

Building on the Affordable Care Act: The Effects on Coverage and Healthcare Spending of Enhancements to the ACA

Final Report

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KNG Health is a small, woman- and minority-owned business located in the Washington, DC metropolitan area.

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Executive Summary

As a result of the Affordable Care Act (ACA), millions of Americans have gained insurance coverage, resulting in the percent of people without insurance falling from 17.7 percent in 2010 to 10.8 percent in 2019. Despite the ACA's successes in reducing the number of uninsured, a third of non-elderly adults experienced a gap in coverage or were underinsured in 2018. In addition, the COVID-19 pandemic has resulted in millions experiencing health insurance coverage interruptions. On March 11, 2021, the American Rescue Plan Act (ARPA) was signed into law to provide a bridge for coverage until the economy recovers. The ARPA includes several temporary provisions to expand insurance coverage and increase its affordability. Supporters of expanding the ACA are seeking to make permanent some of the temporary provisions in the ARPA.

In this study, we estimate the effects of select ACA enhancements, including provisions similar to those in the ARPA. We use the KNG Health Reform Model (KNG-HRM), a microsimulation model used to estimate national and state-level impacts of healthcare reform proposals, to assess the potential impact of these policies on health insurance coverage and healthcare spending.

ACA Enhancements. We modeled the following modifications to the ACA:

1. **Expansion of Premium and Cost-sharing Support:** Eliminate “subsidy cliff” by expanding premium tax credits to those above 400% of Federal Poverty Level (FPL); increase premium tax credits and cost-sharing reductions; increase access to financial assistance to families with an offer or coverage from an employer by eliminating the “family glitch”.
2. **Restoration of ACA Features that Support Premium Affordability:** Establish permanent reinsurance program for Marketplace plans (\$10 billion per year) and increase funding for federal outreach and advertising for federally facilitated Marketplaces (\$100 million per year).
3. **Financial Assistance in States that Have Not Expanded Medicaid:** Extend federal premium tax credits and cost-sharing reductions to those below 100% of FPL and ineligible for Medicaid in a state that did not expand Medicaid (non-expansion state).
4. **Auto Enroll Low-Income Individuals into a Marketplace Plan:** Auto enroll low-income individuals into a no-premium Marketplace plan if eligible for such a plan and if individual is identifiable to the federal government (i.e., individuals who submit a federal tax form or receive food stamps).

Methods. We generated coverage and spending impacts using the KNG-HRM for individuals under the age of 65. The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choice. The model is primarily based on data from the U.S. Census Bureau's American Community Survey (ACS). For our baseline, we modeled the trajectory of coverage, spending and provider impacts from 2023 through 2032 under the current policies of the ACA, before the ARPA. We trended forward coverage, utilization and price changes using data from 2018 and

accounted for Census-projected demographic changes nationally and by state. We then compared our baseline findings to scenarios with a modified ACA.

We estimate healthcare utilization and spending for everyone in the ACS, based on an individual's demographics and imputed health status, including general health, presence of select chronic conditions, and disabilities. We adjusted healthcare utilization rates to account for lower utilization by the uninsured and the application of utilization management tools used by health plans. We convert healthcare utilization into spending by multiplying use rates by provider reimbursement rates, which varied across states and depended on whether an individual is uninsured, on non-group coverage, or on an employer-sponsored insurance plan. We scaled state-level spending estimates for those on employer-sponsored insurance (ESI) or non-group coverage to match external benchmarks.

The KNG-HRM model dynamically adjusts premiums to account for shifts in coverage decisions, prompting all individuals to reevaluate their coverage decisions. In the baseline, we establish premiums for only one non-group plan in each rating area, with the plan assumed to be at the silver-metal level. Premiums are calculated based on the expected plan liability in the rating area and inflated to account for administrative costs. We estimate average administrative cost loads (share of total expenditures by plans on administrative costs) for non-group plans using data from the Medical Loss Ratio data (<https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>). For employer plans, we used a national estimate of administrative load of 12 percent but varied this percentage based on the size of the firm.

To model ACA modifications, we identified individuals in our baseline who would be eligible for the expanded premium and cost-sharing support. We then applied these changes to our sample, calculated household premiums net of subsidies (employer or Marketplace as appropriate), new out-of-pocket spending, and utility under the modified ACA. For individuals in states that did not expand Medicaid as of January 2021, we extended Marketplace premium and cost-sharing support for those households between the states' Medicaid poverty threshold for eligibility and 100 percent of FPL and set this support at the same level as is available to households between 100 and 150 percent of FPL. Reinsurance reduces the insurer's total liability for health care spending. We assume that a \$10 billion fund would be available for states and that 85 percent of the \$10 billion will be available for health care payments in each year.

Finally, we assumed that half of the difference in the reduction in enrollment in federally facilitated Marketplace and state-based Marketplaces between 2016 and 2018 was attributable to the reduction in spending for advertising and outreach. We assumed that this number of individuals would move from being uninsured to obtaining Marketplace coverage with restoration of spending for advertising and outreach.

We modeled firms' decisions to offer coverage. We define the savings to the firm and its employees from dropping ESI as the difference in costs between a scenario where the firm offers coverage and a scenario where the firm drops coverage. If these savings exceed 7 percent of the firm's annual payroll, we assume the firm drops coverage.

Findings. We estimate that roughly 8.1 million (30%) and 9.6 million (34%) fewer people will be uninsured after the ACA enhancements in 2023 and 2032, respectively. Non-group coverage, principally through the ACA Marketplaces, absorbs the enrollment from both the uninsured and those previously enrolled in ESI, with non-group enrollment increasing from about 18 million to 42 million in 2023. This shift in coverage represents an increase from 6.7 percent to 15.7 percent of the population covered through a non-group plan after the ACA enhancements. In 2032, we estimate that non-group enrollment would grow by 33.8 million under the ACA enhancements (from 18.5m in baseline to 52.3m under enhanced ACA), accounting for 18.5 percent of all individuals in our study sample. In contrast, we project ESI coverage in 2023 to fall from 58.2 percent in the baseline to 52.1 percent after the ACA enhancements in 2023 and to continue falling to less than half of the population by 2032 (49.2 percent).

