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THE HEALTH INSURANCE COVERAGE LANDSCAPE IN THE LATE COVID-19 PERIOD

Statement of
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before the
Finance Committee
United States Senate

HEALTH INSURANCE COVERAGE IN AMERICA: CURRENT AND FUTURE ROLE OF FEDERAL PROGRAMS

October 20, 2021

* The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

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Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee:

Thank you for inviting me to address current issues related to health insurance in the US. While I am an employee of the Urban Institute, the views expressed in this testimony are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

Research has demonstrated that the Affordable Care Act has increased health insurance coverage in the US among the nonelderly by more than 20 million people.[1] The enhancements of premium tax credits provided by the American Rescue Plan Act (ARPA) have increased coverage further, albeit temporarily, given the limited duration of the enhanced credit period. These reforms also have improved affordability of insurance coverage and increased access to care for millions of Americans.

As a result, the US health insurance system provided a stronger safety net during the pandemic-induced economic downturn than in prior recessions. According to the Urban Institute's Health Reform Monitoring Survey, the number of nonelderly adults with employer-based insurance fell by approximately 5.5 million between March 2019 and April 2021.[2] Yet unlike prior recessions, the number with Medicaid increased even more. As a consequence, the number of uninsured held steady instead of increasing nationwide. However, while nationwide data is encouraging, the number of uninsured rose in nonexpansion states because smaller shares of people who lost employer coverage were eligible for Medicaid.

Still, nationwide, the private nongroup insurance Marketplaces are, by all indications, fundamentally stable. In 2021, the national average benchmark premium fell for the third year in a row, with average decreases in 43 states and only 1 state with an increase of more than 6 percent, following very large premium increases in 2018.[3] In addition, insurer participation in the Marketplaces has increased since 2017 in many population centers. However, in areas with lower insurer participation and/or consolidation among health providers, premiums and premium growth tend to be higher.

Even recognizing the successes, significant gaps remain in the health insurance system. First, more than 3 million people living below the poverty line and 1.2 million near-poor people are uninsured and ineligible for any financial assistance because they live in states that have not expanded Medicaid eligibility.[4] In addition, absent the temporarily increased ARPA Marketplace subsidies, my Urban Institute colleagues estimate that the number of uninsured nationally would reach 30 million in 2022.[5] Conversely, they estimate that making the ARPA subsidies permanent and extending them to lower-

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[1] Linda J. Blumberg, Michael Simpson, Matthew Buettgens, Jessica Banthin, and John Holahan, "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Washington, DC: Urban Institute, 2020).

[2] Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased: Trends in Health Insurance Coverage between March 2019 and April 2021" (Washington, DC: Urban Institute, 2021).

[3] John Holahan, Jessica Banthin, and Erik Wengle, *Marketplace Premiums and Participation in 2021* (Washington, DC: Urban Institute, 2021).

[4] Michael Simpson, Jessica Banthin, and Matthew Buettgens, "Most Uninsured People Gaining Medicaid Eligibility under Potential Expansion Would Have Incomes below the Federal Poverty Level" (Washington, DC: Urban Institute, 2021).

[5] Jessica Banthin, Michael Simpson, and Andrew Green, "The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress" (New York: Commonwealth Fund, 2021).

income people in nonexpansion states would decrease the uninsured by another 7 million people at a net federal cost of $27.7 billion in 2022, or $333 billion over 10 years. In addition, these estimates indicate that such policies would increase Marketplace enrollment while decreasing Marketplace premiums by 18 percent, on average, because of the relatively better average health of the new enrollees.[6] Taking lower premiums and out-of-pocket costs into account, the average per enrollee health care costs for those insured through the Marketplaces would be over $1,100 lower per year.[7]

While such opportunities exist to expand coverage, further action also must be considered, because the pending end of the national public health emergency (PHE) will also end the requirement that states keep people enrolled in Medicaid, and this transition poses future challenges for coverage. Urban Institute estimates indicate that Medicaid enrollment could decrease by as many as 15 million people during 2022 once the PHE-related maintenance-of-effort requirement ends, including 8.7 million adults and 5.9 million children. These numbers are partly offset by the projection that one-third of those adults would qualify for subsidized private health coverage in the Marketplaces. About two-thirds of the children would be eligible for assistance, much of it through CHIP. However, others have highlighted that the number losing Medicaid coverage at the end of the PHE could exceed 15 million people, given the difficulty of contacting still-eligible people to reverify and renew enrollment when they have not been in contact with state Medicaid systems for up to two years.[8]

Thus, the risk of a significant increase in the number of people uninsured following the end of the PHE is substantial, and such risk merits legislative and administrative consideration. As I have outlined, permanent, enhanced premium tax credits should encourage more people to move from Medicaid to the Marketplace once they lose Medicaid eligibility. Further, aggressive outreach and enrollment efforts at the state and federal levels, in addition to streamlining Medicaid redetermination and enrollment processes, are among viable options available to address the potential for a near-term increase in the number of uninsured Americans.

Thank you for the opportunity to share information with you on these important issues. I'd be happy to answer any of your questions.

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[6] Jessica Banthin, Matthew Buettgens, Michael Simpson, and Robin Wang, "What If the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022" (Washington, DC: Urban Institute, 2021).

[7] Banthin, Buettgens, Simpson, and Wang, "What If the American Rescue Plan's Marketplace Subsidies Were Made Permanent?"

[8] Kinda Serafi, Cindy Mann, and Nina V. Punukollu, "The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID-19 Public Health Emergency Ends," *To the Point* (blog), Commonwealth Fund, September 23, 2021, https://www.commonwealthfund.org/blog/2021/risk-coverage-loss-medicaid-beneficiaries-covid-19.

Large pharmaceutical companies say allowing Medicare to negotiate lower drug prices will stifle innovation in drug development. Read a new op-ed in *Harvard Business Review* to find out why that's not so.

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ISSUE BRIEFS / SEPTEMBER 9, 2021

The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress

TOPLINES

Making the American Rescue Plan Act's health insurance premium subsidies permanent would lower people's costs and encourage more people to sign up for coverage

Extending eligibility for marketplace subsidies in 12 states would give millions of poor people the opportunity to enroll in coverage and improve their access to health care

AUTHORS

Jessica S. Banthin, Michael Simpson, Andrew Green

Errata

On October 5, 2021, we corrected errors in this brief resulting from a coding error that did not apply all cost-sharing reductions to household spending. In the "Changes in Household Spending" section and Appendix Table 3, the increase in households' out-of-pocket spending is $0.6 billion and households' overall savings is $8.2 billion in 2022. Previously, these estimates were $7.0 billion and $1.8 billion.

Highlights

- Making ARPA premium subsidies permanent and filling the Medicaid coverage gap would reduce the number of people without insurance by nearly one-quarter, or 7.0 million people, in 2022.
- All states would see a drop in their uninsured population, with the largest percentage declines in states that have not yet expanded Medicaid eligibility.
- Enrollment in subsidized marketplace plans would nearly double, while premiums would fall by 18 percent on average.
- Federal spending would increase by an estimated $442 billion over 10 years and, after accounting for increased revenues because of higher wages and some offsetting savings, this reform would increase the federal deficit by an estimated $333 billion if no other changes in policy were made.

Introduction

As part of the budget process for fiscal year 2022, Congress is considering a package of two reforms to the Affordable Care Act (ACA). Under the package, the enhanced premium subsidies included in the American Rescue Plan Act (ARPA) would become permanent. Additionally, the so-called Medicaid coverage gap would be filled by extending eligibility for marketplace subsidies to people earning below 100 percent of the federal poverty level (FPL) in 12 states that have not yet expanded Medicaid.

Following is a closer look at the two reforms.

Making the ARPA Premium Subsidies Permanent

Passed in the wake of economic disruption and job losses because of the COVID-19 pandemic, the ARPA temporarily enhances premium tax credits in the marketplace for 2021 and 2022. The law lowers the limits on premiums paid by families who were eligible for subsidies before ARPA and expands eligibility for subsidies to individuals and families who were previously ineligible because their incomes were greater than 400 percent of FPL (more than $106,000 for a family of four).

The new subsidy schedule substantially reduces households' premium payments (see Appendix Table 1). Making these changes permanent would have significant effects on coverage, as we've previously estimated.[1]

Extending Eligibility for Marketplace Subsidies in Nonexpansion States

Under current law, people with incomes below 100 percent of FPL are not eligible for marketplace subsidies. Because of the large gap between traditional Medicaid eligibility levels in some states and 100 percent of FPL, about 5.8 million uninsured adults living in the 12 nonexpansion states do not have access to affordable health insurance coverage. (For example, Texas covers parents below 17 percent of FPL while Alabama covers those below 21 percent of FPL; childless adults are generally not covered in nonexpansion states.)

Although health insurance coverage through the marketplace is not as comprehensive as Medicaid coverage, expanding eligibility for marketplace subsidies to this group results in large increases in coverage.[2]

For this analysis, we examined the coverage and cost impact of these two key reforms together, using the Urban Institute's Health Insurance Policy Simulation Model (see "How We Conducted This Study.") Our analysis incorporates the effect on enrollment of increased federal spending on outreach.

Findings

Changes in Coverage

Implementing these two policies would increase insurance coverage, reducing the number of uninsured people by nearly one-quarter. The number of uninsured people would fall by 7.0 million, from 30.3 million to 23.3 million (Exhibit 1).

EXHIBIT 1

Coverage of the Nonelderly Population Under Pre-ARPA Law and Permanent ARPA Subsidies with Medicaid Gap Filled by the Marketplace, 2022

Thousands of people

	Pre-ARPA	Reform	Change	Change (%)
Employer	149,214	148,543	-670	-0.4%
Subsidized nongroup	9,219	17,252	8,033	87.1%
Unsubsidized nongroup	5,636	5,301	-335	-5.9%
Medicaid/CHIP	71,896	72,242	346	0.5%
Other coverage*	11,213	10,832	-381	-3.4%
Uninsured	30,269	23,276	-6,993	-23.1%
Total	**277,446**	**277,446**	**0**	**0.0%**

Download data

Notes: Reform includes permanent ARPA subsidies and filling the Medicaid gap by expanding subsidies for marketplace plans below 100 percent of the federal poverty level. ARPA = American Rescue Plan Act. CHIP = Children's Health Insurance Program.
* Other coverage includes Medicare and other public coverage and a small amount of Affordable Care Act noncompliant nongroup coverage.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021). https://doi.org/10.26099/4gyx-ry85

The enhanced subsidies would motivate many people who were previously eligible for marketplace subsidies but uninsured to sign up for coverage. Enrollment in the subsidized nongroup marketplace would jump by 8.0 million people, nearly doubling in size to 17.3 million people across the nation.

We also estimate 670,000 fewer people would be covered by employer-sponsored insurance (ESI). Most of the people who would leave ESI are those whose employers still sponsor health insurance but whose offerings are not deemed affordable; only a very small number would likely leave ESI because their companies would stop offering health coverage. This number does not include the reduction in ESI because of an administrative change in the so-called family glitch, which is discussed later in this brief.

We project that Medicaid and Children's Health Insurance Program (CHIP) enrollment would increase slightly by 346,000 people. Higher enrollment in the marketplace would likely trigger eligibility determinations that prompt family members to enroll in Medicaid. (Additional details on coverage changes are available in Appendix Table 2.)

Changes in Marketplace Premiums

An important result of the large increase in marketplace enrollment is the effect on premiums. We estimate that lower health risk scores among new enrollees would reduce premiums by about 18 percent in 2022 if insurers were able to adjust premiums immediately. The main reason average health risk would fall under these policies is that those with greater health care needs are more likely to have already obtained coverage before passage of the ARPA.

Changes in Coverage by Income

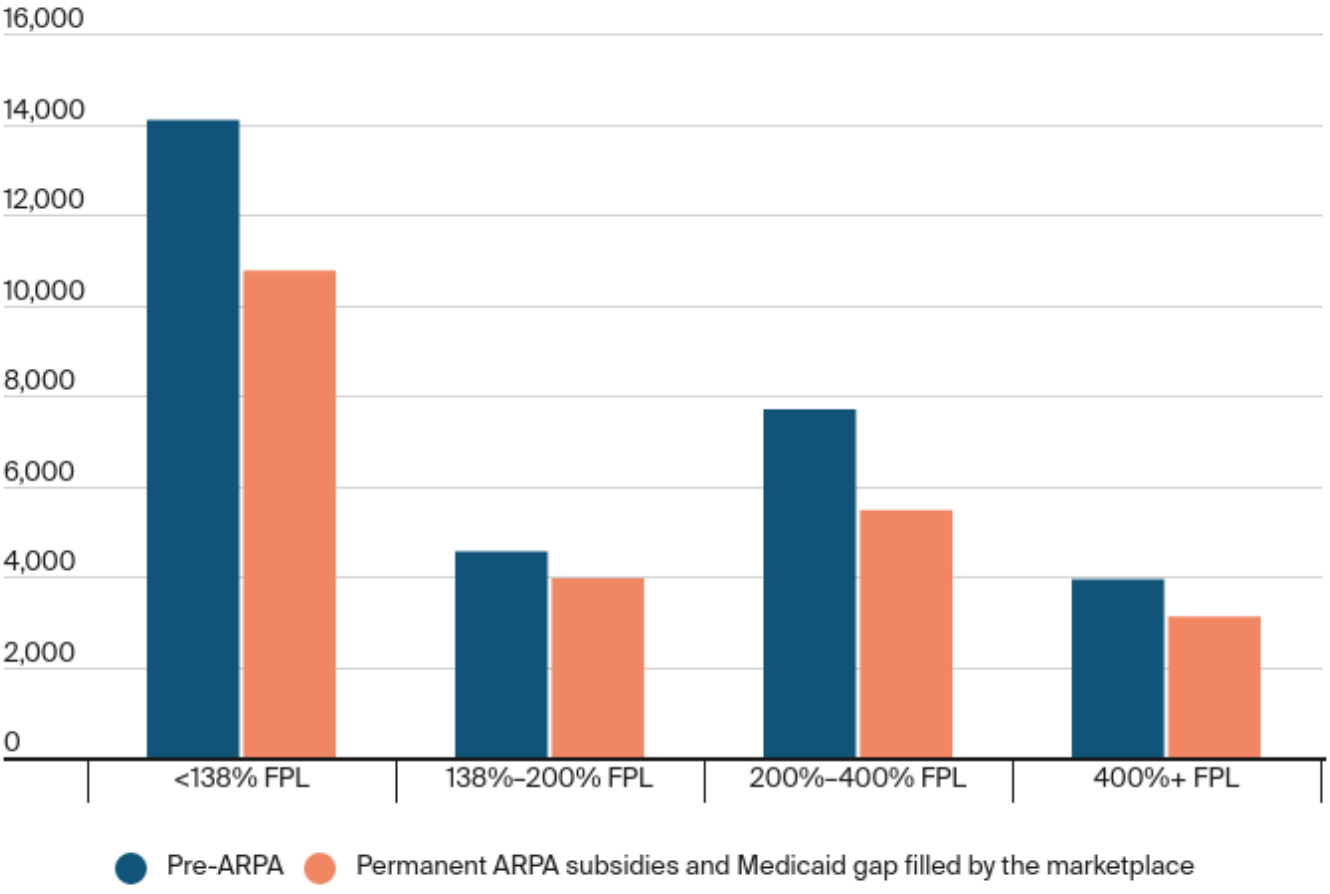
Exhibit 2 shows that reductions in uninsured people would be concentrated in the lowest income categories. About 3.3 million uninsured people with income below 138 percent of FPL would gain coverage, largely because more residents of the 12 nonexpansion states would be eligible for marketplace subsidies. Nearly 600,000 uninsured people with income between 138

percent and 200 percent of FPL would gain coverage, while 2.2 million uninsured people with income between 200 percent and 400 percent of FPL would become covered as well, mainly because of more generous premium subsidies. Among those with income above 400 percent of FPL, 830,000 uninsured people would obtain coverage because of lower premiums and expanded eligibility for premium subsidies under the ARPA.

