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Health Insurance Premium Tax Credit and Cost-Sharing Reductions

Updated February 3, 2022

Congressional Research Service
https://crsreports.congress.gov
R44425

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Certain individuals without access to subsidized health insurance coverage may be eligible for the premium tax credit (PTC) established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and amended under the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) to include several temporary provisions. The dollar amount of the PTC varies from individual to individual, based on a formula specified in statute. Individuals who are eligible for the PTC may be required to contribute some amount toward the purchase of health insurance.

To be eligible to receive the premium tax credit in 2022, individuals must have annual household income at or above 100% of the federal poverty level; not be eligible for certain types of health insurance coverage, with exceptions; file federal income tax returns; and enroll in a plan through an individual exchange. Exchanges (or marketplaces) are not insurance companies; rather, exchanges serve as marketplaces for the purchase of health insurance. They operate in every state and the District of Columbia.

The PTC is refundable, so individuals may claim the full credit amount when filing their taxes, even if they have little or no federal income tax liability. The credit also is advanceable, so individuals may choose to receive advanced payments of the credit (or APTC). APTCs are provided on a monthly basis to coincide with the payment of insurance premiums, automatically reducing consumer costs associated with purchasing insurance. The credit is financed through permanent appropriations authorized under the federal tax code.

Individuals who receive premium credit payments also may be eligible for subsidies that reduce cost-sharing expenses. The ACA established two types of cost-sharing reductions (CSRs). One type of subsidy reduces annual cost-sharing limits; the other directly reduces cost-sharing requirements (e.g., lowers a deductible). Individuals who are eligible for CSRs may receive both types. Plans with CSRs were initially provided payments to reimburse them for the cost of providing the subsidies to eligible consumers. Although applicable health plans must continue to provide these CSRs, such plans no longer receive direct payments.

The ARPA makes temporary changes to the PTC and to CSRs. Its provisions amend statute to

- expand eligibility for and the amount of the PTC applicable to certain exchange plans for tax years 2021 and 2022;
- suspend the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess; and
- expand eligibility for and the calculation of both the PTC and CSRs for individuals who receive unemployment compensation during calendar year 2021.

This report describes current law (including ARPA provisions that are in effect as of the publication date of this report) and applicable regulations and guidance, specifically with regard to how the PTC and CSR requirements apply in 2022.

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American Rescue Plan Act of 2021

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) makes temporary changes to the premium tax credit (PTC) and cost-sharing reductions (CSRs). Of those temporary changes, one pertains to tax year 2022: expand eligibility for and the amount of the PTC applicable to certain exchange plans.

The ARPA temporary changes to the PTC and CSRs that have expired include the provisions that

- suspended the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess and
- expanded eligibility for and the calculation of both the PTC and CSRs for individuals who receive unemployment compensation during calendar year 2021.

This report describes current law and applicable regulations and guidance, specifically how the PTC and CSR requirements apply in 2022, and includes historical enrollment and spending data.

Sources: 26 U.S.C. 36B(b)(3)(A)(iii) and (c)(1)(E); and CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*.

Background

Certain individuals and families without access to subsidized health insurance coverage may be eligible for a premium tax credit (PTC). This credit, authorized under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and amended under the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2), applies toward the cost of purchasing specific types of health plans offered by private health insurance companies.[1] Individuals who receive PTC payments also may be eligible for subsidies that reduce cost-sharing expenses.[2]

To be eligible for the PTC and cost-sharing reductions (CSRs), individuals and families must enroll in health plans offered through health insurance exchanges and meet other criteria. Exchanges operate in every state and the District of Columbia (DC).[3] Exchanges are not insurance companies; rather, they are marketplaces that offer private health plans to qualified individuals and small businesses. The ACA specifically requires exchanges to offer insurance options to individuals and to small businesses, so exchanges are structured to assist these two different types of customers. Consequently, each state has one exchange to serve individuals and families (an *individual exchange*) and another to serve small businesses (a *Small Business Health Options Program*, or *SHOP, exchange*).