Under the modified ACA, total annual spending is projecting to be \$1.8 trillion in 2023 and grow to \$2.7 trillion by 2032. These estimates are similar to our baseline estimates. Spending for hospital care (inpatient, outpatient, and emergency room) remains relatively unchanged (\$110 billion increase over 10 years or slightly more than 1%), although more people received services. Over the ten-year timeline from 2023 to 2032, the mix of spending by source changes. Under the baseline, government spending on non-group coverage is projected to be approximately \$17 billion in 2023 and rise to \$28 billion in 2032. After the ACA enhancements, government spending on non-group coverage is projected to be \$139 billion in 2023 and increase to \$265 billion in 2032.¹ The increase in government spending is a result of greater enrollment on the Marketplace and increased generosity of the tax credits and cost-sharing subsidies for those between 100 and 400 percent of the FPL who were already enrolled in a Marketplace plan. We found that the increase in government spending from the ACA enhancements is predominantly going to low-income individuals and families that newly enroll in a Marketplace plan. Among those who switched from ESI coverage to non-group coverage, 86 percent were under 300-percent FPL and 49 percent were under 200-percent FPL. Among those who switched from being uninsured to non-group coverage, 94 percent were under 300-percent FPL and 77 percent were under 200-percent FPL.

Discussion. Under ACA enhancements as modeled, the number of uninsured would fall significantly. While ESI would remain the predominant source of coverage, the Marketplace would see significant growth in enrollment, because of take-up by those previously covered by ESI or uninsured. The reductions in the ESI market are, in part, due to fixing the family glitch. Those workers and their dependents who switch to a Marketplace plan can achieve better coverage that increases welfare.

¹ Because premiums for ESI are excluded from federal income and payroll taxes, tax revenue will increase as those on ESI switch to a Marketplace plan under ACA enhancements. These increases in tax revenue will offset some of the federal spending on premium tax credits. Government spending estimates in this report do not include these potential tax revenue offsets.

I. Introduction

As a result of the Affordable Care Act (ACA), millions have gained insurance coverage, resulting in the percent of people without insurance falling from 17.7 percent in 2010 to 10.8 percent in 2019.² Despite the ACA's successes in reducing the number of uninsured, a third of non-elderly adults experienced a gap in coverage or were underinsured in 2018.³ In addition, the percent of non-elderly people without insurance has steadily increased since reaching a historical low in 2016 (10%).¹ Observers have cited several potential reasons for the lack of further progress in expanding affordable coverage, including cuts in consumer outreach and advertising; expansion of non-ACA compliant association and short-term, limited-duration plans; and rising health insurance costs.

The COVID-19 pandemic has resulted in millions experiencing health insurance coverage interruptions, in large part because of lost access to employer-sponsored insurance (ESI).⁴ Official numbers for workers and dependents that have lost ESI are currently unavailable, but estimates for ESI losses from April 2020 to December 2020 range from 3.1 million to 27 million.⁵ Although some of those who lose ESI are eligible for Medicaid, many may face long-term challenges in paying for health insurance.

On March 11, 2021, the American Rescue Plan Act (ARPA) was signed into law to provide a bridge for coverage until the economy recovers. The ARPA includes several temporary provisions to expand insurance coverage and increase its affordability.⁶ First, the ARPA makes available premium tax credits for individuals above 400 percent of the Federal Poverty Level (FPL), by capping premiums as a share of income at 8.5 percent for all individuals for 2021 and 2022. Second, it temporarily increases the premium tax credits for individuals between 100 and 400 percent of FPL for the same two years. Third, the ARPA makes individuals who receive or are approved to receive unemployment benefits eligible for the maximum ACA premium tax credits and cost-sharing reductions for 2021. Supporters of expanding the ACA are seeking to make permanent some of the temporary provisions in the ARPA.

In this study, we estimate the effects of select ACA enhancements, including some provisions in the ARPA, on health insurance coverage and spending. We use the KNG Health Reform Model (KNG-HRM), a microsimulation model used to estimate national and state-level impacts of healthcare reform proposals.

² Rachel Garfield and Jennifer Tolbert. What We Do and Don't Know About Recent Trends in Health Insurance Coverage in the US. Kaiser Family Foundation. September 17, 2020. Accessed at <https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/>

³ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty. Health Insurance Coverage Eight Years After the ACA. February 7, 2019. The Commonwealth Fund. Accessed at <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

⁴ Josh Bivens and Ben Zipperer. Health insurance and the COVID-19 shock. August 26, 2020. Economic Policy Institute. Accessed at <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/>

⁵ Paul Fronstin and Stephen Woodbury. Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic? January 11, 2021. Commonwealth Fund blog. <https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic>.

⁶ Katie Keith. The American Rescue Plan Expands The ACA. Health Aff (Millwood). 2021 Apr 12:101377hlthaff202100597. doi: 10.1377/hlthaff.2021.00597. Epub ahead of print. PMID: 33844585.

We examine several changes to the ACA including expanding eligibility for premium tax credits and cost-sharing reductions and eliminating the family glitch.

II. ACA Enhancements

We examine the effects of several modifications to the ACA, all of which have either been included in the ARPA or have been proposed by policymakers. Our modeled changes to the ACA fall into four categories:

1. Expand premium and cost-sharing support;
2. Restore ACA features that support premium affordability;
3. Provide financial assistance to low-income people in non-expansion states; and
4. Auto-enroll select low-income individuals in a low-cost plan.

We summarize our modeled modifications to the ACA in Figure 1 and discuss these policy elements further in the sections below.

Figure 1. Modeled Enhancements to the Affordable Care Act

| Category | Policy |
|--|--|
| Expand Premium and Cost-Sharing Support | Eliminate “subsidy cliff” by expanding premium tax credits to those above 400% of FPL. |
| | Increase the generosity of the premium tax credits by capping premiums at a lower percentage of income for all income groups. |
| | Make available cost-sharing reductions to those with incomes between 250-400% of FPL; increase cost-sharing reductions for those between 200-250% of FPL. |
| | Eliminate the “family glitch” by using household premiums to assess affordability of an offer or coverage from an employer and tying affordability to cap on maximum premium as share of income. |
| Restore ACA Features that Support Premium Affordability | Permanent reinsurance program for Marketplace plans (\$10 billion per year). |
| | Funding for federal outreach and advertising on Marketplace (\$100 million per year). |
| Provide Financial Assistance to Low-Income People in Non-Expansion States | Extend premium tax credits and cost-sharing reductions to those below 100% of FPL and ineligible for Medicaid in state that do not expand Medicaid. |
| Autoenrollment | Automatically enroll in Marketplace plan for low-income individuals who would qualify for a no-premium Marketplace plan and who are required to submit a tax form or who receive food stamps. |

a. Expand Premium and Cost-sharing Support

The ACA provides for premium subsidies through tax credits (“premium tax credits”) to individuals with incomes between 100 percent and 400 percent of the FPL who enroll in a plan offered through the Marketplace. Individuals with an offer from an employer for “affordable” coverage that covers at least 60 percent of expected cost of plan benefits are not eligible for premium tax credits. In addition, individuals are not eligible for premium tax credits if they are eligible for coverage through Medicaid, Medicare, or another government program.⁷ Employer-sponsored insurance is deemed to be affordable if the cost for *self-only coverage* exceeds 9.78 percent (in 2020) of an individual’s *household income*. The rules to assess the affordability of ESI are sometimes referred to as the “family glitch” because it does not incorporate the higher cost of family coverage to an employee in determining whether ESI coverage is affordable.

