverage from April through September 30, 2021. COBRA coverage^[10] lets people who have job-based health insurance retain it for up to 18 months after they lose their job. Usually, people have to pay the full cost of the premium on their own, making this option unaffordable for many, but this provision helps people stay enrolled in their employer-sponsored health plan.

Medicaid Expansion Is Essential in the Pandemic

The American Rescue Plan Act includes a two-year increase in federal Medicaid funding, beginning when a state implements the expansion, as an added incentive for states to newly expand Medicaid. The financial incentive to expand Medicaid is already substantial; the federal government covers 90 percent of the cost of coverage for the expansion group. This provision provides an added incentive to expand coverage at a time when expanding access to health care is particularly important. If the 14 remaining states expand, at least 4 million additional uninsured adults would become eligible for Medicaid coverage, likely more due to the recession. Of these, nearly 60 percent are people of color.^[11]

In states considering the Medicaid expansion, officials sometimes cite state costs as a concern.^[12] While research shows that Medicaid expansion generates enough savings and increased revenue to offset the state's share of the cost,^[13] the new law's robust fiscal incentive goes far to address any remaining cost-related concerns because it would increase a state's overall Medicaid funding by more than the cost of covering the expansion group over the first two years.

The Act increases how much the federal government pays toward a state's Medicaid expenditures (known as the "federal medical assistance percentage" or FMAP) for all groups other than those eligible through expansion by 5 percentage points for two years after a state expands. States would still receive the 90 percent enhanced FMAP for the expansion group. The increased federal funds stemming from the overall increase in the FMAP for the *rest* of the Medicaid program would exceed the full cost of the Medicaid expansion, providing states with additional funds they could use to stave off cuts in Medicaid and in other state services during the economic crisis accompanying the pandemic. Georgia, for example, would receive close to \$2 billion over the two-year period following expansion, more than the cost of providing coverage to the expansion group. (See Appendix Table 3.)

Many people who could gain coverage through the expansion are at elevated risk from COVID-19, because they face a high risk of becoming infected due to their occupation or living conditions or a high risk of serious illness if they become infected because of underlying health conditions. Expanding Medicaid in the remaining states would provide coverage to millions of older adults, people with disabilities, and others with underlying health conditions that increase their risk of complications from the disease.

Expanding Medicaid in the remaining states would result in an estimated 640,000 currently uninsured essential or front-line workers gaining coverage. This includes people who have jobs that likely require them to work in person, such as hospital workers, home health aides, and grocery store workers.^[14] Prior to the COVID-19 crisis, the uninsured rate for low-income workers in these jobs was 30 percent in non-expansion states, nearly double the rate in expansion states.



Strong evidence suggests that, in addition to providing uninsured people with access to needed care, health insurance coverage reduces *economic* hardship, which has been widespread in the pandemic.^[15] Expanding access to Medicaid coverage leads to lower out-of-pocket medical expenditures and medical debt while reducing the likelihood of experiencing catastrophic medical expenditures, not paying other household bills, or borrowing money to pay for medical care, research shows.^[16] Other research found an association between Medicaid expansion and declines in food insecurity.^[17]

Appendix

APPENDIX TABLE 1

American Rescue Plan Act Lowers Marketplace Premiums for Individuals, Couples, and Families at Various Income Levels

	Prior law	Monthly marketplace premiums Under American Rescue Plan Act	Difference
45-year-old individual			
\$18,000 (141% FPL)*	\$54	\$0	-\$54
\$30,000 (235% FPL)	\$195	\$85	-\$110
\$45,000 (352% FPL)	\$369	\$274	-\$95
\$60,000 (470% FPL)**	\$511	\$425	-\$86
60-year-old couple			
\$30,000 (174% FPL)	\$132	\$24	-\$108
\$45,000 (261% FPL)	\$325	\$167	-\$158
\$60,000 (348% FPL)	\$492	\$360	-\$132
\$75,000 (435% FPL)**	\$1,920	\$531	-\$1,389
Family of four***			
\$45,000 (171% FPL)	\$193	\$32	-\$161
\$60,000 (229% FPL)	\$379	\$158	-\$221
\$90,000 (343% FPL)	\$737	\$531	-\$206
\$120,000 (458% FPL)**	\$1,445	\$850	-\$595

* FPL = federal poverty level.

** Prior-law examples for an individual, couple, and family with income over 400 percent of FPL are based on the national average benchmark premium adjusted for age where appropriate. These estimates are different for every state. See Appendix Table 2 for state-specific estimates.