Health insurance companies that participate in the individual and SHOP exchanges must comply with numerous federal and state requirements. Among such requirements are restrictions related to the determination of premiums for exchange plans (*rating restrictions*). Insurance companies are prohibited from using health factors in determining premiums. However, they are allowed to vary premiums by age (within specified limits), geography, number of individuals enrolling in a plan, and smoking status (within specified limits).[4]

[1] §1401 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); new §36B of the Internal Revenue Code of 1986 (IRC); and §§9661-9663 of the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2).

[2] ACA §1402; and new §18071 of the Public Health Service Act (PHSA).

[3] For additional background about the exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[4] For additional discussion regarding these rating restrictions, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

Premium Tax Credit

The dollar amount of the PTC is based on a statutory formula and varies from individual to individual. Individuals who are eligible for the premium credit generally are required to contribute some amount toward the purchase of their health insurance.

The PTC is refundable, so individuals may claim the full credit amount when filing their taxes even if they have little or no federal income tax liability. The credit also is advanceable, so individuals may choose to receive the credit in advance of filing taxes on a monthly basis to coincide with the payment of insurance premiums (technically, advance payments go directly to insurers). Advance payments (or APTC) automatically reduce monthly premiums by the credit amount. Therefore, the direct cost of insurance to an individual or family that is receiving APTC payments generally will be lower than the advertised cost for a given exchange plan.

Eligibility

To be eligible to receive the PTC, individuals must meet the following criteria:

- file federal income tax returns;
- enroll in a plan through an individual exchange;
- have annual household income at or above 100% of the federal poverty level (FPL)[5] for tax year 2022;[6] and
- *not* be eligible for minimum essential coverage (see the "Not Eligible for Minimum Essential Coverage" section in this report), with exceptions.

These eligibility criteria are discussed in greater detail below.

File Federal Income Tax Returns

Because premium assistance is provided in the form of a tax credit, such assistance is administered by the Internal Revenue Service (IRS) through the federal tax system. The premium credit process requires qualifying individuals to file federal income tax returns, even if their incomes are at levels that normally do not necessitate the filing of such returns.

Married couples are required to file joint tax returns to claim the premium credit, with some exceptions. The calculation and allocation of credit amounts may differ in the event of a change in tax-filing status during a given year (e.g., individuals who marry or divorce).[7]

[5] Household income is measured according to the definition for modified adjusted gross income (MAGI); see the "Have Annual Household Income at or Above 100% of the Federal Poverty Level" section of this report. The guidelines that designate the federal poverty level (FPL) are used in various federal programs for eligibility purposes. The poverty guidelines vary by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. See Office of the Assistant Secretary for Planning and Evaluation, "Frequently Asked Questions Related to the Poverty Guidelines and Poverty," at https://aspe.hhs.gov/frequently-asked-questions-related-poverty-guidelines-and-poverty#programs.

[6] ARPA §9661 expands eligibility for the premium tax credit (PTC) by temporarily eliminating the phaseout for households with annual incomes above 400% of FPL. Elimination of the phaseout applies to tax years 2021 and 2022. The phaseout would resume beginning in 2023.

[7] See IRS, "Health Insurance Premium Tax Credit: Final Regulations," 77 *Federal Register* 30377, May 23, 2012.

Enroll in a Plan Through an Individual Exchange

Premium credits are available only to individuals and families enrolled in plans offered through individual exchanges; premium credits are not available through SHOP exchanges. Individuals may enroll in exchange plans if they (1) reside in a state in which an exchange was established; (2) are not incarcerated, except individuals in custody pending the disposition of charges; and (3) are citizens or have other lawful status.[8]

Actuarial Value and Metal Plans

Most health plans sold through exchanges established under the ACA are required to meet actuarial value (AV) standards, among other requirements. AV is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. In other words, the higher the percentage, the lower the cost sharing, on average, for the population. AV is not a measure of plan generosity for an enrolled individual or family, nor is it a measure of premiums or benefits packages.