EXHIBIT 2

Number of Uninsured Nonelderly People, by Income Group, 2022

Thousands of people



Notes: ARPA = American Rescue Plan Act. FPL = federal poverty level. Income groups are based on computations for Medicaid eligibility.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021). https://doi.org/10.26099/4gyx-ry85

Changes in Coverage by Race and Ethnicity

As a result of the new policy, all racial and ethnic groups would experience large declines in the numbers of nonelderly people without insurance (Exhibit 3). According to our estimates, Black non-Latino/Hispanic and white non-Latino/Hispanic groups would see the largest percentage reductions — 33.5 percent and 26.9 percent, respectively.

People of Latino/Hispanic ethnicity have the highest rate of uninsured people (20.9%, data not shown) compared to other groups, owing to the undocumented immigrant population. Under this policy, they would see the smallest percentage reductions in uninsured people, 15.7 percent, compared to other groups.

EXHIBIT 3

Number of Uninsured Nonelderly People, by Race and Ethnicity, 2022

Thousands of people

	Pre-ARPA	Reform	Change	Change (%)
American Indian and Alaska Native	596	455	-141	-23.6%
Asian and Pacific Islander	1,640	1,366	-274	-16.7%
Black, non-Latino/Hispanic	3,638	2,421	-1,217	-33.5%
Latino/Hispanic	10,539	8,883	-1,656	-15.7%
White, non-Latino/Hispanic	13,458	9,836	-3,622	-26.9%
Other	398	316	-83	-20.7%
All racial and ethnic groups	**30,269**	**23,276**	**-6,993**	**-23.1%**

Download data

Notes: Reform includes permanent ARPA subsidies and filling the Medicaid gap by expanding subsidies for marketplace plans below 100 percent of the federal poverty level. ARPA = American Rescue Plan Act.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021). https://doi.org/10.26099/4gyx-ry85

Changes in Spending and Effects on Deficits

By making the ARPA premium subsidies permanent and extending eligibility for marketplace subsidies, we estimate federal spending on marketplace subsidies and Medicaid and CHIP would increase by $36.9 billion in 2022 (see Appendix Table 3). This increased spending would be offset partly by savings from reductions in the demand for uncompensated care. Although we include all of the estimated $7.5 billion reduction in uncompensated care in our calculation, only about half would be realized as savings directly through a reduction in Medicare Disproportionate Share Hospital (DSH) payments. The net effect on the deficit would amount to $27.7 billion in 2022 after accounting for higher federal revenues because of reductions in ESI coverage, which is generally exempt from income and payroll taxes.

The increased cost of marketplace subsidies and Medicaid from 2022 to 2031 would add up to $442 billion (Exhibit 4). After accounting for increased revenues because of reductions in ESI and reductions in uncompensated care, we estimate that the net effect on the federal deficit would be $333 billion over 10 years, from 2022 to 2031. The costs would likely be somewhat lower than presented here because consumers and insurers may take more time than we assumed to fully respond to the new options.

EXHIBIT 4

Federal Spending for the Nonelderly Population Under Pre-ARPA Law and Permanent ARPA Subsidies with Medicaid Gap Filled by the Marketplace, 2022–2031

Billions of dollars

	Pre-ARPA	Reform	Change
Federal spending on acute health care	**5,655**	**6,007**	**353**
Medicaid	4,578	4,603	25
Marketplace tax credits	689	1,106	418
Marketplace cost-sharing reductions	0	0	0
Reinsurance	16	16	0
Uncompensated care*	372	282	-90
Increase in federal revenue**	**n/a**	**n/a**	**20**
Total net change in deficit	**n/a**	**n/a**	**333**

Download data

Notes: Reform includes permanent ARPA subsidies and filling the Medicaid gap by expanding subsidies for marketplace plans below 100 percent of the federal poverty level. ARPA = American Rescue Plan Act. CHIP = Children's Health Insurance Program. n/a = not applicable; HIPSM computes only changes for revenues and deficits.
* Uncompensated care represents demand for care by the uninsured. At the federal level, about half the change in demand resulting from a decrease in the number of uninsured people would automatically be realized as federal savings to Medicare disproportionate share hospitals.
** Change in federal revenue include the income and payroll tax effects of employer-sponsored insurance crowd-out.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021). https://doi.org/10.26099/4gyx-ry85

Changes in Household Spending

We estimate that household spending on premiums would fall $8.8 billion in 2022 even as enrollment increases. However, household spending on out-of-pocket costs for health care services (including deductibles and copayments) would increase by an estimated $0.6 billion in 2022 as access to and utilization of health care increases. Overall, households would save $8.2 billion, according to our estimates. In previous work, we found the ARPA by itself would reduce average household spending per enrollee by 23.1 percent.[3]

Changes in Coverage by State

If passed, this proposal would reduce the number of uninsured people in every state. We find that the largest percentage declines would occur in states that have not yet expanded Medicaid (Appendix Table 4). Declines in the proportion of uninsured people range from nearly 44 percent in Alabama to less than 6 percent in Utah.

Impact of Additional Reforms Through Administrative Action

Our estimates incorporate the effect on enrollment of administrative changes designed to increase participation, including a longer open enrollment period starting with the 2022 plan year and additional federal spending on navigators, advertising, and other types of outreach activity.

Under current law, families are generally ineligible for marketplace subsidies if a family member is offered "affordable," worker-only coverage through an employer. The cost of covering the entire family is not considered and may be unaffordable, resulting in the so-called "family glitch." If this policy were changed through administrative action to allow family members to become

eligible for marketplace subsidies, we estimate that about 710,000 additional people would enroll in the subsidized nongroup market, most switching out of ESI. In addition, about 90,000 family members, mainly children, would newly enroll in Medicaid or CHIP as their parents seek marketplace coverage. There would be 190,000 fewer uninsured people as a result of this change. Families switching from ESI would save about $400 per person in premiums on average. These changes in coverage were estimated separately in a previous report and are not included in the numbers discussed here.[4]

We are not able to specifically model the provision of continuous open enrollment for people below 150 percent of FPL for this report. In our assessment, however, this provision would increase enrollment into the marketplaces by between 100,000 and 200,000 people.

Conclusion

We estimate that making the enhanced ARPA subsidies permanent and filling the Medicaid coverage gap by expanding marketplace eligibility to those earning below 100 percent of FPL would have significant changes on coverage. Together, these two policies would broadly expand eligibility for marketplace subsidies, reduce the number of uninsured people especially at lower income levels, and lessen household financial burdens for health care.

HOW WE CONDUCTED THIS STUDY

Our estimates use the Urban Institute's Health Insurance Policy Simulation Model's (HIPSM) baseline for 2022. HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides a representative sample of families large enough for us to produce estimates for individual states and smaller regions, such as cities.[5]

For the pre-American Rescue Plan Act (ARPA) baseline of our analysis we chose 2022, a year when economic conditions should be more stable, following the COVID-19 pandemic and consequent recession in 2020. We assume, consistent with Congressional Budget Office projections, that the economy will have partly recovered from the pandemic recession by that time.

For this analysis, we also assume that Medicaid's enhanced Federal Medical Assistance Percentage (FMAP) and the maintenance of effort provisions in the Families First Coronavirus Response Act will have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the U.S. Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.[6] This means Medicaid's Maintenance of Eligibility (MOE) requirements, which prohibit states from disenrolling Medicaid enrollees unless they request it, are expected to last through January 2022. After that, the increased enrollment because of the MOE requirements will start to decline as states resume normal eligibility determinations.

Although recent guidance allows states up to 12 months to unwind the MOE provisions, it remains uncertain how fast this will happen. As a result, Medicaid enrollment may be higher in early 2022 than indicated in our estimates. Also, the enhanced FMAP is expected to be available through March 2022. The federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

The baseline and estimates presented here differ from earlier national HIPSM projections of coverage and costs in that we now treat Missouri and Oklahoma as Medicaid expansion states. Both states passed ballot measures in 2020 to expand Medicaid but had not actually begun coverage when we published earlier projections.

The ARPA includes an additional financial incentive for states that have not expanded Medicaid to do so; newly expanding states receive a boost of 5 percentage points to their FMAP for two years. Because neither Oklahoma nor Missouri had begun covering Medicaid expansion beneficiaries as of March 2021 when the ARPA became law, they are eligible for the incentive payment. We estimate that the incentive would shift $808 million of state costs to the federal government in 2022. As limited duration incentive payments, these costs are not included in our baseline or in the estimates presented in this paper.

Acknowledgments

We thank John Holahan for his careful review of this report.

NOTES

1 Jessica Banthin et al., *What If the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022* (Urban Institute, Apr. 2021).

2 John Holahan et al., *Filling the Gap in States That Have Not Expanded Medicaid Eligibility* (Commonwealth Fund, June 2021).

3 Banthin et al., *What If the American Rescue,* 2021.

4 Matthew Buettgens and Jessica Banthin, *Changing the "Family Glitch" Would Make Health Coverage More Affordable for Many Families* (Urban Institute, May 2021).

5 Matthew Buettgens and Jessica Banthin, *The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology* (Urban Institute, Dec. 2020).

6 Norris W. Cochran IV, acting secretary, U.S. Department of Health and Human Services, letter to governors regarding the public health emergency, Jan. 22, 2021.

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TOPICS

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Robert Wood Johnson Foundation

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Design of Public Option and Capped Provider Price Reforms

Important Interactions between Provider Prices and Other Program Features

Linda J. Blumberg

September 2021

The 2020 presidential election brought discussions of introducing a public option into US health insurance markets back to the forefront of health policy debates. A public option would consist of 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 health insurance markets. The federal government would determine payments made to providers (e.g., doctors, hospitals, pharmaceutical manufacturers) participating with a public option or negotiate prices with providers to attract them to participate; alternatively, state governments or a quasi-governmental or nonprofit entity could govern a public option. Conversations about public option plans have also prompted discussions about a related policy option, capping payments made to providers by commercial insurers. This strategy would require providers participating in particular insurance markets to accept prices from commercial insurers at or below a government-designated level. Thus, these capped prices would apply to providers participating in any private insurance plan offering coverage in the specified markets, whereas a public option would apply government-designated rates in new government-administered insurance plans alone.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

These two health reform approaches are related in that both seek to provide insurance options to consumers that would pay providers based upon payments determined (in the case of the public option) or limited (in the case of capped provider prices) by the federal government or its chosen agent. As noted, the public option would do so via a new insurance plan or set of insurance plans administered by the government, and the capped prices would do so via private insurers participating in the markets chosen. Depending on where these rates or rate limits are set, either approach could reduce premiums relative to current levels. Either policy could be used alone or in tandem with the other.

Though people broadly support the idea of a public option and/or lowering the costs of health care (Politico 2020),[1] implementing such policies requires numerous design decisions, can have significant unintended consequences, and is politically challenging. Design decisions profoundly affect such policies' abilities to meet their stated objectives, disruptions to the US health care system, and health care providers' finances. Many of these design decisions interact with one another, meaning they ought to be considered together. This is especially true of how the chosen schedule of provider prices interacts with other design choices. Here I delineate the major design choices that must be made for public option and/or capped provider price reforms and outline their trade-offs in government costs, household costs, impacts on providers, and access to care. I explicitly recognize that a public option and capped provider prices paid by commercial insurers can be implemented independently or simultaneously.

What follows is a summary and interpretation of an extended discussion in 2020 with a small group of health policy experts that included, in addition to me, Michael Chernew, Jack Ebeler, Matt Fiedler, Richard Frank, Sherry Glied, Tim Gronniger, John Holahan, Mark Miller, and Cori Uccello. No particular view presented below should be attributed to any particular participant or organization with which they are affiliated. The central conclusions of the discussion include the following:

- Advocates of public option and capped provider price reforms do not always agree on the reforms' intended objectives. Some see a public option primarily as a cost-containment mechanism, intended to lower public and private health care spending and thereby increase insurance coverage and access to care. Others view a public option as most importantly an

alternative to commercial insurance that could better serve the interests of consumers; these supporters may have little interest in designing a system to reduce the costs of care. Capped provider prices could reduce health care spending, increase coverage, and improve access to care as well but would not provide an alternative to commercial insurance.

- Both reforms could reduce health care spending, but the extent of savings depends on the prices the reforms rely on and the markets in which the reforms are introduced.
- In designing either reform, the interaction of the provider price schedule and the size of the markets included will have powerful implications for the magnitude of system-wide savings and effects on provider revenue. The lower the price schedule and the larger the markets to which they apply, the greater the potential for public and private savings. But greater, too, is the potential to disrupt health care provider markets.
- In either reform, the provider price schedule will directly affect providers' voluntary participation in the insurance plan networks. Lower price schedules will tend to decrease voluntary provider participation and thus make it more difficult to establish broad provider networks. However, prohibiting providers refusing to participate with the public option or commercial insurers relying on capped prices from participating with other insurers in the same market could increase participation.
- A public option reform requires many additional design decisions beyond those required of a capped provider price reform. These include whether state variation in essential health benefit requirements would be permitted, the actuarial value tiers in which a public option would be introduced, risk adjustment participation, applicability of premium taxes, reserve fund requirements, and financing of start-up and administrative costs.
- Setting capped provider prices at a relatively high point in the provider price distribution (e.g., the 75th or 80th percentile) would reduce the prices of the highest-priced insurance plans, and such a reform could be introduced into both employer group and nongroup markets with little anticipated health care delivery disruption. Introducing a public option in nongroup insurance markets would provide new competition in markets dominated by monopolistic providers and/or insurers and would constitute a new tool that could evolve into a valuable option for consumers dissatisfied with private insurance options.

Objectives: Cost Containment versus Availability of Noncommercial Broad Network Plans

Central to the effective design of any public policy is clarity in the policy's intended objectives. Advocates of a public option are not unanimous in their objectives, and design choices will determine which objectives are most likely to be met by the program ultimately introduced.

Some see a public option as a cost-containment mechanism. In many areas of the country, lack of competition among insurers and/or health care providers is associated with high premiums, generally

because of high provider prices.[2] Regardless of the source of high medical prices, many support lowering them to improve access to care and free up public and private funds for other priorities. A public option run by the federal government could make payments to health care providers that are lower than those paid by most commercial insurers. Doing so would mean public option plans could offer consumers actuarially fair premiums lower than many of those offered by commercial insurers. Lower premiums translate into household savings on out-of-pocket costs for people enrolled in the option, and lower premiums may put competitive pressure on private insurers in markets where the public option is introduced (Blumberg et al. 2019). A public option introduced in the employer market could provide a lower-premium insurance option for employers and their workers. Likewise, a public option offered in the private nongroup insurance market could offer a lower-premium option to nongroup enrollees, especially those with higher incomes that make them ineligible for federal financial assistance (Blumberg 2021). In addition, if a public option were to decrease the nongroup Marketplace benchmark premium (currently set at the second-lowest silver Marketplace premium in a person's area of residence), federal spending on premium tax credits would decrease as well, leading to government savings. Likewise, placing caps on provider prices for commercial insurers in all or some markets could generate both private and government savings.[3] Depending on how it is administered, a public option could also operate with lower administrative costs than those typical of private insurers, another possible source of savings that could lower premiums.