*** The sample family includes two 40-year-old adults, a 10-year-old child, and a 5-year-old child.

Source: CBPP calculations. The monthly marketplace premiums for these scenarios are applicable in all states except those with different poverty level standards than the national standard (Alaska and Hawai'i) and those states that subsidize marketplace premiums beyond the federal subsidy (California, Massachusetts, New York, and Vermont).



American Rescue Plan Act Lowers Marketplace Premiums for Those Above 400 Percent of Poverty in All States

State	Monthly marketplace premiums								
	45-year-old individual; \$60,000 (470% FPL*)			60-year-old couple; \$75,000 (435% FPL*)			Family of four;** \$120,000 (458% FPL*)		
	Prior law	Under American Rescue Plan Act ***	Difference	Prior law	Under American Rescue Plan Act	Difference	Prior law	Under American Rescue Plan Act	Difference
U.S. average	\$511	\$425	-\$86	\$1,920	\$531	-\$1,389	\$1,445	\$850	-\$595
Alabama	667	425	-242	2,506	531	-1,975	1,766	850	-916
Alaska****	763	531	-232	2,867	664	-2,203	2,158	1,062	-1,096
Arizona	493	425	-68	1,852	531	-1,321	1,394	850	-544
Arkansas	445	425	-20	1,673	531	-1,142	1,260	850	-410
California	481	425	-56	1,809	531	-1,278	1,362	850	-512
Colorado	397	397	0	1,491	531	-960	1,122	850	-272
Connecticut	655	425	-230	2,463	531	-1,932	1,854	850	-1,004
Delaware	610	425	-185	2,294	531	-1,763	1,727	850	-877
DC	503	425	-78	1,787	531	-1,256	1,387	850	-537
Florida	516	425	-91	1,941	531	-1,410	1,461	850	-611
Georgia	515	425	-90	1,937	531	-1,406	1,458	850	-608
Hawai'i****	540	489	-51	2,030	611	-1,419	1,528	977	-551
Idaho	559	425	-134	2,102	531	-1,571	1,583	850	-733
Illinois	478	425	-53	1,797	531	-1,266	1,352	850	-502
Indiana	476	425	-51	1,788	531	-1,257	1,346	850	-496
Iowa	591	425	-166	2,221	531	-1,690	1,672	850	-822
Kansas	555	425	-130	2,085	531	-1,554	1,570	850	-720
Kentucky	538	425	-113	2,022	531	-1,491	1,522	850	-672
Louisiana	616	425	-191	2,315	531	-1,784	1,743	850	-893
Maine	497	425	-72	1,869	531	-1,338	1,407	850	-557
Maryland	392	392	0	1,474	531	-943	1,109	850	-259
Massachusetts	410	410	0	1,542	531	-1,011	1,161	850	-311
Michigan	392	392	0	1,474	531	-943	1,109	850	-259
Minnesota	347	347	0	1,304	531	-773	1,042	850	-192
Mississippi	519	425	-94	1,950	531	-1,419	1,374	850	-524
Missouri	541	425	-116	2,034	531	-1,503	1,531	850	-681
Montana	532	425	-107	2,001	531	-1,470	1,506	850	-656
Nebraska	790	425	-365	2,969	531	-2,438	2,235	850	-1,385
Nevada	444	425	-19	1,669	531	-1,138	1,257	850	-407
New Hampshire	403	403	0	1,516	531	-985	1,141	850	-291
New Jersey	458	425	-33	1,720	531	-1,189	1,295	850	-445
New Mexico	383	383	0	1,440	531	-909	1,084	850	-234
New York	597	425	-172	1,194	531	-663	1,701	850	-851
North Carolina	583	425	-158	2,192	531	-1,661	1,650	850	-800
North Dakota	557	425	-132	2,094	531	-1,563	1,576	850	-726
Ohio	424	424	0	1,593	531	-1,062	1,199	850	-349
Oklahoma	626	425	-201	2,353	531	-1,822	1,771	850	-921
Oregon	494	425	-69	1,856	531	-1,325	1,308	850	-458
Pennsylvania	514	425	-89	1,933	531	-1,402	1,455	850	-605
Rhode Island	394	394	0	1,482	531	-951	1,116	850	-266
South Carolina	538	425	-113	2,022	531	-1,491	1,522	850	-672
South Dakota	698	425	-273	2,625	531	-2,094	1,976	850	-1,126
Tennessee	527	425	-102	1,979	531	-1,448	1,490	850	-640
Texas	493	425	-68	1,852	531	-1,321	1,394	850	-544
Utah	558	425	-133	1,915	531	-1,384	1,450	850	-600
Vermont	669	425	-244	1,338	531	-807	1,880	850	-1,030
Virginia	541	425	-116	2,034	531	-1,503	1,531	850	-681
Washington	438	425	-13	1,648	531	-1,117	1,241	850	-391
West Virginia	739	425	-314	2,778	531	-2,247	2,091	850	-1,241
Wisconsin	516	425	-91	1,941	531	-1,410	1,461	850	-611
Wyoming	894	425	-469	3,360	531	-2,829	2,529	850	-1,679

* FPL = federal poverty level.