Eligible individuals or households receive premium tax credits such that they pay no more than a fixed percent of their income on premiums (“premium cap”). In 2020, the premium caps (which are on a sliding scale) ranged from 2.06 percent of income for households with incomes at 100 percent of FPL to 9.78 percent for those at 400 percent. For states that expanded Medicaid, the premium caps effectively apply to those with incomes above 138 percent of FPL, because those with incomes between 100 and 138 percent of FPL would be eligible for Medicaid. For households beyond 400 percent of FPL, premium subsidies were unavailable. This policy is often referred to as the “subsidy cliff.”

People that are eligible for the premium tax credits may also qualify for cost-sharing reductions (CSRs), which can lower out-of-pocket spending through lower deductibles, copayments, and coinsurance. Under current law, a household must be eligible for premium tax credits and have an income between 100 and 250 percent of FPL to receive CSRs.⁸ To receive the CSRs, Marketplace participants must enroll in a Silver metal plan, which covers on average 70 percent of covered benefits (i.e., 70% actuarial value). In 2020, a household with access to the CSRs could obtain a plan with an actuarial value of 94 percent (100-150% of FPL), 87 percent (150-200% FPL), or 73 percent (200-250% FPL).

We simultaneously modeled the effects of four enhancements that would expand access to premium tax credits and increase the generosity of financial assistance through lower premium caps and greater CSRs (Figure 2). First, we eliminated the subsidy cliff by expanding the premium tax credits to those above 400 percent of the FPL. Second, we modeled lower premium caps for income groups below 400 percent of the FPL. Under these modifications, premium caps range from 0 percent of income for those at 100 percent of FPL to 8.5 percent for those with incomes above 400 percent of the FPL. We established these premium caps based on H.R. 1425 - Patient Protection and Affordable Care Enhancement Act, which was passed by the U.S. House of Representative on June 29, 2020. Our premium caps modeled are similar to those under the ARPA, with the only differences occurring for those between 150 and 250 percent of

⁷ Kaiser Family Foundation. Explaining Health Care Reform: Questions About Health Insurance Subsidies. January 16, 2020. Access at <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>

⁸ Under the ARPA, there is a 2021 exception for those who received or will receive unemployment benefits. These individuals are eligible for the maximum premium tax credits and cost-sharing reductions.

FPL.⁹ Third, we modeled greater CSRs (in terms of actuarial value) for those between 200 and 400 percent of the FPL. Fourth, we eliminated the “family glitch” by defining an ESI offer as unaffordable if the premium to be paid by a worker for household coverage exceeded 8.5 percent of household income.

Figure 2. Modeled Enhancements to the Affordable Care Act: Premium Caps and Cost-Sharing Reductions

| Income Range | Premium Caps as a Percentage of Household Income | | Cost-Sharing Reductions |
|---------------------------|--|---------------|-------------------------|
| | Initial Premium | Final Premium | Actuarial Value |
| 100 to 150 Percent of FPL | 0.0 | 0.0 | 94% |
| 150 to 200 Percent | 0.0 | 3.0 | 87% |
| 200 to 250 Percent | 3.0 | 4.0 | 80% |
| 250 to 300 Percent | 4.0 | 6.0 | 80% |
| 300 to 400 Percent | 6.0 | 8.5 | 80% |
| 400 Percent and Higher | 8.5 | 8.5 | 70% |

Notes: FPL = Federal Poverty Level; Actuarial Value = the percentage of total average costs for covered benefits that a plan will cover.

b. Restoration of ACA Features that Support Premium Affordability

We modeled two changes to the ACA intended to support premium affordability and expand coverage: (1) a reinsurance program; and (2) enhanced spending on outreach and advertising. Reinsurance helps health plans off-load a portion of payments for very high-cost members, which has the potential to lower premiums offered on the Marketplace. During the period 2014 to 2016, the ACA had a national reinsurance program, whereby the federal government would cover (at least part of) the cost of extremely costly claims in order to stabilize premiums. Since the end of the federal program, several states have established their own reinsurance programs for plans on the Marketplace. We modeled a permanent reinsurance program for plans on the Marketplace. We assume the program has \$10 billion per year (an amount equivalent to reinsurance funds available under the ACA in 2014) to cover a share of high-cost claims and reduce premiums.

Federal and state governments spend funds on consumer outreach and advertising to support enrollment in the Marketplace plans. Such activities foster enrollment and may also help keep premiums low by encouraging the enrollment of younger and healthier people.¹⁰ Between 2016 and 2020, the federal government curtailed spending on federally facilitated Marketplace advertising and outreach, including for navigators to help consumers identify Marketplace health coverage options and complete eligibility and enrollment forms. According to Kaiser Family Foundation, Navigator funding in the federally facilitated Marketplace was reduced from \$63 million (in 2016) to \$10 million (in 2019 and 2020), with

⁹ The ARPA established premium caps on a sliding scale ranging from 0% to 2% for those between 150% to 200% of FPL, and 2% to 4% for those between 200% and 250% of FPL.

¹⁰ Peter V. Lee, Vishaal Pegany, James Scullary and Colleen Stevens. MARKETING MATTERS: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets. September 2017. Covered California. Accessed at https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf

many counties without Navigator services. Funding for advertising during open enrollment was also reduced to \$10 million annually starting in 2017, down from \$100 million in 2016. H.R. 1425 would provide for \$100 million annually for ACA outreach and public education. The Biden Administration has increased spending for Marketplace outreach and advertising to promote the special enrollment period allowed during the COVID-19 Public Health Emergency. We modeled the impact of this level of annual funding for outreach and advertising in support of the federally facilitated Marketplace.

c. Financial Assistance in Non-expansion States

As of January 2021, twelve states have not implemented Medicaid expansion, which extends Medicaid eligibility to those earning up to 138 percent of the FPL. While the federal government cannot force those states to expand Medicaid (non-expansion states), it has tools it could use to encourage states to expand or it could bypass states altogether. The ARPA includes provisions that would create financial incentives to expand Medicaid by offering greater federal funds for states that newly expand Medicaid. An alternative approach that bypasses state decisions is to offer premium tax credits and CSRs to those who are below 100 percent of the FPL in non-expansion states.¹¹ Following this approach, in states that did not expand Medicaid, we extended access to premium free Marketplace plans with an actuarial value of 94 percent to households with incomes falling between a states' Medicaid poverty threshold for eligibility and 100 percent of FPL (See Figure 2; we establish premium caps and actuarial value at the same levels as available to individuals between 100% and 150% of FPL).

d. Autoenrollment

We modeled an autoenrollment policy such that all uninsured households that receive government assistance for food (food stamps) or have income high enough to require them to submit a tax form and would face a \$0 non-group premium (after subsidy) would be auto-enrolled in a Marketplace plan. Our assumptions are based on the idea that autoenrollment would be built on existing systems that would allow the identification and enrollment of low-income individuals into a Marketplace plan.