Lower health care spending during the first year of the COVID-19 pandemic reduced the sense of urgency some felt in addressing rising health care spending via a public option or provider price caps. However, the drivers of increased health care spending in private markets that many were concerned about before the pandemic have not changed, meaning those concerns will return. Moreover, an ongoing focus has been placed on the extent to which Medicare and private insurers overspend on prescription drugs, and concerns remain about how Medicare Advantage plan pricing potentially increases health care costs. In addition, the Biden administration has already issued an executive order instructing federal agencies to work on addressing broad issues related to the economic consequences of market consolidation, including in the health care sector. This signals that health care cost containment strategies remain an important policy interest.

Others see a public option as an alternative insurance vehicle that would be more responsive to the interests of consumers than profit-motivated insurers. Some people are concerned with the narrow provider networks offered in many nongroup insurance market plans in particular, and they see a public option as a way to offer consumers broad provider networks at an affordable premium, not unlike the traditional Medicare program. Some people value a single insurance plan being available to everyone across the country, particularly one theoretically less likely to deny claims or limit important benefits. Some view a public option as a vehicle for providing subsidized coverage to populations currently without coverage options (e.g., those in the Medicaid eligibility gap),[4] whereas others see it as a first step toward a Medicare for All program.

Capping provider prices for all commercial insurers could create public and private health care savings, as noted above, regardless of whether capped prices are implemented alongside a public

option. In fact, because most insurer premiums could be affected by the caps, depending on where they are set, the caps could lead to greater aggregate private savings than a public option alone. However, capping prices paid by commercial insurers cannot satisfy the desire for an alternative to insurers motivated by profit or other interests that benefit certain private entities (e.g., private nonprofit insurers), as the public option could do. Consequently, the primary purpose of capped provider prices is to reduce health care spending by reducing providers' and/or insurers' market power over prices while maintaining sufficient quality of and access to care. In addition, such an approach can improve equity in the markets by reducing the variation in prices paid across providers and markets.

These different objectives will often be in some tension with one another. Creating and maintaining broad provider networks, for example, generally requires paying providers higher prices to attract their participation. Higher provider prices, in turn, will generally translate into higher premiums and reduce the opportunities for private and public savings. Plans with lower rates of claims denials will also, however, tend to increase provider participation even at lower prices (Dunn et al. 2021), but they may lead to increased costs as well.[5] Therefore, I refer to these somewhat competing objectives while presenting the advantages and disadvantages of specific design choices.

Private and public savings resulting from lowering payments to providers under either a public option or capped provider prices can increase health insurance coverage. Combined with current medical loss ratio restrictions, lower payments to providers per service should translate into lower premiums. In turn, lower premiums facing consumers can increase the number of people purchasing coverage in the nongroup market. For employers, lower premiums can translate into greater enrollment by workers and some current premium spending being transformed into higher taxable wages. Government savings from lower premium tax credits in the nongroup market and/or greater tax revenue from increased wages in the employer market make more dollars available to enhance financial assistance in the nongroup market (e.g., improved premium tax credits) or expand eligibility for public programs (e.g., filling in the Medicaid coverage gap).

Though related, the public option and caps on private insurers' provider prices will likely affect different insurance markets differently. Capped provider prices constrain the range of prices of participating insurers but otherwise leave the markets structured as they are today. The public option introduces a new and potentially lower-priced insurer into the market, but it does not explicitly constrain commercial insurers' pricing. Depending on the characteristics of particular insurance and provider markets, the resulting competitive responses could differ.

The Foundation for Developing Provider Price Schedules

Both a public option and capped provider prices for private insurers require delineating provider price schedules. With a public option, a schedule would determine the reimbursements for medical services provided to enrollees. With capped prices, a schedule would limit commercial insurers' provider payments to no more than specified levels. Schedules could be based on services for health care professional payments and per admission diagnostic related groups for hospital payments, for

example, as is the case for the Medicare program. Under either approach, payment schedules or limits on prices should reflect the intensity of services provided. The main foundations considered for creating such payment schedules are the traditional Medicare schedule and commercial insurer fees. Both have distinct advantages and disadvantages for public option and capped provider price policies.

The Medicare Fee Schedule

This schedule is an existing set of prices that accounts for geographic variation in the costs of providing care. Consequently, the Medicare schedule could be applied to new programs or plans quickly. A small number of services, particularly those for pediatric care, may need to be added to the existing schedule, but it already accounts for the vast majority of care. The Medicare fee schedule has also been developed with the intent to reimburse providers at levels relative to each other based on variations in input costs and the relative value of different services provided. Thus, price differences across the schedule have a rational basis. Depending on how high policymakers want prices to be, multiples of Medicare prices could be used, for example, 110 or 160 percent of Medicare prices. Different multiples could be used for hospital versus professional care. This would account for current commercial rates for professionals already being closer to Medicare rates than are hospital rates. And, institutionally, provider participation issues for public insurance programs have been a greater concern for physicians than for hospitals. More complexity could be introduced by varying the percent adjustments more finely, for example, by treating different types of hospitals differently (e.g., teaching hospitals, rural hospitals) or treating various physician specialties differently.

The Medicare fee schedule–based approach also has the advantage of containing a ready-made measure of provider volume. One risk of lowering provider prices is that some providers could respond to the ensuing reduction in revenue by increasing the volume of services they provide per patient on average. Medicare's relative value units and diagnostic related groups can be aggregated for each provider, as measures of each provider's volume. These can be used as a basis for further price adjustments should the average volume of services provided per patient increase significantly under reform.

The trade-off of using the Medicare payment schedule, however, is that it could complicate the general Medicare rate setting process and the process of establishing these rates (e.g., the recommendations of the Relative Value Scale Update Committee). If a public option or commercial provider price limits were to rely on the Medicare schedule, then any discussion or debate over modifications to Medicare rates (e.g., productivity adjustments, growth rates) would have implications for provider prices more generally. Lobbying around the Medicare schedule would become more complicated and fraught, and these pressures could push Medicare rates higher than they otherwise would be, because a larger share of provider revenues would be at stake, leading providers to lobby harder to keep prices up. However, the savings to government and consumers would be commensurately larger, potentially leading policymakers to pursue them more aggressively; consequently, the ultimate impact of a public option or capped provider prices on Medicare payment rates is uncertain.

Provider Prices Used by Commercial Insurers

These prices vary dramatically across insurers, providers, and even plans offered by the same insurers. A substantial part of the variation in commercial insurers' provider prices likely relates to geographic variation in provider and/or insurer competition. A schedule for a public option or capped prices could be developed using a specified percentile of the distribution of commercial provider prices, say the median, depending on the payment schedule desired. The advantages of relying on a payment schedule based in commercial rates are that the schedule (1) may be more politically palatable to health care providers and (2) would not interfere with negotiations between providers and the federal government over Medicare rates. However, that political appeal may fall appreciably if provider prices are set well below the median of current rates (e.g., at the 35th percentile).

If a schedule based on a low percentile of national commercial rates were chosen, the impact of consolidation and noncompetitive markets that have inflated prices in some areas would be less likely to affect the delineated schedule. For example, if the 20th percentile of the commercial rate distribution for each service were chosen as a benchmark, those rates could be multiplied by a factor greater than 1 to increase payment levels without having the relative prices for different services affected by existing monopolistic behavior. Geographic cost adjustments could be applied after the fact. In addition, the commercial rate approach does not require providers or insurers to change the definition of services they use to be consistent with Medicare definitions; however, commercial insurers' definitions of services likely vary, so some disruptions and system modifications would be required to standardize these definitions regardless.

The first disadvantage of the commercial benchmark is that determining the distribution for every existing medical service would be a significant data-collection undertaking. This information does not currently exist, so collecting it will take considerable time and resources. In addition, market forces, not relative value, determine commercial providers' prices, an important difference from the Medicare schedule, which explicitly accounts for relative value. Consequently, the current variation in commercial prices across the country is tremendous. Any particular point in the pricing distribution may not appear to make sense based on rational criteria, because the pricing distribution is the product of market distortions. Plus, many commercial insurers pay hospitals based on days instead of admissions, which tends to increase spending by private payers. Further, coding across private insurers is seldom comparable, which creates considerable complexity in comparing current prices across these insurers.

Regardless of which benchmark is used, the final payment schedule and annual update approach chosen will determine a reform's effect on the provider market (i.e., savings and access to care). Theoretically, using an upwardly adjusted Medicare schedule as a benchmark (e.g., 120 percent of Medicare rates) could achieve similar savings as using the distribution of commercial prices as a benchmark, depending on which percentile is chosen and whether any additional adjustments are applied. The same is true regarding the annual adjustment chosen. The closer rates remain to current ones, the lower the risk of disruption to the health care system, but the lower, too, are savings from the reform.

Managing a public option or capped prices, including the level and growth of prices, could be entrusted to an active administrator or possibly to a state department of insurance if national variation were permitted. In this way, the administrator could adjust prices (including for geographic variation) as a function of information collected on access to different types of care, provider participation, the quality of care provided, and aggregate spending. Such discretion would create some additional uncertainty about ultimate public and private savings, but the flexibility would provide the administrator with the nimbleness necessary to modify prices and correct for unintended consequences of over- or underpricing particular services. Limits on the flexibility provided to such an administrator would likely be needed, however. Otherwise, providers with market strength could effectively negotiate prices with the public option and drive prices higher than appropriate or desirable. In addition, the capabilities of different departments of insurance vary considerably across states. Thus, if they were to administer a public option or capped prices, they could define important economic parameters differently, which could lead to some positive and some negative outcomes.

Interaction of the Provider Price Schedule and the Size of Markets Included in a Reform

As analysts have shown (Holahan and Simpson 2021), introducing a public option or capped provider prices into nongroup insurance markets alone is unlikely to generate large aggregate savings. This is purely because the number of people buying coverage in those markets is small, an estimated 15 million people in 2022 (Banthin et al. 2020). The employer group market is roughly 10 times as large, an estimated 150 million people in 2022. Consequently, implementing these types of reforms in the employer group market creates more potential for private and public savings and disruption of the health care delivery system. Commercial insurers' payments to providers in many nongroup insurance markets are also likely already significantly lower than those paid in employer-sponsored insurance markets, an additional reason why these types of reforms have greater savings potential in the employer market than the nongroup market (Blumberg et al. 2020). For example, according to Urban Institute estimates, introducing a public option paying providers rates modestly above Medicare's (Medicare plus 10 percent for professionals and Medicare plus 25 percent for hospitals) in nongroup insurance markets alone would reduce health system spending (public and private combined) by $15 billion in 2022 (Holahan and Simpson 2021). Introducing that same public option into both nongroup and employer markets would reduce health system spending by $156 billion in 2022, more than a 10-fold difference. Capping provider prices across both markets at the same rates would reduce health system spending by more than double that amount, $331 billion in 2022.

Lower prices applied to a smaller number of consumers will affect overall provider revenues less, and thus the risk of health care delivery system disruption is rather small. That means that reforms using provider prices well below commercial levels only for public option enrollees in the nongroup market would carry less risk of delivery system disruption than broad caps on provider prices for all insurers in both the employer group and nongroup insurance markets. But the former reform would also achieve smaller aggregate savings than would the latter.[6] In addition, lower provider prices could

limit the number of providers willing to participate with these plans, especially if the enrollees constitute a small percentage of the providers' expected revenue.

A more limited public option or capped prices targeted solely to nongroup insurance consumers could also phase in lower prices more quickly without significantly disrupting health care delivery (Skopec and Holahan 2021). Conversely, the larger the share of health care consumers affected by lower prices, the longer it will likely take for health care providers to respond with the organizational changes necessary to preserve supply and quality.

One policy option that has been discussed is creating a public option solely to provide coverage for adults with low incomes caught in the Medicaid eligibility gap. In the 12 states that continue to refuse to expand Medicaid eligibility under the Affordable Care Act, more than 3 million uninsured people living in poverty are ineligible for any financial assistance to enroll in insurance coverage, because their incomes are too low to qualify for Marketplace subsidies but too high to be eligible for their states' traditional Medicaid programs (Simpson, Banthin, and Buettgens 2021). Because the population in the eligibility gap in these states is largely uninsured today, providing them coverage through a federal public option, even one paying Medicare rates, would put additional revenue into the health care delivery system, not less. Consequently, such a narrow program should not risk significantly disrupting health care delivery.

Interaction of Provider Price Schedule and Network Breadth

In recent years, many nongroup insurers have built narrow provider networks to be able to offer price-competitive plan options to consumers (Wengle et al. 2020). Including only health care providers willing to take lower prices in a provider network translates into lower insurance premiums. Creating broader provider networks generally requires paying some providers at higher prices or having some other type of purchasing leverage that attracts more providers to participate.[7]

Consequently, ensuring voluntary participation of a broad network of providers is difficult if a public option pays providers substantially below typical commercial prices. Relying on voluntary provider participation will most likely lead to a trade-off between network breadth and premium savings. Requiring providers participating with the Medicare program (or the Medicaid program) to also participate in the public option may increase provider participation, even at relatively low payment levels. However, this could also risk some providers leaving the Medicare or Medicaid programs instead. In addition, physician participation is difficult to enforce. Thus, one option is to require hospitals to participate, say, as a requirement of participation in the Medicare program, but not requiring the same of physicians. Because all hospitals participate with the Medicare and Medicaid programs and those programs constitute a large share of hospital revenues, hospitals are far less likely to stop participating in those programs, even if public option participation is tied to them. The most challenging network breadth issue is related to physicians in this context. Failing to enforce

consequences for physicians declining to participate with the public option could lead to a significantly narrower provider network than envisioned, however.

Another option for increasing physician participation is prohibiting physicians who decline to participate with the public option from participating in other plans serving that same market.[8] For example, if a public option were introduced into the nongroup market in a given area, a physician refusing to participate in the public option would be prohibited from participating with the private nongroup insurers offering coverage in that area. If physicians' decisions not to participate with the public option depend on their desires to protect their pricing leverage with private insurers, this approach could significantly increase physician participation. In addition, it would not risk a decrease in Medicare or Medicaid participation. The same approach could be used for hospitals as well.

Capping provider prices for commercial insurers at low levels raises similar concerns about physician participation. However, if providers are reticent to participate with the public option over concerns that doing so could jeopardize their pricing negotiation leverage with private insurers, capping prices for all insurers in a given market minimizes participation concerns. In general, though, the larger the number of insured people in the markets where the caps are implemented, the harder it is for physicians to avoid accepting those prices. For example, capping commercial prices in the nongroup market alone would affect physician revenues less than would capping them in the nongroup and employer group markets, because the employer insurance markets are so much larger. But at the same time, physicians can more easily refuse to participate with nongroup insurers than they can refuse to take patients with employer-based insurance, because the number of enrollees in the former is so much smaller than the number in the latter.