** The sample family includes two 40-year-old adults, a 10-year-old child, and a 5-year-old child.

*** For a small number of states in this scenario, the monthly premiums under prior law did not exceed the income cap of 8.5 percent under the American Rescue Plan Act. In those cases, the current- and prior-law premium payments are equal.

**** Poverty standards for Alaska and Hawai'i are higher than the national standard. For example, 470 percent of poverty for an individual is \$74,965 in Alaska and \$68,996 in Hawai'i, as opposed to \$60,000 in all other states. As a result, premiums under the new law for those above 400 percent of the poverty line will be higher in Alaska and Hawai'i than in other states, but still lower than under prior law.

Source: CBPP calculations.

APPENDIX TABLE 3

State Estimates of Increase in Federal Funding From Higher FMAP Under American Rescue Plan Act

State	Additional federal funding due to FMAP increase (in \$millions)
Alabama	940
Florida	3,540
Georgia	1,880
Kansas	330
Mississippi	890
Missouri	1,730
North Carolina	2,430
Oklahoma	860
South Carolina	960
South Dakota	180
Tennessee	1,660
Texas	5,970
Wisconsin*	1,000
Wyoming	120

*The Wisconsin estimate assumes that childless adults currently enrolled in BadgerCare are moved to the Medicaid expansion population, which means they are not included in the Act's FMAP increase. Wisconsin would receive the higher, expansion population FMAP for covering this population rather than the base FMAP, but the additional funds Wisconsin would receive from that shift are not shown here.

Note: FMAP = federal medical assistance percentage. Our estimates are based on baseline Medicaid spending figures that account for increased Medicaid expenditures during the COVID-19 pandemic. All estimates are rounded to the nearest \$10 million. The listed states have not implemented Medicaid expansion.

Source: CBPP analysis using Urban Institute estimates of Medicaid spending (2020) and Congressional Budget Office (CBO) baseline data.

For fiscal year 2021 through fiscal year 2023 expenditures, we inflate 2020 total traditional (non-expansion group and non-disproportionate-share-hospital) Medicaid spending from the Urban Institute using CBO's baseline estimates. We assume the federal share of all traditional Medicaid spending is increased by 5 percentage points from July 1, 2021 through July 1, 2023 for those states that have yet to implement the Medicaid expansion to low-income adults permitted under the Affordable Care Act.

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[2] Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," CBPP, March 21, 2019, <https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing>.

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[4] CBPP calculations. Examples assume consumers face the national average marketplace benchmark premium. The family of four is composed of two 40-year-old parents, a 5-year-old, and a 10-year-old. The benchmark plan is the second-lowest-cost silver tier plan offered where the consumer lives.

[5] CBPP calculations. Information on the lowest-cost gold plan is available at <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

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A Pathway to Equitable Health Care in America

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 See also Benjamin, p. 542, and Glied, p. 612.

The COVID-19 experience has underscored the inequities, silos, and disjointed nature of our health system. The double whammy of a job loss and the consequential loss of coverage exposed the precarious nature of employment-based health coverage, especially for lower-paid workers and their families. By June 2020, layoffs meant that as many as 7.7 million workers and 6.9 million dependents¹ lost their insurance. It should be impossible today for anyone to ignore the disgraceful gaps and inherent inequities in the system, with uncertain coverage for millions and poorer coverage and health for Black and Hispanic Americans.

Addressing these structural issues is no easy task in a political system that is so riven with discord. For the foreseeable political future, neither the Left nor the Right is likely to achieve its vision of a redesigned system that addresses today's structural flaws. Americans are also, by nature, suspicious of radical change in health care. So, if we are to reach the goal of an adequate level of affordable and accessible care for all, the Biden Administration and health reformers would be wise to adopt an approach that can be built gradually from what we have, and that draws on ideas that can appeal to both sides of the aisle.