III. Methods

We generated coverage and spending impacts using the KNG-HRM for those who are either uninsured, who receive coverage through an employer, or who receive coverage through a non-group plan (e.g., a Marketplace plan). We excluded Medicaid, Medicare, and other government coverage from the analyses, as we assume no effect on these populations. A detailed description of the KNG-HRM is available in an online technical appendix.¹² We compared projected outcomes of the ACA under current law (baseline ACA) and under our modified or enhanced ACA. For our baseline, we modeled the trajectory of coverage,

¹¹ For a prior example of modeling this policy see the Urban Institute's study on various health reform options at. <https://www.urban.org/research/publication/incremental-comprehensive-health-reform-how-various-reform-options-compare-coverage-and-costs>

¹² <https://www.knghealth.com/kng-health-develops-health-reform-model/>

spending and provider impacts for 2023 and 2032 under the current policies of the ACA.¹³ We trended forward coverage, utilization and price changes using data from 2018 and accounted for Census-projected demographic changes nationally and by state. We then compared our baseline findings to scenarios with a modified ACA. In this section, we briefly review key methods underlying the KNG-HRM.

a. Overview of KNG-HRM

The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choice. The model is based on data from the U.S. Census Bureau’s American Community Survey (ACS), with significant inputs from the U.S. Agency for Healthcare Research and Quality’s Medical Expenditure Panel Survey (MEPS), the U.S. Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), and other sources.^{14,15,16} In our model, individuals consider several coverage decisions, maximizing utility for their “health insurance unit (HIU).” Changes from status quo policy result in a dynamic, iterative process with HIUs selecting new coverage choices and premiums being recalculated until a new equilibrium is reached. An individual’s utility is a function of healthcare consumption; out-of-pocket spending including premiums, cost-sharing reduction subsidies and tax credits; and variance in out-of-pocket spending (to capture the value of insurance to mitigate risk of unexpectedly high healthcare expenditures). For HIUs where the predicted choice differed from the observed choice, we calibrated the utility function by adding a preference term to the observed baseline coverage choice of the HIU. We retained these preference terms as part of the utility function under the ACA enhancements modeled.

Estimating Healthcare Utilization and Spending. We estimated healthcare utilization and spending for everyone in the ACS, based on an individual’s demographics and imputed health status, including general health, presence of select chronic conditions, and disabilities. We estimated a series of zero-inflated Poisson (ZIP) regressions using the MEPS with healthcare use as the dependent variable (number of prescription medications, hospital discharges, outpatient department physician visits, office-based physician visits, and emergency room visits). We included age, race, gender, geographic region, household size, perceived health status, smoking status, chronic condition indicators, and disability indicators as explanatory variables. We then evaluated the regression model estimated in MEPS for each respondent in the ACS to develop estimates of healthcare use by service category.

Based on findings from the Oregon Health Insurance Experiment (OHIE), we lowered healthcare utilization for the uninsured population. We also assume those enrolled in health maintenance organizations (HMOs) or point-of-service (POS) plans have 2.5-percent lower utilization than preferred

¹³ The American Rescue Plan Act provides for temporary changes in ACA coverage. All the enhanced premium tax credits and expanded access to the credits and CSR are set to expire by 2023, the first year of our simulation.

¹⁴ American Community Survey. US Census Bureau. Accessed at <https://www.census.gov/programs-surveys/acs/>

¹⁵ Medical Expenditure Panel Survey. Agency for Healthcare Research and Quality. Accessed at <https://meps.ahrq.gov/mepsweb>.

¹⁶ Behavioral Risk Factor Surveillance System. US Center for Disease Control and Prevention. Accessed at <https://www.cdc.gov/brfss/index.html>.

provider organization (PPO) enrollees, and that those enrolled in high-deductible plans (HDPs) have 5-percent lower utilization than PPO enrollees.

We converted healthcare utilization into spending by multiplying use rates by prices. Commercial insurer prices were obtained from publicly available data from the Health Care Cost Institute (HCCI). We developed comparable Medicare prices using studies from the Congressional Budget Office (CBO) and other sources that compare commercial provider payment rates to Medicare. In addition, we allowed both commercial and Medicare prices to vary geographically. For commercial prices, we used the HCCI Healthy Marketplace Index (HMI) to develop a commercial price index by geographic area and imputed an index value for geographic areas not included in the HMI. To account for geographic and provider variation in Medicare prices, we used the input price and policy adjustments under the Medicare fee schedules (e.g., wage index, indirect medical education, and geographic practice cost index).

We recognize that our price and utilization estimates are approximations that may differ from those experienced by consumers on either ESI or insured through the non-group market. Therefore, we scaled spending to match external benchmarks for ESI and Marketplace premiums (see calculation of premiums discussed below). Specifically, we calculated a scaling factor for ESI prices and utilization such that our ESI premiums match the average state premiums in MEPS¹⁷. Similarly, for marketplace premiums, we calculated a scaling factor based on premiums found on the Marketplaces, and scale prices and utilization to match the benchmark exchange premiums.

There are limited data available on prices paid by uninsured populations. People without health insurance coverage are often billed charges, but then receive discounts through charity care programs. Following analyses of the AHA Annual Survey data for hospital services and estimates in the literature, we assumed that the uninsured pay rates comparable to Medicare for hospital services and rates comparable to commercial payers for other services.^{18,19}

Setting Premiums. Coverage decisions are made to maximize utility for the HIU. When new policies or events upset the status quo equilibrium, individuals change their coverage category, leading to shifts in the average healthiness of local risk pools. The model dynamically adjusts premiums to account for these shifts, prompting all individuals to reevaluate their coverage decisions. When a new equilibrium is reached, we observe coverage decisions and premiums. In the baseline, we establish premiums for one non-group plan in each rating area, with the plan assumed to be at the silver-metal level. For small employers (fewer than 50 employees), we also established premiums by pooling all employees within a state at small firms together. However, large firms are experience-rated, where we established premiums based on those employees and family members enrolled in each firm's plan. Premiums are calculated based on the expected plan liability in the rating area and inflated to account for administrative costs. We

¹⁷ https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2019/tiic1.htm

¹⁸ Melnick and Fonkych. Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices? Health Affairs. 2008. Accessed at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.w116>.