Provider Payment Schedules and the Interaction of a Public Option with Capped Prices for Commercial Insurers

At least theoretically, the reach of a public option is smaller than that of capped provider prices for commercial insurers. The primary effect of a public option would be on the people who choose to enroll in it, though some evidence shows that a public option could alter the dynamics of provider-insurer negotiations and lead to somewhat lower private insurer prices as well, particularly in highly concentrated markets (Blumberg et al. 2019). Capping commercial insurer prices, depending on where the rates are set, could affect all commercial insurance enrollees to some degree, thereby affecting a larger group of people and potentially to a greater extent. Consequently, the prices used for a public option could be set below capped prices for all commercial insurers. Either of these policies could be implemented alone or together, using different price schedules for the two strategies. With such an approach, the public option can provide broadly available insurance options designed by the government and not motivated by profit, whereas the capped prices play the central cost-containment role and somewhat improve equity of payments among providers and markets.

Additional Design Considerations for a Public Option

Though capping provider prices used by commercial insurers has various benefits, as noted earlier, it is primarily designed to lower insurance premiums. This is achieved by either reducing the most extreme prices, by setting capped prices at a higher point in the price distribution, or by reducing prices more broadly, by setting the capped prices at a lower point in the price distribution. Capped provider payments do not, however, provide an insurance product that is not subject to profit motives or other private entities' interests. To address the latter, a government-designed and administered plan, the public option, is needed. Because it would create a new public source of insurance, a public option would require additional design considerations beyond the prices the plan pays to providers.

State Variation in Essential Health Benefit Requirements

Although the 10 categories of essential health benefits defined in the Affordable Care Act must be covered in each state's nongroup and small-group markets, the rules surrounding benefit definitions and the quantity limits on some of these benefits vary (dollar limits on benefits are prohibited, however). Benefits covered by a public option could be made uniform nationally or could vary modestly by state to be consistent with the other qualified health plans sold in each state.

Though a public option offering a uniform set of benefits ensures everyone in the country has access to at least one plan, offering a public option plan (or plans) that differs from the other plans offered in the markets where the public option is sold carries significant risks. Benefit variations can make it more difficult for consumers to compare their options, but more importantly, they can lead to adverse selection either into the public option or private plans. To the extent that either the public option's or private plans' benefits in a state are more or less attractive to higher-risk enrollees, the risk-adjustment system may be unable to completely compensate for the difference. Consequently, if uncorrected adverse selection escalates premiums in the plan(s) selected against, the public option or the private health plans may be unable to compete for consumers in the long term.

Actuarial Value Tier Participation

Likewise, if no private insurers offer a particular actuarial tier of coverage (current law only requires insurers to offer silver and gold levels), introducing a public option in that tier could create selection problems. For example, a significant number of Marketplace rating areas currently lack an insurer offering a platinum (90 percent actuarial value) option, largely because these high-value plans are felt to attract enrollees with higher medical needs. If a platinum public option were introduced in these areas, all else staying the same, it could attract enrollees with higher-than-average health care costs. Given the imperfection of risk adjustment, this outcome could make it hard for the public option to compete with private insurers in the area.[9]

Level Playing Field Issues

The politics of the public option are also extremely challenging. Many consumer advocates' distaste for for-profit commercial insurance leaves them uninterested in designing a system that provides these insurers with the level playing field they feel they need to compete with a public option. In other words, some are happy to let an uneven playing field lead to a fully public system, like Medicare for All. Meanwhile, the private insurers with which a public option would compete are focused on any possible unfair advantages a government insurer would have over them in their markets. And, in truth, a large financial advantage that allows a public option to set its premiums well below those of private insurers could drive at least some current private options out of the markets—for better or for worse, depending on one's perspective. Beyond the core component of provider payments discussed above, at least four categories of expenses can affect the extent to which a public option competes with private insurers on a level playing field: risk adjustment, premium taxes, reserve funds, and start-up and management costs.

Risk adjustment. In nongroup insurance markets, risk adjustment reallocates a portion of insurers' premium revenues to compensate insurers that disproportionately enroll people with higher-than-average health care costs in a year. The objective of this strategy is to allow all insurers to set premiums in a manner that reflects the average risk of the entire pool of people enrolled in nongroup insurance in the state, enabling insurers with higher-cost enrollees to remain attractive and affordable to potential enrollees with various medical needs. Risk adjustment also undermines the incentives for insurers to attempt to enroll healthier people and to dissuade people with greater medical needs from enrolling in their plans.

Consequently, creating a level playing field within an insurance market that includes a public option would require that the public option participate in the risk-adjustment system. It is unclear *a priori* whether a public option would attract disproportionately healthy or sick enrollees, or neither. Therefore, excluding the public option from the system could help or hurt private insurers and similarly increase or decrease actuarially fair premiums associated with the public option based on the risk profile of those enrolled. In turn, this could make it difficult, if not impossible, for either the public option or private insurers to remain viable.

Likewise, including the public option in risk adjustment could result in the government plan making payments to some private insurers or vice versa. The Affordable Care Act's risk adjustment payments are calculated as a function of the differential risk of enrollees and the average premium in a state. As such, if a public option were to lower the average premium in a state, it would also lower the size of risk-adjustment payments between insurers. This could disadvantage some higher-priced private insurance plans should they be selected against, which would benefit plans enrolling healthier people.

Premium taxes. Almost every state and the District of Columbia imposes taxes on insurers' gross premium revenues. The most common tax rate is 2.5 percent, though such rates range as high as 4 percent (Grace, Sjoquist, and Wheeler 2007). Usually, these taxes take the place of corporate income taxes on insurers and are likely passed on to consumers purchasing insurance through higher

premiums.[10] Consequently, private insurers would be at a direct pricing disadvantage if equivalent taxes were not imposed on a public option plan introduced in the state. Leveling the playing field to improve private insurers' abilities to compete would therefore require the public option to pay premium taxes as well.

Reserve funds. Typically, state laws require insurers to maintain reserve funds that ensure the company would be able to pay enrollee claims even if premium revenue for the year fell short of actual claims. States regulate the level of required surpluses, but they typically range from 15 to 25 percent of expected annual claims. Insurers cannot increase premiums in subsequent years to cover costs associated with underestimates in prior years; doing so could run afoul of medical loss ratio requirements, and insurers doing so would be placed at a competitive pricing disadvantage. Though the federal government could obviously use general revenues to cover any public option shortfalls in a given year, doing so would create, at minimum, a perception of an unfair competitive advantage from private insurers' perspectives. Including small premium add-ons to build up reserve funds for a public option may be unnecessary as a practical manner but could enhance private insurers' sense of competitive fairness.

Start-up and ongoing administrative costs. The administrative costs associated with starting a private insurance plan and supporting its ongoing operations are generally recouped by the administrative load added on to expected annual claims when computing premiums. These costs include such necessities as provider network development, data infrastructure development and maintenance, claims payment, and customer service. The instinct with a public option may be to build off the government's existing infrastructure for the Medicare and Medicaid programs in the Centers for Medicare & Medicaid Services, for example. Depending on one's perspective, using existing infrastructure could be considered good savings or an unfair advantage, however. Start-up costs could, for example, be amortized in the premium or absorbed via general revenues along with those for the other existing public insurance programs. Adding something small to the premiums to account for a reasonable level of such costs may be unnecessary but, again, could improve private insurers' perceptions of fairness.

Discussion

Public option advocates do not always share the same objectives for establishing such a program. However, the central design choices necessary to develop a public option are inextricably tied to the intended objectives. The level and growth of payments to providers are critical features of a public option, and these choices have tremendous implications for premium affordability and cost-savings potential, network breadth, and disruption to the health care delivery system. Sufficient political support for a public option will likely require greater agreement on such a program's objectives than is apparent today; some people currently focus on a public option's cost-savings potential, whereas others focus on the availability of a consumer-motivated, instead of profit-motivated, broad-network plan.

As research has indicated (Holahan and Simpson 2021), a public option alone has limited power to contain health care system costs broadly, particularly when only made available in the nongroup insurance market. It would, however, provide new competition in markets dominated by monopolistic providers and/or insurers. It would also be a new tool that could evolve into a valuable consumer-oriented, administratively efficient entity that serves as an alternative coverage option for those dissatisfied with their commercial insurance options.

Capping provider prices paid by commercial insurers is primarily a cost-containment tool that could be implemented with or without a public option. In the presence of a public option, capping commercial prices paid to providers may allow private insurers to lower their premiums and compete more effectively. Setting such caps at a relatively high point in the provider price distribution (e.g., at approximately the 75th or 80th percentile) would primarily reduce the prices of outlier plans, whereas setting the caps at a lower percentile would reduce costs more broadly.

Regardless of the presence of a public option, caps on provider prices would have the greatest effect when applied broadly to insurers in the group and nongroup markets, as opposed to nongroup markets alone. Caps could be set high initially, thereby lowering provider prices and associated premiums only in the highest-priced markets to start. Caps could then be lowered over time in conjunction with a significant data collection and monitoring effort that could be used to prevent provider price adjustments from significantly disrupting the health care delivery system, a particularly important consideration if the caps are implemented across all commercial insurers.

Notes

1 Gaby Galvin, "About 7 in 10 Voters Favor a Public Health Insurance Option. Medicare for All Remains Polarizing," Morning Consult, March 24, 2021, https://morningconsult.com/2021/03/24/medicare-for-all-public-option-polling/.

2 Though monopolistic (or otherwise strongly consolidated) insurers should have substantial leverage to reduce provider prices and thus reduce premiums, many areas with highly concentrated insurance markets also have highly concentrated provider markets. Even when that is not the case, dominant insurers do not face strong incentives to be tough negotiators with providers, and thus they seldom use that leverage to significantly reduce prices. For example, highly concentrated insurance markets are strongly correlated with high premiums in the nongroup market (Holahan, Banthin, and Wengle 2021).

3 The greatest savings resulting from lower nongroup Marketplace premiums accrue to people with incomes sufficiently high that they pay for full premiums independently, without federal premium subsidies. However, lower premiums can also generate savings for people eligible for premium subsidies who choose insurance options that are more expensive than the second-lowest silver (benchmark) premium available, since these consumers are liable for the full difference between premiums for the benchmark and the more expensive plan. In addition to government savings resulting from lower nongroup Marketplace benchmark premiums, lower commercial insurance premiums in the employer market can also generate government savings. Economic theory and empirical research suggest lower employer spending on health insurance premiums tends to translate into higher wages. Because wages are taxable as income but health insurance contributions are not, lower premiums in the employer market tend to increase government tax revenue.

4 Currently, 12 states continue to refuse to expand Medicaid eligibility to all lawfully present residents with incomes up to 138 percent of the federal poverty level (FPL). Because the Affordable Care Act was written assuming Medicaid expansion would be implemented in all states, its drafters only made people with incomes

above the FPL eligible for premium tax credits through the Marketplaces. Consequently, many people with incomes below the FPL are ineligible for any financial assistance obtaining health insurance in 11 of those states, because those states' traditional Medicaid eligibility rules exclude nonparents and are generally very limited for parents. For example, in Alabama, only parents with incomes up to 18 percent of FPL are eligible for Medicaid and nonparents are ineligible regardless of income. In Texas, parents with incomes up to 17 percent of FPL are eligible and all nonparents are ineligible. The one notable exception is Wisconsin, which has not expanded Medicaid eligibility under the Affordable Care Act but extended its traditional Medicaid program to all adults with incomes up to the FPL. In addition to people with incomes below the FPL in these states, others with incomes between 100 and 138 percent of FPL are excluded from Marketplace assistance if someone in their family is eligible for worker-only employer-based insurance deemed affordable to them.

[5] Lower claims denial rates will generally mean higher total amounts of claims paid. Higher spending on claims payments translates into higher premiums.

[6] If a public option or capped provider prices were available only in the nongroup market, these large price differences between the employer and nongroup markets could, at least theoretically, pressure more people to seek nongroup insurance coverage and decrease incentives for some employers to provide insurance. However, evidence shows the provider prices in nongroup insurance markets made competitive by Affordable Care Act reforms are considerably lower than prices in employer markets, yet employer-provided coverage has not decreased. The value of the tax subsidy provided for those with employer-based insurance, benefits tailored to worker preferences, frequently broader provider networks, and ease of enrollment seem to keep workers in their employer-provided policies.

[7] For example, the traditional Medicare program offers enrollees a very broad network of providers, even though it pays providers at rates below those of commercial insurers, because few providers can turn down the large volume of Medicare enrollees and their high average use of medical services.

[8] This approach is discussed in Fiedler (2020) and (2021).

[9] If, however, the premium tax credit benchmark plan were changed to gold (instead of the current silver) under broader reforms, platinum plans could be much more attractive, leading more private insurers to offer them.

[10] The precise incidence of premium taxes depends on elasticities of demand and supply, which may differ by market and geography.

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The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased

Trends in Health Insurance Coverage between March 2019 and April 2021

Michael Karpman and Stephen Zuckerman

August 2021

Rapid job losses in the early months of the COVID-19 pandemic raised fears that millions of people would lose their health insurance coverage and become uninsured (Banthin et al. 2020; Garfield et al. 2020; Garrett and Gangopadhyaya 2020). In previous recessions, laid-off workers who lost employer-sponsored insurance (ESI) faced limited coverage options through Medicaid and the private nongroup insurance market and the number of people uninsured increased (Holahan and Chen 2011). The Affordable Care Act (ACA) significantly expanded access to those options in 2014, driving the uninsurance rate to record lows (ASPE 2021; Obama 2016). And as the pandemic posed the first test of the post-ACA health insurance safety net during an economic downturn, Congress further supported access to coverage by not allowing disenrollment from Medicaid through the March 2020 Families First Coronavirus Response Act (Brooks and Schneider 2020).[1]

In this brief, we examine changes in health insurance coverage among nonelderly adults ages 18 to 64 during the pandemic using data from the Urban Institute's Health Reform Monitoring Survey (HRMS). Since it was launched in 2013, the HRMS has provided timely information on coverage before data from federal surveys become available (Long et al. 2014). Our analysis focuses on changes in coverage across three rounds of the survey: March 2019; March/April 2020, just after the pandemic caused a steep decline in employment; and April 2021, more than one year after the secretary of health and human services declared a national public health emergency on January 31, 2020. We estimate regression-adjusted changes for the national nonelderly adult population overall, by state Medicaid expansion status,[2] and by annual family income as a percentage of the federal poverty level

(FPL). We focus on adults with low incomes targeted by the ACA Medicaid expansion (with incomes at or below 138 percent of FPL) and adults with moderate incomes eligible for ACA Marketplace premium tax credits (with incomes between 139 and 399 percent of FPL).[3] We find the following:

- Between March 2019 and April 2021, the share of nonelderly adults reporting ESI declined from 65.0 to 62.3 percent, a decrease of approximately 5.5 million adults. The share reporting public coverage increased from 13.6 to 17.5 percent, an increase of approximately 7.9 million adults. The national uninsurance rate held steady at approximately 11 percent.
- The share of adults reporting public coverage increased between 2019 and 2021 in both states that had and had not expanded Medicaid under the ACA (hereafter called expansion and nonexpansion states). Such coverage increased from 14.9 to 19.2 percent in expansion states and from 10.7 to 14.3 percent in nonexpansion states.
- In Medicaid expansion states, the uninsurance rate was near 8 percent across all three study years. In nonexpansion states, the uninsurance rate was higher in 2021 (18.2 percent) than in 2020 (16.5 percent) and 2019 (17.2 percent), though the difference between 2019 and 2021 was not statistically significant. Adults in nonexpansion states were more than twice as likely as adults in expansion states to be uninsured in 2021 (18.2 percent versus 7.7 percent).
- Declines in ESI and increases in public coverage between 2019 and 2021 were concentrated among adults with low and moderate incomes. Uninsurance rates among the national nonelderly adult population did not change significantly for any income group examined.
- The share of adults with low incomes reporting public coverage increased in both expansion states (from 54.6 to 62.9 percent) and nonexpansion states (from 30.4 to 37.3 percent) between 2019 and 2021. More than one in three adults with low incomes in nonexpansion states (37.7 percent) were uninsured in 2021, compared with about one in seven of such adults in expansion states (14.5 percent).