One potential approach would have three elements: it would provide a strong community health system in every neighborhood, achieve equity in financial assistance to afford coverage wherever a person works, and permit states to adapt and innovate within national goals and a national framework.²

CREATE EFFECTIVE GRASSROOTS HEALTH SERVICES

Community health centers serve approximately one in every 12 US residents. Funded by Medicare, Medicaid, private insurance, and direct federal and local support, they are the basic health delivery system for millions of modest income and minority households, including undocumented residents and families that have lost employer coverage. Importantly, they have a long history of bipartisan support, and, through local partnerships, they often are action hubs for tackling some of the housing, transportation, and other needs of their patients that are referred to as social determinants of health.

Significantly expanding support for community clinics would help build a much stronger foundation of

affordable, accessible care for families that fall through eligibility gaps for many programs and plans and otherwise could not afford care. In tandem with this expansion, further increasing the flexibility of Medicaid and Medicare to pay for nonclinical services related to health, such as housing, transportation, and nutrition, would help address factors that contribute to poor health in many communities and demographic groups.

TRANSITION TO MEDICARE ADVANTAGE FOR ALL

In an economy with many high employee-turnover sectors, tying health coverage to the place of work makes little sense. The practice continues because the compensation earmarked for health insurance is tax free to the worker, a break known as a tax exclusion. That can be a good deal to a well-paid employee with long-term job security (who receives the biggest tax break). For lower-paid workers, however, the tax benefit is small. And for many part-time employees, service and gig-economy workers, and employees in small firms, employer-sponsored insurance and the tax break are not even available. Unless these workers qualify for Medicaid or for subsidies to purchase health exchange plans, they are on their own.

The regressive subsidies and coverage in employer-sponsored insurance is a major contribution to inequities in the health system. These need to be replaced gradually with a subsidy system based on the principle of "horizontal equity." That means households with the same income and insurance needs would receive the same tax benefit or direct subsidy to purchase insurance.

They could keep that insurance wherever or however they are employed.

Converting the tax exclusion into a progressive, refundable income tax credit related to income would rearrange a roughly \$270 billion annual federal tax break to achieve much greater equity and consistency. A refundable credit means those below the tax threshold would receive the equivalent of a tax credit to pay for insurance. By also adjusting the subsidy structure for exchange plans to make it consistent with the proposed credit system and allowing credits to be used for health exchange plans, the federal support for working households to obtain coverage would be the same regardless of place and type of work.

The exclusion-credit conversion has a long history of support even among Republicans; the main Republican alternative to President Clinton's reform in the 1990s took this progressive approach, and a variety of tax credit proposals have come from that side of the aisle since then. So, there is a basis of support to build on. Moreover, as managed care plans are increasingly common in Medicare, Medicaid, and private coverage, the result of workers utilizing credits would likely look much like a version of Medicare Advantage plans—the regulated private plans that are increasingly popular with seniors. Thus, we could see the system for working-age Americans evolving into what might best be characterized as “Medicare Advantage for All.” It is worth noting that Medicare Advantage has enjoyed bipartisan support, and so progressives would be far more likely to

achieve this form of Medicare for All than a disruptive version based on sweeping away private insurance.

CREATE A NATIONAL SYSTEM WITH STATE VARIATION

While the appeal of a “national” health system is that everyone, everywhere, can be assured the same level of affordable and accessible care, that does not mean the system has to be organized in the same way throughout the country. Moreover, the US system of federalism and state variation makes it easier for us to achieve an equitable national system.

One reason federalism helps is by allowing contentious features to be tried first at the state level using waivers. This can pave the way for more consensus by giving reformers with different philosophies the opportunity to showcase their ideas at the state level. To build bipartisan support for reform, the Biden Administration thus should make use of the waiver authority under Medicaid and the Affordable Care Act (ACA) to test both conservative and progressive concepts. Waivers could allow variations in ACA subsidies and benefit design, for instance, and allow more flexible Medicaid payment rules to explore the health benefits of addressing social determinants.

Federalism also allows states to adopt a more politically acceptable pathway to the same goal. That could help bring on board the states that have so far refused to accept federal funds to expand Medicaid. These nonexpansion states could be offered the same federal funds if they created their own programs that

achieved the equivalent extent and quality of Medicaid coverage.

To be sure, the political devil is in the details for each of these elements, and much needs to be done to restore more trust among lawmakers before the reforms can be accomplished. But by seeking gradual rather than radical change, by strengthening the community clinic system, by making progress toward horizontal equity in subsidies for coverage, and by recognizing that federalism is a tool for building acceptance of reform, we would have a bipartisan pathway to reach the goal of an equitable and comprehensive health system. *AJPH*

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CONFLICTS OF INTEREST

The author has no conflicts of interest.

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