¹⁹ Gruber and Rodriguez, How Much Uncompensated Care Do Doctors Provide? Journal of Health Economics. 2007. Accessed at <https://economics.mit.edu/files/6423>.

assumed an administrative burden of 12 percent, based on private health insurance expenditure estimates reported in the National Health Expenditure Accounts. We adjusted non-group premiums to reflect a “silver loading” effect based on estimates of marketplace premiums across metal levels, as reported by Kaiser Family Foundation. Family premiums are assigned using the Marketplace age- and tobacco-rating rules.

Projections. We used information on demographic trends from the U.S. Census Bureau, which reports population projections by combinations of single year of age, sex, race, Hispanic status, and native status.²⁰ We also adjusted spending and income in future years, relying on National Health Expenditure Account projections to inflate healthcare spending and CBO’s projections of CPI-U to project income.²¹

b. Modeling a Modified ACA

To determine the effects of modeled ACA modifications, we recalculated plan, employer, and household premium responsibilities and out-of-pocket expenses. We briefly described our approach in each of the policy areas discussed in Section II.

Expanded Premium and Cost-sharing Support. We identified individuals in our baseline who would be eligible for the expanded premium and cost-sharing support. We then applied these changes (shown in Figure 1) to our sample, calculated household premiums net of subsidies (employer or Marketplace as appropriate), new out-of-pocket spending, and utility under the modified ACA. Individuals were then put through the simulation model and assigned a coverage option. We then recalculated premiums and repeated the process until the model converged (i.e., coverage stabilized).

Restoration of ACA Features that Support Premium Affordability. Reinsurance reduces the insurer’s total liability for health care spending. In scoring H.R. 1425, the CBO assumed that most states would use the money to fund a reinsurance program.²² As of August 2019, seven states were already operating reinsurance programs for the non-group insurance market. CBO estimated that approximately 70 percent of funds for these state reinsurance programs were available to reduce premiums in the first year of the programs, with the balance presumably used to set up the programs and administer them, and that this share would rise over time.

We assumed under our modified ACA model that a \$10 billion fund would be available for states to either establish or continue to fund (if already established) a reinsurance program. We assumed that 85 percent of the \$10 billion will be available for health care payments in each year. We reduced non-group

²⁰ 2017 National Population Projections Datasets. U.S. Census Bureau. Accessed at <https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html>.

²¹ www.cbo.gov/publication/56020

²² CBO. Estimated Effect on the Deficit of Rules Committee Print 116-56, the Patient Protection and Affordable Care Enhancement Act. Accessed at https://www.cbo.gov/system/files/2020-06/Patient_Protection_and_Affordable_Care_Enhancement_Act_0.pdf

premiums by \$8.5 billion divided by total non-group premiums.

According to Kaiser Family Foundation, Navigator funding in the federal-based Marketplaces was reduced from \$63 million (in 2016) to \$10 million (in 2019 and 2020), with many counties without Navigator services. In addition, CMS reduced funding for outreach/advertising during open enrollment to \$10 million annually starting in 2017, down from \$100 million in 2016. There is limited empirical data demonstrating the impact of outreach and advertising on enrollment. What evidence does exist is generally supportive of the idea that advertising, public outreach, and consumer assistance increase participation. Between 2016 and 2018, enrollment in federally facilitated Marketplace (FFM) fell by 10 percent, while enrollment in state-based Marketplaces (SBMs) held steady or even increased.²³ The SBMs are responsible for their own advertising, consumer assistance, and public outreach efforts. While there are other factors that explain the divergent performance of FFM and SBMs, some of this performance difference can be associated with differences in support for marketing, consumer assistance, and public outreach.

We assumed that half of the difference in the reduction in enrollment in FFM and SBMs between 2016 and 2018 was attributable to the reduction in spending for advertising and outreach. This increases our target number of Marketplace enrollees by approximately 400,000 individuals.

Financial Assistance to Low-income People in Non-expansion States. For individuals in states that did not expand Medicaid as of January 2021, we extended Marketplace premium and cost-sharing support for those households between the states' Medicaid poverty threshold for eligibility and 100% of FPL, and we set this support at the same level as is available for households between 100 and 150 percent of FPL. We identified individuals in our baseline who would be eligible for the expanded financial assistance in non-expansion states. We then applied these changes to our sample and included them in our simulation of the modified ACA.

Modeling Employer Offer Decisions. To model firm behavior, we evaluated premiums, out-of-pocket costs, financial penalties, and other costs (see Figure 3). We defined the savings to a firm and its employees from dropping coverage as the difference in costs between a scenario where the firm offers coverage and a scenario where the firm drops coverage. If these savings exceed a minimum savings threshold, we assumed the firm drops coverage. We established each firm's minimum savings threshold (i.e., the minimum savings needed for a firm to drop coverage) at 7 percent of its annual payroll. Under our ACA enhancements, we modeled employer decision to offer coverage as an iterative process. Once HIUs choose a coverage category and premiums are reset, we recalculated firm decision to offer coverage based on updated premiums. If a firm drops coverage, we excluded the option to enroll in an employer-sponsored plan from HIU choice set. For employers who did not offer insurance in the baseline, we did not allow them to begin offering under the ACA enhancements.

²³ Jane M. Zhu, Daniel Polsky, and Yuehan Zhang. State-Based Marketplaces Outperform Federally-Facilitated Marketplaces. Analysis of premiums, enrollment, and insurers from 2016-2018. March 21, 2018. Volume 22; Issue I. Penn LDI Issue Brief. <https://ldi.upenn.edu/brief/state-based-marketplaces-outperform-federally-facilitated-marketplaces>.

Figure 3. Description of Components in Firm Cost Model

| Cost Component | If the employer maintains coverage... | If the employer drops coverage... |
|---|--|--|
| Premiums for workers and dependents, net of subsidy | The sum of: <ul style="list-style-type: none"> • The employee’s and employer’s share of ESI premiums for those taking up ESI coverage, reduced by the enrolling family’s marginal tax rate; and • Net premiums for those opting out of ESI coverage. | Marketplace net premiums for all workers and dependents. |
| Out-of-Pocket Costs | Out-of-pocket health costs for workers and dependents either participating in the ESI plan or receiving coverage through non-group coverage. | Out-of-pocket health costs for workers and dependents receiving coverage through non-group coverage. |
| Financial Penalties | None. | For applicable large firms, shared responsibility payment per the ACA. |
| Other Costs | The internal HR administrative burden of offering coverage. | None. |

IV. Findings

a. Coverage

We estimated coverage for 2023 and 2032 using the pre-ARPA policies as our baseline. In 2023, the projected US population under the age of 65 is 271 million (Figure 4). In 2023, we estimated that slightly more than 58 percent of the non-elderly population will receive coverage through an employer, and approximately 7 percent and 10 percent will be either covered under a non-group plan or uninsured, respectively.