An exchange plan that is subject to the AV standards is given a precious metal designation: platinum (AV of 90%), gold (80%), silver (70%), or bronze (60%).

Undocumented individuals (individuals without proper documentation for legal residence) are prohibited from purchasing coverage through an exchange, even if they could pay the entire premium. Because the ACA prohibits undocumented individuals from obtaining exchange coverage, these individuals are not eligible for the PTC. Although certain individuals are not eligible to enroll in exchanges due to incarceration or legal status, their family members may still receive the PTC as long as those family members meet all eligibility criteria.

Have Annual Household Income at or Above 100% of the Federal Poverty Level

Individuals generally must have household income (based on FPL) that meets a minimum level to be eligible for the PTC in 2022, as specified under the ARPA. [9] Household income is measured according to the definition for modified adjusted gross income (MAGI).[10] An individual whose MAGI is at or above 100% of FPL may be eligible to receive the PTC for tax year 2022.[11]

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[8] Generally, enrollment through individual exchanges is restricted to a certain time period: an open enrollment period (OEP). The OEP for exchanges occurs near the end of a given calendar year for enrollment into health plans that begin the following year. Under certain circumstances, individuals may enroll in exchange plans outside of the OEP. For individuals who experience a "triggering event" during the plan year, exchanges are required to provide a "special enrollment period" (SEP) to allow such individuals the option of enrolling into an exchange for that plan year. SEP rules are specified at 45 C.F.R. 155.40, at https://www.govinfo.gov/content/pkg/CFR-2013-title45-vol1/xml/CFR-2013-title45-vol1-sec155-420.xml.

[9] There are exceptions to the lower bound income threshold at 100% of FPL. One exception relates to the state option under the ACA to expand Medicaid for individuals with income up to 138% of FPL. If a state chooses to undertake the ACA Medicaid expansion (or has already expanded Medicaid above 100% of FPL), eligibility for premium credits would begin above the income level at which Medicaid eligibility ends in such a state. (Note that in states that do not expand Medicaid to at least 100% of FPL, some low-income residents in those states are *ineligible* for both premium credits and Medicaid.) Another exception is for lawfully present aliens with incomes below 100% of FPL, who are *not* eligible for Medicaid for the first five years that they are lawfully present. The ACA established §36B(c)(1)(B) of the IRC to allow such lawfully present aliens to be eligible for premium credits. Lastly, the final regulation on premium credits provided a special rule for credit recipients whose incomes at the end of a given tax year end up being less than 100% of FPL. Such individuals will continue to be considered eligible for the PTC for that tax year.

[10] See CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, for background information about the use of MAGI in determining eligibility for premium tax credits.

[11] ARPA §9661 expands eligibility for the PTC by temporarily eliminating the phaseout for households with annual incomes above 400% of FPL. Elimination of the phaseout applies to tax years 2021 and 2022. The phaseout would

Table 1 displays the income levels equivalent to 100% of FPL, for the location and size of family, that correspond to the eligibility criteria for the PTC in 2022 (using poverty guidelines updated by the Department of Health and Human Services [HHS] for 2021).[12]

Table 1. Income Levels Applicable to Eligibility for the Premium Tax Credit for 2022, by Selected Family Sizes

(based on 2021 HHS poverty guidelines)

Number of Persons in Family	Income Levels Equivalent to 100% of FPL		
	48 Contiguous States and DC	Alaska	Hawaii
1	$12,880	$16,090	$14,820
2	$17,420	$21,770	$20,040
3	$21,960	$27,450	$25,260
4	$26,500	$33,130	$30,480

Source: Congressional Research Service (CRS) computations based on Department of Health and Human Services (HHS), "Annual Update of the HHS Poverty Guidelines," 86 *Federal Register* 7732, February 1, 2021, at https://www.govinfo.gov/content/pkg/FR-2021-02-01/pdf/2021-01969.pdf.