Between 2019 and 2021, the rise in public coverage helped offset a decline in ESI, and unlike in previous recessions, the uninsurance rate did not change. Medicaid and, to a lesser extent, private nongroup insurance sold through the Marketplaces have provided many adults with coverage options following unprecedented job and income losses. However, more than 1 in 10 adults were uninsured in April 2021, including nearly 1 in 5 adults in nonexpansion states.

Maintaining the current uninsurance rate will require protecting coverage for current and prospective Medicaid enrollees as the economy improves and the disenrollment freeze is lifted (which is unlikely to occur before early 2022). Adults eligible for Medicaid may be at risk of having their applications or renewals erroneously rejected if states resume normal operations for reviewing eligibility too rapidly (Rosenbaum, Handley, and Morris 2021). Other adults will no longer be eligible for Medicaid when their incomes recover and will need to seek private coverage to remain insured. For those without access to affordable ESI, outreach efforts can raise their awareness of the enhanced premium tax credits for Marketplace plans made available under the March 2021 American Rescue Plan Act (Haley and Wengle 2021). States will also need to assess eligibility for subsidized Marketplace

coverage for people losing Medicaid eligibility after the public health emergency ends (Musumeci and Dolan 2021). Permanently extending the American Rescue Plan Act's enhanced tax credits could further reduce the number of uninsured people over the long term, and adults with moderate incomes would experience the largest decline in uninsurance (Banthin et al. 2021). Policymakers can also build on coverage gains under the ACA by addressing the persistently high uninsurance rates among adults with low incomes, particularly in nonexpansion states.

Results

Between March 2019 and April 2021, the share of nonelderly adults reporting ESI declined and the share reporting public coverage increased; the national uninsurance rate held steady.

Approximately 65 percent of nonelderly adults reported having ESI coverage in March 2019 and March/April 2020 (figure 1).[4] This share had declined to 62.3 percent by April 2021, when many adults remained out of work just over one year after the pandemic recession began.[5] The 2.7 percentage-point decline in ESI between 2019 and 2021 represents a decrease of approximately 5.5 million adults (95 percent confidence interval: 2.5 million, 8.5 million).[6] During this period, the share of adults reporting public coverage—including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other state or government plans based on income or disability[7]—increased from 13.6 percent in 2019 to 17.5 percent in 2021, representing an increase of approximately 7.9 million adults (95 percent confidence interval: 5.4 million, 10.4 million).[8]

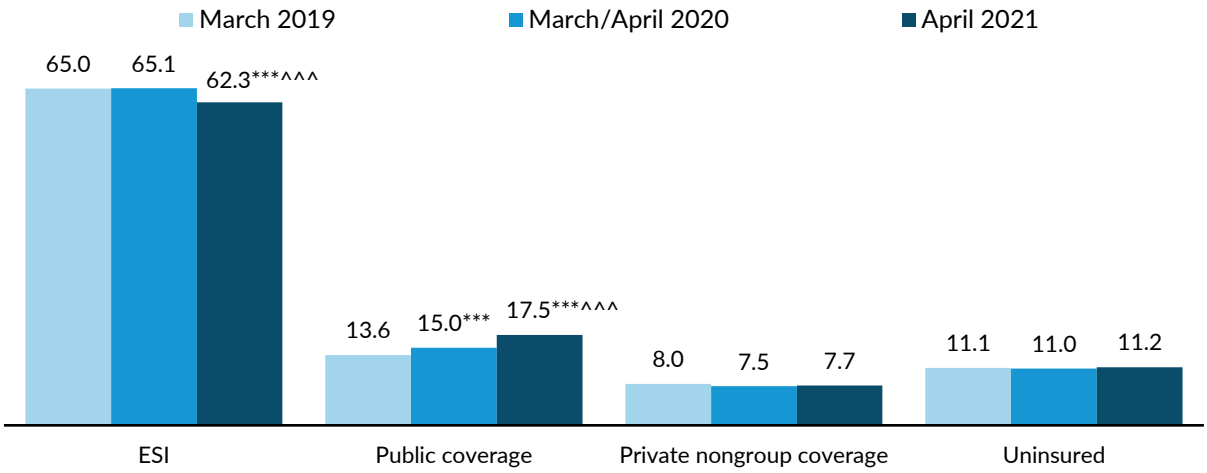
We did not observe a statistically significant change in private nongroup coverage, which approximately 8 percent of adults reported in each year and includes plans purchased through and outside the ACA Marketplaces.[9] But the share of adults with unspecified coverage (i.e., reporting the name of a comprehensive health plan but not the type of coverage) declined by 1.1 percentage points between 2019 and 2021.[10] The share of adults with unspecified coverage was also slightly higher in 2019 than in March 2018, suggesting an anomalous result in 2019 (data not shown). Despite the significant loss of ESI, the uninsurance rate held steady nationally at approximately 11 percent in each study year.

Net changes in ESI, public coverage, and private nongroup coverage do not fully capture the transitions across coverage types that may have occurred during the pandemic. Income losses made some adults eligible for Medicaid and others eligible for subsidized Marketplace coverage, regardless of whether they were previously covered by ESI. The lack of net change in nongroup coverage could indicate that new Marketplace enrollment among people who became eligible for premium tax credits was not large enough to offset transitions from Marketplace or non-Marketplace nongroup coverage to Medicaid. In addition, the sample size of the HRMS may not be large enough to detect statistical significance for the relatively small changes in Marketplace enrollment found in administrative data.

FIGURE 1

Health Insurance Coverage among Adults Ages 18 to 64, March 2019 to April 2021

Percent



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Source: Health Reform Monitoring Survey, March 2019 through April 2021.

Notes: ESI is employer-sponsored insurance. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type (2.3 percent in 2019, 1.4 percent in 2020, and 1.3 percent in 2021).

*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

The share of adults reporting public coverage increased in both Medicaid expansion and nonexpansion states.

As shown in figure 2, ESI coverage declined between 2019 and 2021 in expansion states (from 67.0 to 64.6 percent) and nonexpansion states (from 61.3 to 57.9 percent). But public coverage increased during this period in both groups of states, from 14.9 to 19.2 percent in expansion states and from 10.7 to 14.3 percent in nonexpansion states. These patterns are consistent with Centers for Medicare & Medicaid Services data showing rapid Medicaid enrollment growth in both expansion and nonexpansion states during the pandemic (Corallo and Rudowitz 2021; Khorrami and Sommers 2021).[11]

The higher rates of public coverage in expansion states than in nonexpansion states in both 2019 and 2021 largely reflect the former's more generous eligibility for Medicaid; nearly all adults living in expansion states with incomes below 138 percent of FPL are eligible.[12] In nonexpansion states, nondisabled, nonpregnant parents typically must have very low incomes to qualify for Medicaid (e.g., 17 percent and 18 percent of FPL in Texas and Alabama) and nonparents are ineligible.[13] The increase in reported public coverage in nonexpansion states over the study period was concentrated among the groups most likely to be eligible for Medicaid or CHIP.[14]

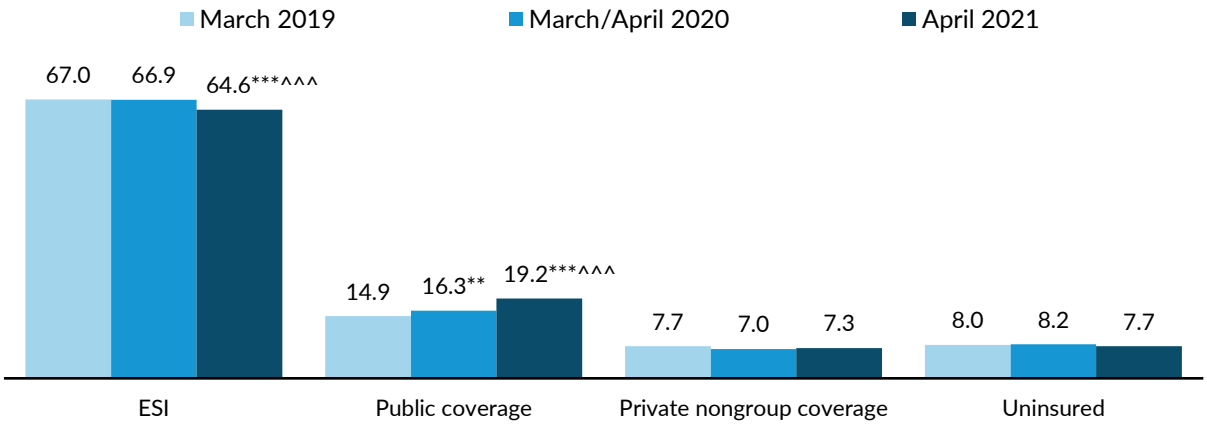
The uninsurance rate in Medicaid expansion states was approximately 8 percent between 2019 and 2021. In nonexpansion states, the uninsurance rate was higher in 2021 (18.2 percent) than in

2020 (16.5 percent) and 2019 (17.2 percent), though the difference between 2019 and 2021 was not statistically significant. As in prior years, adults in nonexpansion states were more than twice as likely as adults in expansion states to be uninsured in 2021 (18.2 versus 7.7 percent). However, differences in uninsurance are not entirely attributable to differences in Medicaid eligibility, because other factors (e.g., access to ESI, funding for outreach and enrollment assistance) likely affect coverage status.

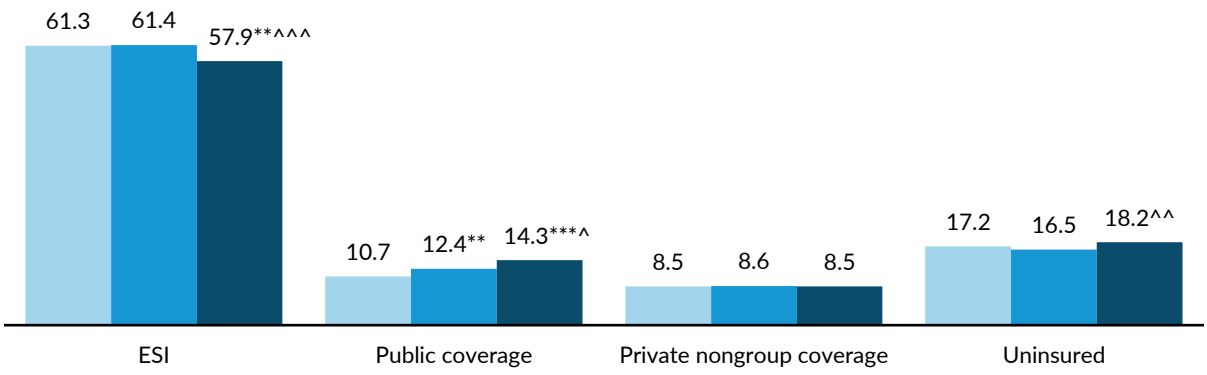
FIGURE 2

Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status, March 2019 to April 2021

Expansion states (%)



Nonexpansion states (%)



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Source: Health Reform Monitoring Survey, March 2019 through April 2021.

Notes: ESI is employer-sponsored insurance. Medicaid expansion states implemented expansions by April 2021. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type; these shares were 2.4 percent, 1.6 percent, and 1.3 percent in expansion states in 2019, 2020, and 2021 and 2.3 percent, 1.1 percent, and 1.2 percent in nonexpansion states in 2019, 2020, and 2021.

*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Declines in ESI and increases in public coverage between 2019 and 2021 were concentrated among adults with low and moderate incomes.

Adults with low and moderate incomes were hardest hit by the recession (Karpman, Zuckerman, and Kenney 2020)[15] and reported the largest declines in ESI over the study period. Among adults with past-year incomes at or below 138 percent of FPL, the share with ESI fell from 21.4 to 16.0 percent during this period (table 1). Among adults with incomes between 139 and 399 percent of FPL, the share with ESI fell from 64.5 to 60.0 percent. We did not find a statistically significant change in ESI among adults with incomes at or above 400 percent of FPL.

Increased public coverage among adults with low incomes, from 45.0 to 52.6 percent, and those with moderate incomes, from 9.7 to 14.3 percent, helped offset declines in ESI among these groups. Most adults must have incomes below 138 percent of FPL to qualify for Medicaid in expansion states, and eligibility in nonexpansion states is limited to parents with even lower incomes and generally nonexistent for nonparent adults. However, eligibility is based on current monthly income, meaning an adult whose annual family income in the past year was above the eligibility threshold may qualify if they experience a loss of income that places them below the threshold.

The uninsurance rate did not change significantly in any of the income groups examined. Nearly one in four adults with low incomes (23.7 percent) and about one in eight with moderate incomes (12.8 percent) were uninsured in April 2021.

TABLE 1

Health Insurance Coverage among Adults Ages 18 to 64, by Family Income, March 2019 to April 2021

Percent

Family income	March 2019	March/April 2020	April 2021
At or below 138% of FPL			
ESI	21.4	21.5	16.0***^^^
Public coverage	45.0	48.5**	52.6***^^
Private nongroup coverage	6.8	5.5	5.6
Uninsured	24.3	22.4	23.7
139–399% of FPL			
ESI	64.5	64.0	60.0***^^^
Public coverage	9.7	10.8	14.3***^^^
Private nongroup coverage	11.3	10.8	11.8
Uninsured	11.8	12.9	12.8
At or above 400% of FPL			
ESI	86.9	88.1	87.8
Public coverage	1.5	1.6	2.1**
Private nongroup coverage	6.1	5.8	5.3
Uninsured	3.6	3.5	3.7

Source: Health Reform Monitoring Survey, March 2019 through April 2021.
Notes: FPL is federal poverty level. ESI is employer-sponsored insurance. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type, which is between 1 and 3 percent across income groups and years.
*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.
^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

The share of adults with low incomes reporting public coverage increased in both Medicaid expansion and nonexpansion states between 2019 and 2021. More than one in three adults with low incomes in nonexpansion states were uninsured in 2021, compared with about one in seven of such adults in expansion states.

Among adults with incomes at or below 138 percent of FPL, the share reporting public coverage increased from 54.6 to 62.9 percent in Medicaid expansion states and from 30.4 to 37.3 percent in nonexpansion states between 2019 and 2021 (table 2). The uninsurance rate for adults with low incomes was statistically unchanged in both groups of states, but wide disparities by Medicaid expansion status persisted. In 2021, more than one in three adults with low incomes (37.7 percent) in nonexpansion states were uninsured, compared with about one in seven (14.5 percent) of such adults in expansion states. Adults with moderate incomes in nonexpansion states were nearly twice as likely as those in expansion states to be uninsured (17.8 versus 10.1 percent).