Under the ACA enhancements, ESI remains the predominant source of coverage but total enrollment declines from 158 million to 141 million. The effects on the ESI market are largely a result of fixing the family glitch in combination with the more generous premium tax credits and CSRs. Overall, slightly more than 10 million of the reduction in ESI is a result of individuals, with access to ESI, becoming eligible for federal assistance and enrolling in a Marketplace plan. These declines in ESI also occur because employers choose not to offer coverage because the modeled savings to the firm and its employees from dropping coverage exceed our threshold. We project that 85 percent of firms with fewer than 10 employees and 14 percent of firms with 10 to 49 employees drop coverage because the savings from dropping were sufficiently large. The workers at these small firms then had to decide between being uninsured or joining the non-group market, most of whom chose the non-group market.

We estimated that roughly 8.1 million (30%) fewer people will be uninsured in 2023 after the ACA changes (Figure 5). Non-group coverage, principally through the ACA Marketplaces, absorbs the enrollment from both the uninsured and those previously enrolled in ESI, with non-group enrollment increasing from about 18 million to 42 million. This shift in coverage represents an increase from 6.7 percent to 15.7 percent of the population covered through non-group insurance (Figures 4 and 6). By 2032, the ACA enhancements reduce the number of uninsured by 9.6 million (33.8%) and increase non-group enrollment by 33.8 million (Figure 4). In contrast, ESI coverage in 2023 is projected to fall by 24.1 million after the ACA enhancements and to continue falling to less than half the population in 2032 (49.2 percent).

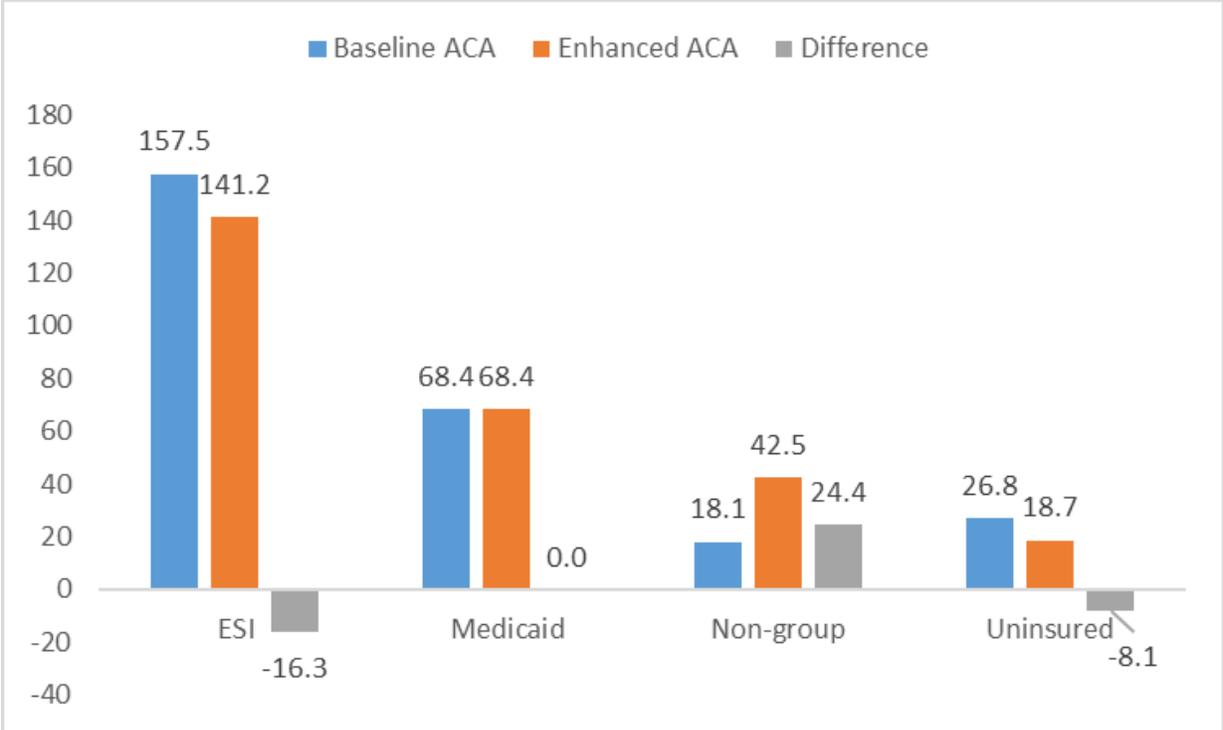
Figure 4: Projected Number (Millions) and Percent of People by Coverage Category

| Coverage | Number of People | | | | Percent of People | | | |
|--------------|------------------|--------------|--------------|--------------|-------------------|---------------|---------------|---------------|
| | 2023 | | 2032 | | 2023 | | 2032 | |
| | Baseline | Enhanced | Baselined | Enhanced | Baseline | Enhanced | Baseline | Enhanced |
| ESI | 157.5 | 141.2 | 163.1 | 139.0 | 58.2% | 52.1% | 57.8% | 49.2% |
| Medicaid | 68.4 | 68.4 | 72.3 | 72.3 | 25.3% | 25.3% | 25.6% | 25.6% |
| Non-group | 18.1 | 42.5 | 18.5 | 52.3 | 6.7% | 15.7% | 6.6% | 18.5% |
| Uninsured | 26.8 | 18.7 | 28.4 | 18.8 | 9.9% | 6.9% | 10.1% | 6.7% |
| Total | 270.8 | 270.8 | 282.4 | 282.4 | 100.0% | 100.0% | 100.0% | 100.0% |

Source: KNG Health analysis using the KNG Health Reform Model

Notes: Baseline = Current ACA; Enhanced = Enhanced ACA. ESI = employer-sponsored insurance. Numbers may not add due to rounding.

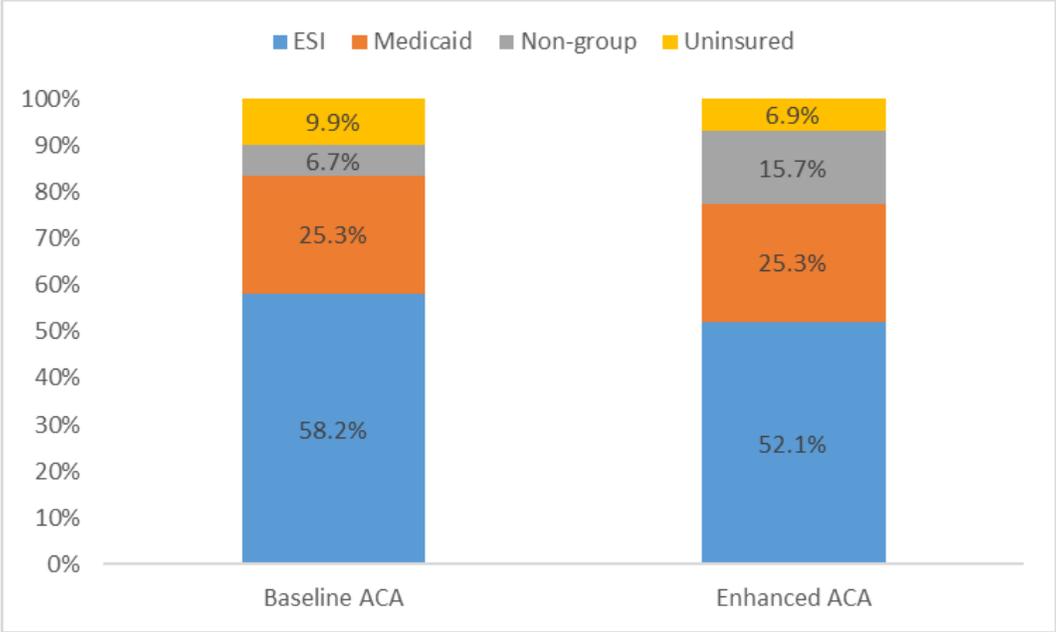
Figure 5. Projected Baseline and Enhanced ACA Coverage in 2023



Source: KNG Health analysis using the KNG Health Reform Model

Notes: Baseline = Current ACA; Enhanced = Enhanced ACA. ESI = employer-sponsored insurance. Numbers may not add due to rounding.

Figure 6. Coverage Distribution in Baseline and Enhanced ACA in 2023



Source: KNG Health analysis using the KNG Health Reform Model
Notes: ESI = employer-sponsored insurance. Numbers may not add due to rounding.

b. Spending

Under the modified ACA, total annual spending is projected to increase to \$1.8 trillion in 2023 and grows to \$2.7 trillion by 2032. These estimates are close to our baseline estimates (Figure 7). Total spending for inpatient hospitalizations remains relatively stable despite the ACA enhancements, increasing from \$371 billion to \$375 billion in 2023. However, spending changes to reflect the enrollment changes. That is, aggregate inpatient hospital spending by the ESI population declines (\$229 billion v. \$203 billion) but is offset by increases in spending on the non-group population (\$26 billion v. \$62 billion).

We estimated the ACA enhancements would result in relatively small changes in total healthcare spending, with an additional \$110 billion in hospital spending over the 10-year period from 2023 to 2032 (Figure 8). This increase in spending can be explained by a higher number of individuals and families with coverage but is offset by lower hospital reimbursement rates by Marketplace plans as compared to under ESI.

Figure 7: Projected spending by type of service and coverage category, 2023 and 2032 (billions)

| Coverage | Baseline ACA | | | | | | Enhanced ACA | | | | | |
|--------------|--------------|--------------|--------------|--------------|--------------|----------------|--------------|--------------|--------------|--------------|--------------|----------------|
| | Inpatient | Outpatient | ER | Physician | Pharmacy | Total | Inpatient | Outpatient | ER | Physician | Pharmacy | Total |
| 2023 | | | | | | | | | | | | |
| ESI | \$229 | \$135 | \$85 | \$93 | \$233 | \$1,225 | \$203 | \$121 | \$75 | \$83 | \$209 | \$1,094 |
| Medicaid | \$98 | \$26 | \$19 | \$21 | \$55 | \$314 | \$98 | \$26 | \$19 | \$21 | \$55 | \$314 |
| Non-group | \$26 | \$16 | \$9 | \$9 | \$26 | \$134 | \$62 | \$34 | \$22 | \$21 | \$61 | \$305 |
| Uninsured | \$18 | \$6 | \$4 | \$10 | \$38 | \$105 | \$12 | \$4 | \$3 | \$6 | \$25 | \$71 |
| Total | \$371 | \$183 | \$117 | \$132 | \$353 | \$1,778 | \$375 | \$186 | \$119 | \$132 | \$349 | \$1,784 |
| 2032 | | | | | | | | | | | | |
| ESI | \$346 | \$201 | \$129 | \$140 | \$347 | \$1,838 | \$289 | \$171 | \$109 | \$119 | \$295 | \$1,556 |
| Medicaid | \$149 | \$39 | \$30 | \$33 | \$83 | \$479 | \$149 | \$39 | \$30 | \$33 | \$83 | \$479 |
| Non-group | \$39 | \$23 | \$13 | \$13 | \$39 | \$198 | \$111 | \$60 | \$40 | \$38 | \$106 | \$540 |
| Uninsured | \$28 | \$10 | \$7 | \$15 | \$59 | \$162 | \$18 | \$6 | \$4 | \$10 | \$36 | \$104 |
| Total | \$561 | \$273 | \$179 | \$200 | \$527 | \$2,677 | \$566 | \$277 | \$182 | \$199 | \$520 | \$2,679 |

Source: KNG Health analysis using the KNG Health Reform Model

Note: ESI = employer-sponsored insurance. ER = Emergency Room. Sum of columns do not equal total spending for each coverage category because there is an "Other services" Spending category not shown. Numbers may also not add due to rounding.

Figure 8: Aggregate 10-year spending impact by service category (billions)

| | Hospital | Other | Total |
|-------------------|--------------|--------------|-------------|
| Baseline ACA | \$8,423 | \$13,853 | \$22,275 |
| Enhanced ACA | \$8,533 | \$13,780 | \$22,313 |
| Difference | \$110 | -\$72 | \$38 |

Source: KNG Health analysis using the KNG Health Reform Model

Under the ACA enhancements, the mix of spending among payers (e.g., government, individuals, and employers) changes as more people are eligible for federal subsidies. Under the baseline, government spending on non-group coverage is projected to be approximately \$17 billion in 2023 and rise to \$28 billion in 2032. After the ACA enhancements, government spending on non-group coverage is projected to be \$139 billion in 2023 and increase to \$265 billion in 2032 (Figure 9).²⁴

Figure 9: Projected Changes in Government Spending by Baseline and Enhanced ACA Coverage Category

| Baseline Coverage | Enhancement Coverage | Number of People | Baseline Gov't Spending (millions) | Enhance Gov't Spending (millions) | Difference in Government Spending |
|-------------------|----------------------|-------------------|------------------------------------|-----------------------------------|-----------------------------------|
| 2023 | | | | | |
| ESI | Non-group | 16,032,678 | \$0 | \$51,795 | \$51,795 |
| Non-group | ESI | 668,689 | \$18 | \$0 | -\$18 |
| Non-group | Non-group | 17,200,829 | \$17,298 | \$38,520 | \$21,222 |
| Non-group | Uninsured | 220,322 | \$1 | \$0 | -\$1 |
| Uninsured | Non-group | 9,257,458 | \$0 | \$48,592 | \$48,592 |
| Total | | 43,379,976 | \$17,317 | \$138,907 | \$121,590 |
| 2032 | | | | | |
| ESI | Non-group | 24,172,767 | \$0 | \$112,717 | \$112,717 |
| Non-group | ESI | 1,111,909 | \$23 | \$0 | -\$23 |
| Non-group | Non-group | 17,099,436 | \$28,463 | \$65,832 | \$37,369 |
| Non-group | Uninsured | 328,144 | \$1 | \$0 | -\$1.4 |
| Uninsured | Non-group | 11,060,544 | \$0 | \$86,8434 | \$86,844 |
| Total | | 53,772,800 | \$28,487 | \$265,393 | \$236,906 |

Source: KNG Health analysis using the KNG Health Reform Model

Note: ESI = employer-sponsored insurance. Numbers may not add due to rounding.