TABLE 2

Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status and Family Income, March 2019 to April 2021

Percent

	Expansion States			Nonexpansion States		
Family income	March 2019	March/ April 2020	April 2021	March 2019	March/ April 2020	April 2021
At or below 138% of FPL						
ESI	20.7	21.2	15.7***^^^	22.7	22.2	16.2*^^^
Public coverage	54.6	57.3	62.9***^^^	30.4	34.3	37.3**
Private nongroup coverage	5.3	3.7**	4.4	8.8	8.3	7.6
Uninsured	16.5	15.0	14.5	36.3	34.3	37.7
139–399% of FPL						
ESI	65.4	64.8	61.2**^^^	63.1	62.6	57.7***^^
Public coverage	11.4	12.2	16.6***^^^	6.2	8.0*	10.3***^
Private nongroup coverage	11.5	10.7	11.3	10.9	10.8	12.9
Uninsured	9.3	10.8	10.1	16.8	16.8	17.8
At or above 400% of FPL						
ESI	87.9	88.3	88.4	84.6	87.3**	86.4
Public coverage	1.3	1.5	2.1***	2.2	1.8	2.5
Private nongroup coverage	5.9	5.7	5.5	6.5	6.1	4.9*
Uninsured	2.9	3.2	3.0	4.9	4.2	5.3

Source: Health Reform Monitoring Survey, March 2019 through April 2021.

Notes: FPL is federal poverty level. ESI is employer-sponsored insurance. Medicaid expansion states implemented expansions by April 2021. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type, which is between 0 and 3 percent across income levels, state groups, and years.

*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

Despite losses of jobs, income, and ESI during the pandemic, the uninsurance rate did not change between March 2019 and April 2021. Increased public coverage helped counter ESI losses, protecting many adults from becoming uninsured both in Medicaid expansion and nonexpansion states. But in April 2021, the uninsurance rate in nonexpansion states was higher than it had been in March/April 2020 and was more than double the uninsurance rate in expansion states.

The growth in public coverage reflects several factors, including expanded Medicaid eligibility under the ACA that has strengthened the safety net in 37 states and the District of Columbia, the freeze on Medicaid disenrollment under the Families First Coronavirus Response Act, and the historic pattern of rising Medicaid enrollment during recessions (Corallo and Rudowitz 2021).[16] Assessing how each factor has affected coverage during the pandemic is beyond the scope of this brief. However, the study findings highlight several challenges and opportunities for protecting and expanding coverage in the near term.

Though the public health emergency and Medicaid disenrollment freeze will likely be extended at least until early 2022,[17] states will need to process a backlog of coverage renewals and redeterminations when the freeze is lifted (Musumeci and Dolan 2021). Resuming normal operations too quickly could lead to a surge in erroneously rejected applications and renewals, putting coverage at risk for people who are eligible for Medicaid (Rosenbaum, Handley, and Morris 2021). The Centers for Medicare & Medicaid Services recently issued updated guidance stating Medicaid eligibility and enrollment backlogs should be processed within 12 months of the end of the public health emergency.[18] The guidance also prohibits states from terminating Medicaid coverage for people deemed ineligible during the public health emergency until the state has completed an additional redetermination of eligibility after the emergency ends. Finally, under previous guidance from December 2020, the Centers for Medicare & Medicaid Services expected states to prioritize eligibility and enrollment actions for people most likely to no longer be eligible for coverage (Musumeci and Dolan 2021). The updated guidance requires states to consider how their approaches for processing these actions will ensure continuity of coverage for eligible people and limit delays for those who become newly eligible. State officials can begin preparing for the end of the public health emergency now and avoid terminating coverage based on outdated information for eligible enrollees, many of whom experienced disruptions to their employment and housing during the pandemic (Wagner 2020).

Medicaid enrollees whose incomes have risen above the eligibility threshold in their state will no longer qualify for coverage when the disenrollment freeze expires. If such adults lack access to affordable ESI, they will need to turn to the private nongroup market to remain insured. The temporarily expanded Marketplace premium tax credits under the American Rescue Plan Act will make Marketplace plans more affordable, but some adults may not be aware of the availability of zero-premium or low-cost plans. Outreach and enrollment assistance can help adults transition from Medicaid to Marketplace coverage and avoid disruptions in care (Haley and Wengle 2021). State agencies will also need to assess eligibility for subsidized Marketplace coverage and other insurance

affordability programs for adults who lose Medicaid eligibility after the public health emergency ends (Musumeci and Dolan 2021).

The American Rescue Plan Act increased the subsidy amounts of Marketplace premium tax credits, reducing the percentage of income people have to pay toward premiums, and expanded eligibility for premium tax credits to adults with incomes above 400 percent of FPL. If Congress does not extend these changes, they will expire at the end of 2022. Making the enhanced subsidies permanent could reduce the number of people uninsured in the longer term, and most of the coverage gains would occur among adults with moderate incomes (Banthin et al. 2021).

Policymakers can further reduce uninsurance by addressing the high uninsurance rates among adults with low incomes, particularly in the remaining Medicaid nonexpansion states, where more than one-third of adults with incomes at or below 138 percent of FPL are uninsured. The American Rescue Plan Act provides these states with new incentives to expand Medicaid by increasing the federal matching rate for regular (i.e., nonexpansion) Medicaid populations for two years (Musumeci 2021). If the nonexpansion states had adopted Medicaid expansion in 2020, 4.4 million fewer people would have been uninsured that year (Buettgens 2021). Federal policymakers are also considering approaches for closing the Medicaid coverage gap in states that have not expanded eligibility under the ACA.[19]

Additional health care reforms, ranging from incremental improvements to the ACA to more comprehensive approaches, can advance the US toward universal coverage, though they have different trade-offs in costs, provider payment rates, and disruptions to the existing health care system (Blumberg et al. 2019).

Data and Methods

This brief draws on data from the Urban Institute's Health Reform Monitoring Survey, a nationally representative, internet-based survey of adults ages 18 to 64. Launched in 2013, the HRMS provides timely information on health insurance coverage, health care access and affordability, and other health topics before federal survey data become available. For each round of the HRMS, we draw a stratified, random sample of nonelderly adults from Ipsos's KnowledgePanel, the nation's largest probability-based online panel. Members of the panel are recruited from an address-based sampling frame covering approximately 97 percent of US households, including those without internet access. If needed, panel members are given internet access and web-enabled devices to facilitate their participation.

For this analysis, we used data from the March 2019, March/April 2020, and April 2021 rounds of the HRMS. The 2019 round was fielded March 4 through 14; it had a sample size of 9,596 adults, and 91 percent completed the survey in the first week of fielding. The 2020 round was fielded March 25 through April 10; it had a sample size of 9,032 adults, and 75 percent completed the survey in the first week. And the 2021 round was fielded April 2 through 20; it had a sample size of 9,067 adults, and 82 percent completed the survey in the first week.

The 2019 round of the HRMS included an oversample of adults with incomes below 138 percent of FPL. In 2020, we changed the survey's design to include larger oversamples of adults in low- and moderate-income households, nonwhite and Hispanic/Latinx adults, and young adults. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population, based on benchmarks from the Current Population Survey and the American Community Survey. Participants can take the survey in English or Spanish, and the survey takes a median of 15 minutes to complete. The margin of sampling error, including the design effect, for the full sample of adults in the 2021 survey round is plus or minus 1.2 percentage points for a 50 percent statistic at the 95 percent confidence level.

Health Insurance Coverage Measures

In all rounds of the HRMS, respondents received a question, adapted from the American Community Survey, about their current health insurance coverage. Respondents could report more than one type of coverage, and those who did not report any coverage were asked to verify if they have health insurance. We used additional follow-up questions to determine whether respondents enrolled in their health plan through the Marketplace, whether they enrolled in a private plan through the Marketplace, whether they are covered under certain state programs, and the name of the health plan for their main source of coverage.

Because respondents could report more than one coverage type, we established a hierarchy of responses to assign coverage types so that coverage estimates sum to 100 percent: ESI/military coverage; public coverage, including Medicare, Medicaid, and CHIP; private nongroup coverage purchased through or outside the Marketplaces; and other unspecified coverage. To address the challenges associated with identifying health insurance coverage type in surveys (Call et al. 2013; Klerman et al. 2009; Pascale 2008; Pascale, Fertig, and Call 2019), we used a logical editing process to identify the most likely type of health insurance coverage held by respondents, based on the information they provided in the survey (Blavin, Karpman, and Zuckerman 2016). However, measurement error still occurs in survey estimates of coverage type, particularly in reports of private nongroup coverage (which can be purchased through government-run Marketplaces with public subsidies) and Medicaid coverage (which is often provided through private Medicaid managed-care plans).

Estimates from this brief are not directly comparable with estimates from HRMS analyses from before 2020 because of a change in the coverage editing process for respondents who reported having insurance but did not report a specific coverage type and who did not enroll in a health plan through the Marketplace. Under the previous approach, these respondents were identified as insured with an unspecified coverage type if they reported having a deductible. The updated approach only assigns unspecified coverage to these respondents if they report the name of a health plan that provides a valid form of comprehensive health insurance coverage. Based on this update, respondents reporting plans that do not offer comprehensive health insurance (e.g., health care sharing ministries) are considered uninsured, yielding slightly higher estimates of uninsurance in this brief than in

previous analyses of the HRMS. Under this updated coverage editing approach, estimates of the share of uninsured nonelderly adults in previous rounds of the HRMS would be 1 to 2 percentage points higher than under the previous approach. We applied the updated coverage editing process consistently for all years of data in this brief.

Analysis

Estimated changes in coverage are regression adjusted to control for any changes in the demographic and socioeconomic characteristics of respondents in each survey round not fully captured in the survey weights. This allows us to remove variation in coverage caused by changes in the observable characteristics of people responding to the survey over time. We control for measures used in poststratification of both the KnowledgePanel and the HRMS, including gender, age, race and ethnicity, primary language, educational attainment, marital status, presence of children in the household, household income, family income, homeownership status, internet access, urban/rural residence, and region. We also control for citizenship status and participation in the previous round of the survey. In presenting the regression-adjusted estimates, we use the predicted rate of each coverage measure in each year for the same nationally representative population. For this analysis, we base the nationally representative sample on respondents for the 2020 and 2021 rounds of the survey. We emphasize changes in coverage that are statistically different from 0 at the 5 percent level or lower and provide a 95 percent confidence interval for key estimates of changes in the number of adults with selected coverage types.

Limitations

This analysis has several limitations. First, studies have found significant measurement error in reported health insurance coverage type across surveys (Call et al. 2013; Klerman et al. 2009; Pascale 2008; Pascale, Fertig, and Call 2019). We attempt to mitigate this error using a logical editing process for coverage type that relies on multiple data elements (Blavin, Karpman, and Zuckerman 2016). Second, the probability-based internet panel underlying the HRMS does not cover some adult populations, including those who are homeless, are institutionalized, or do not speak English or Spanish. Third, the HRMS has a low cumulative response rate, and nonresponse bias is likely only partially mitigated by the survey weights. However, previous studies assessing recruitment for the panel from which HRMS samples are drawn have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008). Further, HRMS estimates of changes in coverage have been consistent with estimates from federal surveys with larger samples sizes, higher response rates, and stronger designs (Karpman and Long 2015). Finally, though nonresponse in federal surveys increased significantly during the pandemic (Dahlhamer et al. 2021; Rothbaum and Bee 2021), we find little change in nonresponse in the HRMS. Probability-based internet panels could potentially have more stable response patterns because panel members have previously agreed to participate in surveys. However, the impact of the pandemic on these types of surveys is not yet fully understood.

Notes

[1] The Families First Coronavirus Response Act has provided all states with a temporary increase in federal matching funds for Medicaid beneficiaries not in the ACA Medicaid expansion population. To receive the higher rate, states must follow several maintenance-of-effort requirements, including not disenrolling people from Medicaid unless they request termination of coverage or move to a different state. These provisions will remain in place at least until the end of the calendar quarter when the secretary of health and human services declares the end of the public health emergency.

[2] The states that did not expand Medicaid by April 2021 are Alabama, Georgia, Florida, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Wisconsin has used state funding to expand eligibility to nonelderly adults with incomes up to the FPL. In other nonexpansion states, parents generally must have very low incomes to qualify for Medicaid, and nonpregnant, nondisabled adults who are not parents living with dependent children are ineligible. In 2020, voters in Missouri and Oklahoma approved ballot initiatives to expand Medicaid by July 1, 2021. Oklahoma's expansion took effect as scheduled. However, the Missouri legislature did not provide funding for the expansion in the state budget, and the governor withdrew the state plan amendment for the expansion. On July 22, 2021, the Missouri Supreme Court ruled that the state must implement the Medicaid expansion. For this analysis, we treat Missouri and Oklahoma as nonexpansion states because they did not implement their expansions by April 2021.

[3] Under the American Rescue Plan Act, many people with incomes above 400 percent of FPL are eligible for premium tax credits, but expanded eligibility is set to expire after 2022.

[4] Coverage estimates often vary across surveys because of differences in survey design (Au-Yeung and Hest 2019). In this brief, we discuss statistically significant changes in coverage over the study period. Previous analyses have found HRMS estimates of coverage changes to be consistent with estimates from other surveys (Karpman and Long 2015).

[5] US Bureau of Labor Statistics, "The Employment Situation – May 2021," news release, June 4, 2021, https://www.bls.gov/news.release/pdf/empsit.pdf.

[6] We multiplied the estimated 2.7 percentage-point change in ESI between March 2019 and April 2021 by the projected number of adults ages 18 to 64 in 2021. We used national population predictions from the US Census Bureau stratified by race, ethnicity, and sex for people of all ages from 2016 to 2060, based on estimated birth, death, and net migration rates over the period. Using the "main series" file, we summed the 2021 population projections for all nonelderly adults to arrive at 203,018,143 such adults that year. See "2017 National Population Projections Datasets," US Census Bureau, February 20, 2020, https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html.

[7] In this brief, we combine Medicare, Medicaid, CHIP, and other government- or state-sponsored health plans into a single measure of public coverage because survey respondents may confuse the names of these coverage types (Pascale 2008). For a previous fact sheet based on data from the March/April 2020 HRMS and the Urban Institute's September 2020 Coronavirus Tracking Survey, we excluded Medicare from estimated changes in public coverage (Karpman and Zuckerman 2020). Estimates in this brief also differ slightly from estimates in that analysis because of differences in the survey weights and the regression adjustment, which we describe in the Data and Methods section.

[8] Administrative data show an increase of approximately 6 million adults enrolled in Medicaid between February 2020 and January 2021 in the 49 states and DC that report adult and child enrollment separately (Corallo and Rudowitz 2021). Differences between the HRMS estimates of changes in public coverage and administrative data for Medicaid enrollment may reflect several factors, including differences in the study period; inclusion of 18-year-olds as adults in the HRMS; inclusion of Medicare, CHIP, and state programs other than Medicaid in the definition of public coverage in the HRMS; survey sampling error; and measurement error in coverage type reported in the survey.

[9] The number of people selecting Marketplace plans increased from 11.4 million during the 2019 open enrollment period (November 1–December 15, 2018) to approximately 12 million during the 2021 open enrollment period (November 1–December 15, 2020). The Centers for Medicare & Medicaid Services reported

an additional 940,000 people enrolled in Marketplace coverage during the special enrollment period between February 15 and April 30, 2021, compared with 266,000 and 391,000 people who signed up through special enrollment periods based on qualifying life events during the same periods in 2019 and 2020. Though the 2021 special enrollment period was extended to August 15, about half of new enrollment during the period's original time frame (February 15–April 30, 2021) occurred in April. Thus, some of these enrollments may have occurred after the HRMS was fielded. See "2021 Open Enrollment Report," Centers for Medicare & Medicaid Services, accessed June 30, 2021, https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf; and "2021 Marketplace Special Enrollment Report," Centers for Medicare & Medicaid Services, May 6, 2021, https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-1.

[10] The shares of adults with an unspecified coverage type were 2.3 percent in 2019, 1.4 percent in 2020, and 1.3 percent in 2021.

[11] Joan Alker and Allie Corcoran, "What Is Happening with Medicaid Enrollment in Q1 of 2021?" *Say Ahhh*! (blog), Georgetown University Health Policy Institute, Center for Children and Families, May 21, 2021, https://ccf.georgetown.edu/2021/05/21/what-is-happening-with-medicaid-enrollment-in-q1-of-2021/.

[12] Noncitizens' eligibility for Medicaid depends on several factors, including whether they are lawfully present, considered qualified noncitizens based on their immigration status, and subject to the five-year waiting period after receiving qualified status. See "Coverage for Lawfully Present Immigrants," Centers for Medicare & Medicaid Services, accessed June 30, 2021, https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

[13] "State Health Facts: Medicaid and CHIP," Kaiser Family Foundation, accessed June 30, 2021, https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/.

[14] The increase in public coverage between 2019 and 2021 in nonexpansion states was concentrated among the group of adults most likely to be eligible for Medicaid or CHIP: 18-year-olds (who qualify for Medicaid or CHIP based on eligibility thresholds for children), adults living with children under 18 in the household (who potentially qualify as parents or caregivers), and adults in Wisconsin, which has used state funds to provide coverage to adults with incomes up to the FPL (data not shown). The increase in public coverage for other adults was statistically significant but small in magnitude.

[15] "Opportunity Insights Economic Tracker," Harvard University, accessed July 14, 2021, https://www.tracktherecovery.org/.

[16] Alker and Corcoran, "What Is Happening with Medicaid Enrollment in Q1 of 2021?" *Say Ahh!*.

[17] Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

[18] Daniel Tsai (deputy administrator and director, Centers for Medicare & Medicaid Services), letter to state health officials regarding, "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency," August 13, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

[19] Rachel Roubein and Alice Miranda Ollstein, "Plugging Obamacare's Biggest Hole Poses Dilemma for Democrats," *Politico*, July 10, 2021, https://www.politico.com/news/2021/07/10/obamacare-medicaid-coverage-gap-democrats-499013.

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Extending the American Rescue Plan Act's Enhanced Marketplace Affordability Provisions Could Benefit Nearly 1 Million Uninsured Children and Parents

Stacey McMorrow, Jessica Banthin, Matthew Buettgens, Michael Simpson, Genevieve M. Kenney, and Clare Wang Pan

October 2021

Signed into law in March 2021, the American Rescue Plan Act (ARPA) contained numerous provisions aimed at supporting recovery from the COVID-19 pandemic and associated recession.[1] Among these provisions are changes to the subsidy schedule governing access to financial assistance to purchase health insurance coverage in the Affordable Care Act (ACA) Marketplaces. These changes give Americans access to greater financial assistance purchasing coverage through 2022 and have the potential to reduce uninsurance and make coverage more affordable for those already purchasing nongroup coverage. Making these provisions permanent is a topline priority in Senate Democrats' fiscal year 2022 budget resolution.[2]

Though children were not the primary target of the ACA coverage expansions or subsequent efforts to strengthen the ACA, recent increases in children's uninsurance rates and the critical need to address unmet health needs and catch up on forgone care during the pandemic suggest that removing barriers to health care for children could be particularly important in the coming years (Alker and Corcoran 2020; McMorrow et al. 2020; Gonzalez, Karpman, and Haley 2021). These risks for children are also exacerbated by parents' rising uninsurance rates and pandemic-related unmet health needs (Gonzalez et al. 2020; Haley, Kenney, Wang Pan, et al. 2021).

Children may benefit from extending the ARPA's enhanced subsidies if they gain coverage or their parents gain coverage or experience premium or OOP cost savings (Wright Burak 2019). In this brief, we consider the impacts of extending the enhanced subsidies on all children and their parents and

children under age 6 and their parents. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we find the following:

- Nearly 1 million uninsured children and parents, including approximately 300,000 uninsured children, would gain insurance coverage if ARPA subsidy enhancements were made permanent.
- About 67,000 uninsured children who would gain coverage through these provisions would be under age 6, and approximately 267,000 uninsured parents who would gain coverage would have a child under age 6. This suggests even more young children could benefit when their parents gain coverage.
- Nearly two-thirds of the coverage gains for families would be concentrated among children and parents with incomes between 200 and 400 percent of the federal poverty level (FPL).
- If ARPA subsidy enhancements were made permanent, we project that about 3.3 million children and 6.3 million parents would remain uninsured in 2022, unless additional policy changes are introduced. Most remaining uninsured children would be eligible for Medicaid or the Children's Health Insurance Program, or CHIP (57.2 percent), or tax credits (13.6 percent). But about 41.2 percent of parents would be ineligible for subsidized coverage because of their immigration status or residence in a state that has not expanded Medicaid under the ACA; this represents approximately 2.6 million parents, including 636,000 uninsured parents who would become eligible for Medicaid if their state were to expand Medicaid under the ACA.
- Approximately 4.5 million children and parents who had nongroup coverage before the ARPA would experience household premium reductions of 28 percent per person, on average; those with incomes below 200 percent of FPL would save even more, 41 percent per person. Total household spending on premiums and OOP costs would fall by averages of 18 percent per person overall and 25 percent per person in families with income below 200 percent of FPL.

Background

The ACA expanded coverage options for millions of Americans, and though such options focused largely on childless adults, children's and parents' uninsurance also declined (Karpman et al. 2016). From 2013 to 2016, uninsurance fell from 7.0 to 4.3 percent among children and from 17.6 to 11.0 percent among parents (Haley, Kenney, Wang Pan, et al. 2021). In recent years, however, declines in children's and parents' uninsurance have stalled (Haley et al. 2019, 2020), and uninsurance increased for both groups in 2019 (Haley, Kenney, Wang Pan, et al. 2021). From 2018 to 2019, uninsurance increased from 4.8 to 5.2 percent among children and from 11.2 to 11.7 percent among parents.

Thus, many families with children faced precarious health care access and affordability as the COVID-19 pandemic and resulting recession took hold in 2020, and numerous families experienced additional economic and health challenges in the ensuing months. Many families with children lost jobs and incomes during the recession, but parents who kept working through the pandemic also faced

challenges related to child care safety and availability (Karpman, Gonzalez, and Kenney 2020). Both children and parents have reportedly faced significant mental health challenges during the pandemic (Hamel et al. 2020; Panchal et al. 2021), as well as forgone and delayed care (Gonzalez et al. 2020, 2021). As of now, no definitive estimates of the number of children and parents who lost health insurance coverage during the pandemic exist,[3] but several protections have likely prevented catastrophic coverage losses. Under the Families First Coronavirus Response Act, for example, states became eligible for an increase in federal Medicaid funding throughout the public health emergency, so long as they maintain eligibility for those enrolled on or after March 18, 2020. As the recovery continues and some of these protections expire, it will be critical for families to be able to access affordable coverage and care, especially given the urgent need for children and parents to catch up on care they missed during the pandemic. Moreover, both physical and mental health care needs for children and families may have increased because of the pandemic and the associated stressors of remote learning and social isolation.

The ARPA included numerous provisions with the potential to benefit families and children, including a child tax credit and efforts to make insurance coverage more widely available and affordable (Acs and Werner 2021; Wheaton, Giannarelli, and Dehry 2021). The changes to the Marketplace subsidy schedule were particularly important for children and parents, especially those whose families may have lost jobs and access to employer-sponsored insurance during the pandemic. Specifically, premium contributions for those with incomes below 150 percent of FPL were reduced to zero; required premium contributions were significantly reduced for those with incomes between 150 and 400 percent of FPL; and premium contributions were capped at 8.5 percent of income for people with incomes above 400 percent of FPL, who were previously ineligible for any subsidies (table 1). As under current law, people not meeting immigration requirements and those with access to an employer-sponsored plan deemed affordable under the ACA (i.e., with employee premiums at or below 9.8 percent of household income) would remain ineligible for subsidies under extended ARPA subsidies.

TABLE 1

Subsidy Schedules under Current Law and the American Rescue Plan Act, 2022

Premium contribution percentage-of-income limits for benchmark coverage

Income (% of FPL)	Before ARPA	Under ARPA
< 138	2.07	0.0–0.0
138–150	3.10–4.14	0.0–0.0
150–200	4.14–6.52	0.0–2.0
200–250	6.52–8.33	2.0–4.0
250–300	8.33–9.83	4.0–6.0
300–400	9.83	6.0–8.5
400–500	n/a	8.5–8.5
500–600	n/a	8.5–8.5
600+	n/a	8.5–8.5

Sources: Internal Revenue Service, Health and Human Services Department, and American Rescue Plan Act of 2021, Pub. L. No. 117-2.

Notes: FPL is federal poverty level. ARPA is American Rescue Plan Act. n/a is not applicable; people with incomes above 400 percent of FPL are ineligible for subsidies under current law. Percentage-of-income caps applied in 2022; current-law caps are for 2021 and indexed each year. Annual adjustments to caps have been modest and are not made until close to the end-of-year open enrollment period.

Children and their parents may benefit from these enhanced affordability provisions in at least three ways. First, uninsured children may gain coverage if subsidy enhancements allow families to newly purchase coverage for children. Second, uninsured parents may gain coverage with newly affordable options, and their already insured children may benefit from the associated health and financial improvements for their family (Wright Burak 2017). Finally, household spending on premiums would decline for families who already had nongroup coverage before the subsidy enhancements, which frees up resources for other needs. Understanding these effects will provide policymakers with insights for strengthening the health and financial well-being of children and families and identify remaining gaps in coverage affordability and accessibility.

Methods

We used the Urban Institute's Health Insurance Policy Simulation Model to produce the estimates in this brief. HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. Results from HIPSM simulations have been shown to be consistent with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

An earlier report modeled the effects of the ARPA's enhanced subsidies on coverage for the entire nonelderly population in 2022 (Banthin et al. 2021). That simulation assumed the ARPA's changes to the subsidy schedule were permanent and the changes were fully phased in by 2022. In other words, consumers, employers, and insurers in the model had fully adapted their decision making to the new schedule. Additional details on the 2022 HIPSM baseline estimates, including assumptions about the pandemic's economic effects, can be found in the earlier report.

In this brief, we present estimates from the same simulation for children and parents overall and young children and their parents. We describe changes in the coverage distribution for children and parents under the enhanced subsidy schedule, and we consider changes in premiums and OOP spending for families who had nongroup coverage before the ARPA. Children are those ages 18 and younger and parents are nonelderly adults (ages 19 to 64) with a child in their tax unit. We produce estimates for young children ages 5 and younger and their parents because of the importance of early childhood to future health and well-being.

This analysis has some limitations. First, assumptions about population, income, and health cost growth are always somewhat uncertain, but the additional uncertainty associated with the current economic recovery and frequently changing pandemic-related policies exacerbate the issue. For example, the current projections assume the Medicaid maintenance-of-effort provisions will expire in

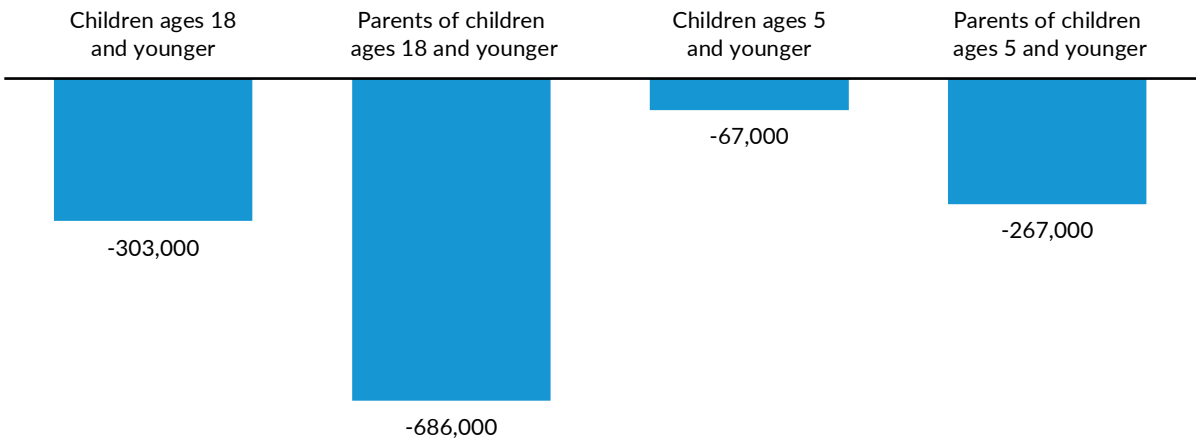
early 2022, and states have up to 12 months to complete the redetermination process.[4] It is impossible to predict how quickly individual states will work through verifications, redeterminations, and renewals, however, so Medicaid enrollment may be higher in 2022 than these estimates indicate. In addition, our definition of parents excludes noncustodial parents and some unmarried parents living together with their children but assigned to different tax units.

Results

If the ARPA's enhanced subsidies were made permanent, we find that the number of uninsured children would fall by approximately 303,000, and the number of uninsured parents would fall by about 686,000 (figure 1). The number of uninsured young children would fall by about 67,000, and about 267,000 parents of young children would gain coverage.

FIGURE 1

Change in the Numbers of Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: ARPA is American Rescue Plan Act.

Uninsurance rates would drop from 4.6 to 4.2 percent for children and from 10.8 to 9.8 percent for parents (table 2). The increases in private nongroup coverage, of 0.5 and 1.2 percentage points for children and parents, are the key drivers of the projected decline in uninsurance. Young children have somewhat lower uninsurance rates than children overall, whereas their parents have somewhat higher uninsurance rates than parents overall both before and under the permanent ARPA subsidy schedule. But, the projected effects of the subsidies on young children and their parents are similar to those for parents and children overall; for both groups, reductions in uninsurance under the ARPA would be largely offset by gains in private nongroup coverage.