The increase in government spending from the ACA enhancements is predominantly going to low-income households. Among those who switched from ESI coverage to non-group coverage, 86 percent were under 300 percent FPL and 49 percent were under 200 percent FPL. Among those who switched from being uninsured to non-group coverage, 94 percent were under 300 percent FPL and 77 percent were under 200 percent FPL.

The premium subsidies improved for all income levels under the ACA Enhancements and the CSRs improved for those between 200 and 400 percent of FPL. Figure 10 shows OOP spending for the different FPL categories and shows that the total OOP spending decreases for each income group, apart from those in the highest income category.

²⁴ Because premiums for ESI are excluded from federal income and payroll taxes, tax revenue will increase as those on ESI switch to a Marketplace plan under ACA enhancements. These increases in tax revenue will offset some of the federal spending on premium tax credits. Government spending estimates in this report do not include these potential tax revenue offsets.

Figure 10: Projected Total Out-of-Pocket Spending by FPL Category, 2023 and 2032 (billions)

| FPL Category | 2023 | | | | 2032 | | | |
|--------------|--------------|--------------|----------|------------|--------------|--------------|----------|------------|
| | OOP Baseline | OOP Enhanced | OOP Diff | OOP % Diff | OOP Baseline | OOP Enhanced | OOP Diff | OOP % Diff |
| < 100% | \$54 | \$38 | -\$16 | -29.0% | \$83 | \$59 | -\$25 | -29.7% |
| 100 to 150% | \$21 | \$16 | -\$5 | -23.4% | \$33 | \$25 | -\$8 | -23.7% |
| 150 to 200% | \$27 | \$21 | -\$6 | -23.0% | \$41 | \$30 | -\$12 | -28.3% |
| 200 to 250% | \$28 | \$25 | -\$3 | -10.2% | \$43 | \$38 | -\$5 | -11.7% |
| 250 to 300% | \$23 | \$22 | -\$2 | -7.3% | \$36 | \$32 | -\$3 | -9.5% |
| 300 to 400% | \$42 | \$41 | -\$2 | -3.6% | \$64 | \$61 | -\$3 | -4.8% |
| >400% | \$138 | \$139 | \$1 | 0.4% | \$204 | \$206 | \$1 | 0.7% |

Source: KNG Health analysis using the KNG Health Reform Model

Notes: OOP = out-of-pocket

While OOP increased overall for those at greater than 400 percent of FPL, the increase in this income category is due to higher OOP costs among those enrolled in the ESI market (Figure 11). On the other hand, those enrolled in non-group coverage and uninsured with FPL greater than 400 percent of FPL see declines in OOP costs under the ACA enhancements.

Figure 11: Projected Difference in Total OOP spending by FPL and Baseline Coverage (Millions)

| FPL Category | ESI | | Non-group | | Uninsured | |
|--------------|----------------|------------------|----------------|------------------|----------------|------------------|
| | OOP Difference | OOP % Difference | OOP Difference | OOP % Difference | OOP Difference | OOP % Difference |
| 2023 | | | | | | |
| < 100% | -\$1,393 | -12.7% | -\$1,964 | -28.9% | -\$12,282 | -34.0% |
| 100 to 150% | -\$1,420 | -18.6% | -\$1,031 | -52.9% | -\$2,578 | -21.7% |
| 150 to 200% | -\$2,310 | -18.7% | -\$816 | -28.6% | -\$3,087 | -26.1% |
| 200 to 250% | -\$311 | -2.0% | -\$421 | -13.2% | -\$2,121 | -22.2% |
| 250 to 300% | -\$154 | -1.0% | -\$361 | -14.3% | -\$1,200 | -19.8% |
| 300 to 400% | \$38 | 0.1% | -\$463 | -11.4% | -\$1,101 | -14.0% |
| >400% | \$1,710 | 1.5% | -\$450 | -4.2% | -\$655 | -6.0% |
| 2032 | | | | | | |
| < 100% | -\$2,177 | -12.8% | -\$2,986 | -29.5% | -\$19,564 | -34.8% |
| 100 to 150% | -\$2,154 | -18.1% | -\$1,242 | -50.0% | -\$4,343 | -23.7% |
| 150 to 200% | -\$4,416 | -23.2% | -\$1,402 | -33.7% | -\$5,914 | -32.4% |
| 200 to 250% | -\$594 | -2.5% | -\$736 | -15.5% | -\$3,712 | -25.1% |
| 250 to 300% | -\$457 | -2.0% | -\$646 | -17.3% | -\$2,302 | -24.7% |
| 300 to 400% | -\$176 | -0.4% | -\$823 | -13.8% | -\$2,083 | -17.3% |
| >400% | \$3,423 | 2.0% | -\$755 | -4.8% | -\$1,240 | -7.5% |

Source: KNG Health analysis using the KNG Health Reform Model

Notes: OOP = out-of-pocket

V. Discussion

While the ACA has resulted in significant gains in insurance coverage, many non-elderly adults still experience gaps in coverage and face high premiums and out-of-pocket costs. The COVID-19 pandemic has resulted in millions more experiencing health insurance coverage interruptions and affordability challenges. The American Rescue Plan Act provides temporary financial support to individuals and families by expanding access to premium tax credits and other financial assistance to those that lost insurance coverage due to the pandemic. The pandemic has highlighted some of the limitations of the ACA and may increase support for making permanent changes to the ACA.

In this study, we modeled the effects of a set of feasible ACA enhancements to increase coverage and affordability of a Marketplace plan. We estimated that under these enhancements, insurance market participation would increase, leaving 19 million uninsured (a reduction of 8.1 million individuals). The non-group market would increase from 18 to 42 million, due to the modeled ACA enhancements. Fifteen of the 24-million increase (or 63%) in non-group market participation is coming from ESI, while the other 9 million, or 37% of the increase, is coming from the uninsured population. Much of the benefits under the ACA enhancements are projected to accrue to low-income individuals and families.