TABLE 2

Coverage Distribution of Children and Parents before and under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

	Children ages 18 and younger			Parents of children ages 18 and younger		
	Before ARPA (%)	Under ARPA (%)	Percentage-point change	Before ARPA (%)	Under ARPA (%)	Percentage-point change
Employer	46.0	45.9	-0.1	60.2	60.0	-0.2
Private nongroup	1.7	2.2	0.5	4.8	6.0	1.2
Medicaid/CHIP	45.1	45.1	0.1	21.4	21.5	0.1
Other public	1.8	1.8	0.0	2.2	2.2	0.0
Noncompliant nongroup	0.8	0.7	-0.1	0.6	0.5	-0.1
Uninsured	4.6	4.2	-0.4	10.8	9.8	-1.1
	Children ages 5 and younger			**Parents of children ages 5 and younger**		
	Before ARPA (%)	**Under ARPA (%)**	**Percentage-point change**	**Before ARPA (%)**	**Under ARPA (%)**	**Percentage-point change**
Employer	42.1	42.1	0.0	55.9	55.7	-0.2
Private nongroup	1.3	1.7	0.4	4.1	5.2	1.1
Medicaid/CHIP	50.3	50.3	0.0	25.3	25.4	0.1
Other public	2.1	2.1	0.0	2.1	2.1	0.0
Noncompliant nongroup	0.7	0.7	-0.1	0.6	0.5	-0.1
Uninsured	3.4	3.1	-0.3	12.0	11.0	-0.9

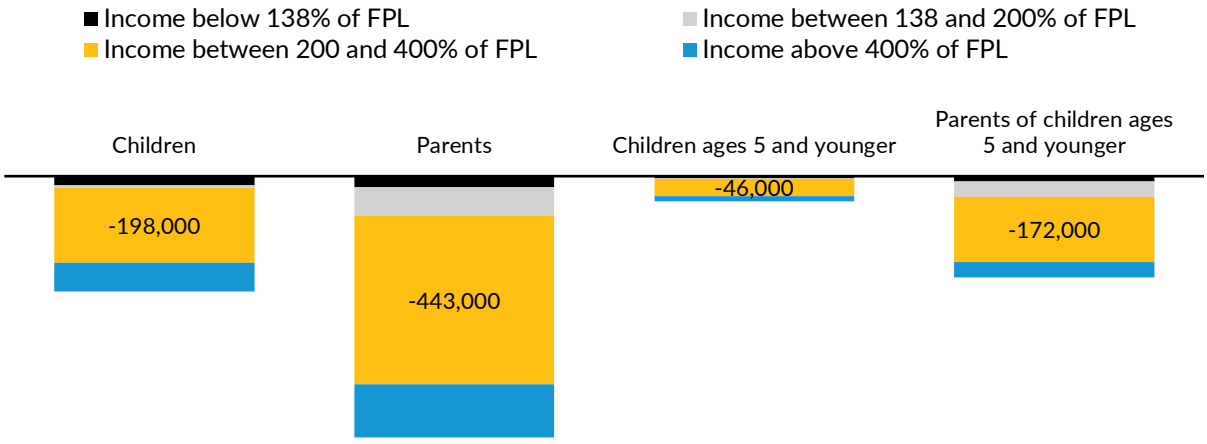
Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA is American Rescue Plan Act. CHIP is Children's Health Insurance Program. Estimates may not add to 100 percent because of rounding.

If the ARPA subsidies were made permanent, the declines in uninsurance would be concentrated among children and families with incomes between 200 and 400 percent of FPL (figure 2). Of the approximately 303,000 children who would gain coverage, about 198,000 would live in families with moderate incomes. About 443,000 of the 686,000 parents expected to gain coverage would have incomes in this range. An additional 75,000 children and 139,000 parents expected to gain coverage would have incomes above 400 percent of FPL. These patterns are similar for young children and their parents. However, compared with all parents, a slightly larger share of parents of young children gaining coverage would have incomes between 138 and 200 percent of FPL.

FIGURE 2

Change in the Numbers of Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022



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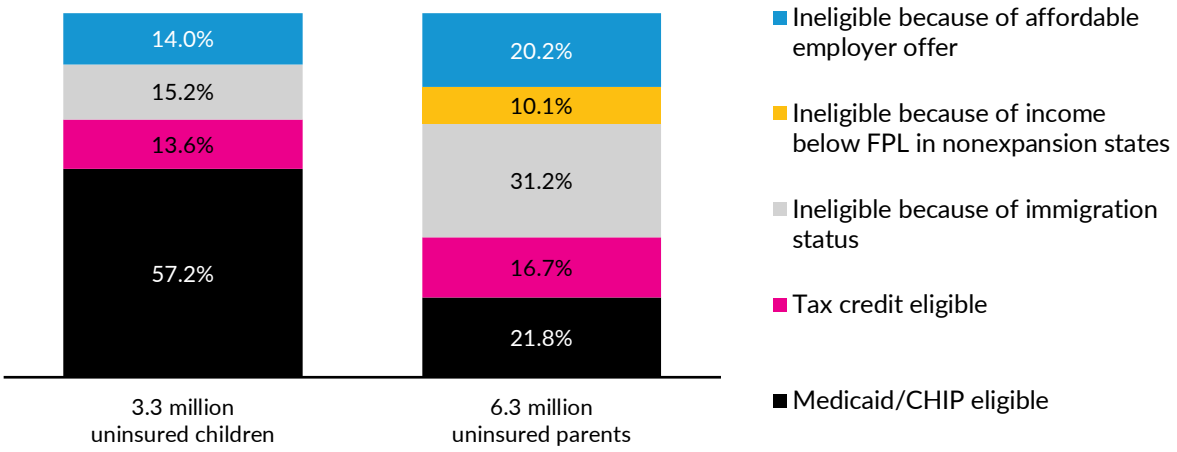
Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: FPL is federal poverty level. ARPA is American Rescue Plan Act. Income groups are based on calculations for Medicaid eligibility.

If the ARPA subsidy schedule were made permanent and no other coverage changes were enacted, we project 3.3 million children and 6.3 million parents would remain uninsured in 2022 (figure 3). Among the remaining uninsured children, we estimate about 57.2 percent would be eligible for Medicaid or CHIP coverage and another 13.6 percent would be eligible for Marketplace subsidies. About 29.2 percent of uninsured children would be ineligible for publicly subsidized coverage, including 15.2 percent ineligible because of their immigration status and 14.0 percent ineligible because they have access to an affordable employer offer of coverage.

FIGURE 3

Eligibility for Publicly Subsidized Coverage among Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022



URBAN INSTITUTE

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA is American Rescue Plan Act. FPL is federal poverty level. CHIP is Children's Health Insurance Program. Income groups are based on calculations for Medicaid eligibility.

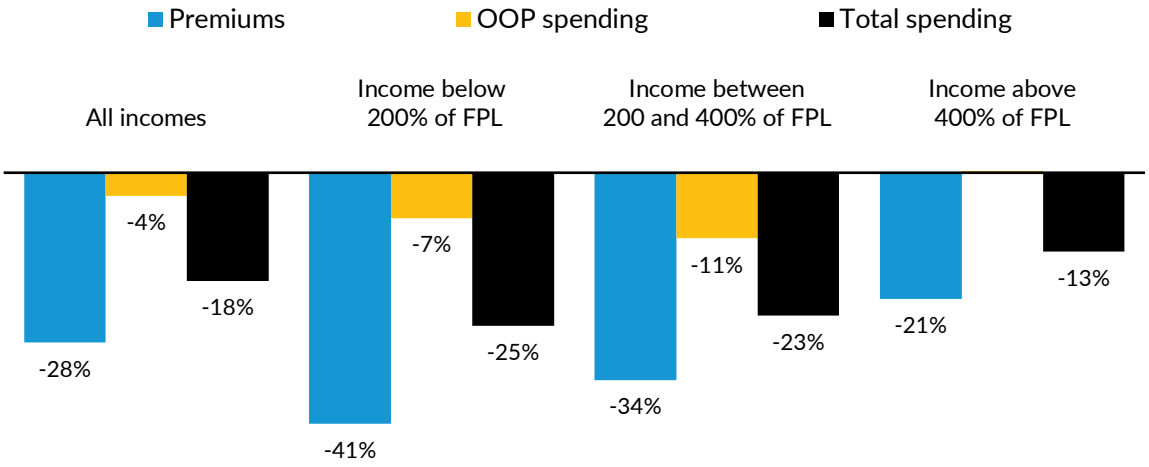
This distribution differs markedly for uninsured parents. Compared with more than 70 percent of uninsured children, only 38.5 percent of uninsured parents would be eligible for Medicaid/CHIP (21.8 percent) or Marketplace subsidies (16.7 percent). Nearly one-third of uninsured parents would be ineligible for publicly subsidized coverage because of their immigration status, and another 10.1 percent (or about 636,000 parents) would be ineligible for having income below the FPL in a state that did not expand Medicaid under the ACA. Finally, 20.2 percent of uninsured parents would be ineligible because they have access to an affordable employer offer. These patterns are quite similar to those for young children and their parents, except young children are far less likely to be ineligible because of their immigration status (data not shown).

Approximately 4.5 million children and parents who had nongroup coverage before the ARPA could also benefit from the enhanced subsidies through reductions in household premiums and OOP spending. Across all income groups, these families would experience an average reduction in premium spending of about 28 percent per person and an average reduction in OOP spending of 4 percent per person; the overall reduction in household spending would be 18 percent per person (figure 4). These cost savings would be larger for families with incomes below 400 percent of FPL. On average, families with incomes below 200 percent of FPL would experience a 41 percent reduction in premiums per person and a 7 percent reduction in OOP spending per person. Those with incomes between 200 and 400 percent of FPL would experience an average premium reduction of about 34 percent per person and an average OOP spending reduction of about 11 percent per person. Total household spending on premiums and OOP costs would decline by an average of 25 percent per person for those with

incomes below 200 percent of FPL and by 23 percent per person for those with incomes between 200 and 400 percent of FPL.

FIGURE 4

Change in Households' per Person Health Care Spending under a Permanent ARPA Marketplace Premium Subsidy Schedule among Families Who Had Nongroup Coverage before the ARPA, by Income Group, 2022



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA is American Rescue Plan Act. OOP is out-of-pocket. FPL is federal poverty level. Sample includes families in which at least one parent or child had nongroup coverage before the ARPA. Income groups are based on calculations for Medicaid eligibility. There is a small (0.3 percent) increase in OOP spending for families with incomes above 400 percent of FPL.

Discussion

This analysis finds that almost 1 million children and parents could gain coverage under extension of the ARPA Marketplace subsidy enhancements. These coverage gains would be concentrated among families with incomes between 200 and 400 percent of FPL and would likely improve access to needed care for children and parents in lower- and moderate-income families. In addition to those directly gaining coverage through the enhanced subsidies, many already insured children will likely benefit if their uninsured parents gain coverage. Evidence strongly suggests that parents having health insurance coverage has both health and economic benefits for children and families (Wright Burak 2017). Further, more than 4 million children and parents who had nongroup coverage before the ARPA could experience significant household premium and OOP cost savings, especially those with incomes below 400 percent of FPL.

Both children's and parents' uninsurance rates were increasing leading up to the pandemic (Haley, Kenney, Wang Pan, et al. 2021), and many families with children were struggling to meet health care and other basic needs (Karpman et al. 2018; Karpman, Kenney, and Gonzalez 2018). Since early 2020, pandemic-related job losses, fears of coronavirus exposure, and associated concerns have contributed

to continued problems accessing needed health care and affording food, housing, and other basic needs (Gonzalez et al. 2020, 2021; Gonzalez, Karpman, and Haley 2021; Karpman et al. 2020; Karpman, Gonzalez, and Kenney 2020). Though some of these concerns may ease as the pandemic recedes and the economy recovers, new complications will likely arise as pandemic protections run out and prepandemic inequities remain unchanged. Thus, making the enhanced ARPA subsidies permanent will provide much needed relief for many families struggling to afford health insurance and health care, and the additional cost savings may free up resources for other family needs.

Still, we project that more than 3 million children and 6 million parents would remain uninsured in 2022 even if the ARPA subsides were made permanent. Congress and the Biden administration are tackling several of the remaining barriers to coverage identified in this analysis. First, a federal program targeting people in the Medicaid coverage gap has been identified as a priority in Senate Democrats' fiscal year 2022 budget resolution.[5] Urban Institute estimates indicate that in combination with the extension of the ARPA subsidies, filling the Medicaid coverage gap would reduce the number of nonelderly uninsured people by 7.0 million, or about 2.8 million more than extending the ARPA subsidies alone (Banthin, Simpson, and Green 2021). Our analysis suggests an estimated 636,000 uninsured parents with incomes below the FPL in the 12 states that have not yet expanded Medicaid under the ACA would become eligible for subsidized coverage under the Democrats' proposed reforms.

Second, the Biden administration is committed to improving outreach and enrollment efforts to ensure people are aware of their eligibility for assistance and have the support needed to enroll.[6] In addition to the 2021 COVID-19 special enrollment period, which has resulted in at least 2.5 million new Marketplace enrollees,[7] the administration intends to expand the 2022 open enrollment period by 30 days and to invest $80 million in the navigator program. The latter will provide outreach and enrollment assistance targeted to people of color; rural communities; immigrant communities; people facing language, transportation, or internet access barriers; and other underserved populations. The administration has also proposed creating a special enrollment period for certain consumers with low incomes who may be eligible for the most generous Marketplace subsidies.[8] Taken together, these outreach and enrollment efforts could have meaningful impacts for the 70 percent of uninsured children and nearly 40 percent of uninsured parents who are already eligible for Medicaid or Marketplace tax credits.

Changing the employer affordability provision, which restricts otherwise eligible people from accessing Marketplace subsidies if they have access to an employer plan that costs the employee less than 9.8 percent of their household income, could affect about 20 percent of uninsured parents. One modest policy change would be eliminating the "family glitch," which restricts eligibility for subsidized coverage for the whole family even when the only affordable employer offer is for a single employee plan. Analyses of such a proposal have not found large effects on uninsurance, but they have found potential for household cost savings (Buettgens and Banthin 2021). To further reduce uninsurance for people affected by the employer affordability provision, however, lowering or eliminating the affordability threshold may be necessary.

Addressing immigration restrictions on receiving Medicaid and Marketplace subsidies will also be critical to closing coverage gaps, because almost one-third of uninsured parents are ineligible for publicly subsidized coverage because of their immigration status. Though the Biden administration reversed the Trump administration's changes to the public charge rule that made many immigrant families afraid to use public benefits for which they were eligible (Haley, Kenney, Bernstein, et al. 2021), further efforts to expand eligibility for affordable coverage to undocumented or otherwise ineligible immigrants will be needed to achieve universal coverage. Finally, children and families need far more than health insurance to thrive, so ongoing attention to paid leave, child care, and educational and income supports will also be critical to ensure all children and their families have the opportunity for healthy, stable futures.

Notes

1 American Rescue Plan Act, Pub. L. No. 117-2 (2021).

2 "FY2022 Budget Resolution Toplines," US Senate Democratic Leadership, August 9, 2021, https://www.democrats.senate.gov/imo/media/doc/Topline%20Summary%20of%20FY2022%20Budget%20Resolution.pdf.

3 Joan Alker, "Q: How Many Children Were Uninsured in 2020?" *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, August 10, 2021, https://ccf.georgetown.edu/2021/08/10/how-many-children-were-uninsured-in-2020/.

4 Daniel Tsai (deputy administrator and director, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services), letter to state health officials, regarding "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency," August 13, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

5 "FY2022 Budget Resolution Toplines," Senate Democratic Leadership.

6 Katie Keith, "ACA Round-Up: Navigator Grantees, GAO Investigation, Contraceptive Mandate, and More," *Health Affairs Blog*, September 1, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210901.961047/full.

7 Katie Keith, "Marketplace Special Enrollment Reaches 2.5 Million; Administration Announces Health Care Reconciliation Priorities," *Health Affairs Blog*, August 10, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210810.821428/full.

8 Centers for Medicare & Medicaid Services, "CMS Proposed Rule to Increase Americans' Access to Health Coverage for 2022," news release, June 28, 2021, https://www.cms.gov/newsroom/press-releases/cms-proposed-rule-increase-americans-access-health-coverage-2022.

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