Notes: For 2022, the income levels used to calculate premium credit eligibility and amounts are based on 2021 HHS poverty guidelines. The poverty guidelines are updated annually for inflation. FPL = Federal Poverty Level. DC = District of Columbia.

Not Eligible for Minimum Essential Coverage

To be eligible for a premium credit, an individual may *not* be eligible for *minimum essential coverage* (MEC), with exceptions (described below). The ACA broadly defines MEC to include Medicare Part A; Medicare Advantage; Medicaid (with exceptions); the State Children's Health Insurance Program (CHIP); Tricare; Tricare for Life, a health care program administered by the Department of Veterans Affairs; the Peace Corps program; any government plan (local, state, federal), including the Federal Employees Health Benefits Program (FEHBP); any plan offered in the individual health insurance market; any employer-sponsored plan (including group plans regulated by a foreign government); any grandfathered health plan; any qualified health plan offered inside or outside of exchanges; and any other coverage (such as a state high-risk pool) recognized by the HHS Secretary.[13]

resume beginning in 2023.

[12] The poverty guidelines are updated annually, at the beginning of the year. However, premium credit calculations are based on the prior year's guidelines to provide individuals with timely information as they compare and enroll in exchange plans during the OEP (which occurs prior to the beginning of the plan year).

[13] See CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*.

However, the ACA provides certain exceptions regarding eligibility for MEC and PTC. An individual may be eligible for premium credits even if he or she is eligible for any of the following sources of MEC:

- the individual (nongroup) health insurance market;[14]
- an employer-sponsored health plan that is either unaffordable[15] or inadequate;[16] or
- limited benefits under the Medicaid program.[17]

Medicaid Expansion

Under the ACA, states have the option to expand Medicaid eligibility to include all nonelderly, nonpregnant individuals with incomes up to 138% of FPL.[18] If an individual who applied for premium credits through an exchange is determined to be eligible for Medicaid, the exchange must have that individual enrolled in Medicaid instead of an exchange plan. Therefore, in states that implemented the optional Medicaid expansion to include individuals with incomes at or above 100% of FPL (or any state that decided to expand eligibility to individuals irrespective of the ACA's Medicaid expansion provisions), premium credit eligibility begins at the income level at which Medicaid eligibility ends.

Determination of Required Premium Contributions and Premium Tax Credit Amounts

Required Premium Contribution Examples

The amount of the PTC varies from individual to individual. Calculation of the credit is based on the annual household income (i.e., MAGI) of the individual (and tax dependents), the premium for the exchange plan in which the individual (and any dependents) is enrolled, and other factors. For simplicity's sake, the following formula illustrates the calculation of the credit:

Standard Plan Premium – Required Premium Contribution = Premium Tax Credit Amount

Premiums are allowed to vary based on a few characteristics of the person (or family) seeking health insurance. *Standard Plan Premium* refers to the premium for the second-lowest-cost silver plan (see text box in the "Eligibility" section of this report) in the person's (or family's) local area. *Required Premium Contribution* refers to the amount that a premium credit-eligible individual (or family) may pay toward the exchange premium. The required premium contribution is capped according to household income, with such income measured relative to FPL (see **Table 1**). The cap requires lower-income individuals to contribute a smaller share of income toward the monthly premium for the standard plan, compared with the requirement for

[14] The private health insurance market continues to exist outside of the ACA exchanges. Moreover, almost all exchange plans may be offered in the market outside of exchanges.

[15] For 2022, if the employee's premium contribution toward the employer's self-only plan exceeds 9.61% of household income, such a plan is considered unaffordable for premium credit eligibility purposes. For additional information, see IRS, Revenue Procedure 2021-36, at https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36.

[16] If a plan's actuarial value is less than 60%, the plan is considered inadequate for premium credit eligibility purposes.

[17] Limited benefits under Medicaid include the pregnancy-related benefits package, treatment of emergency medical conditions only, and other limited benefits.

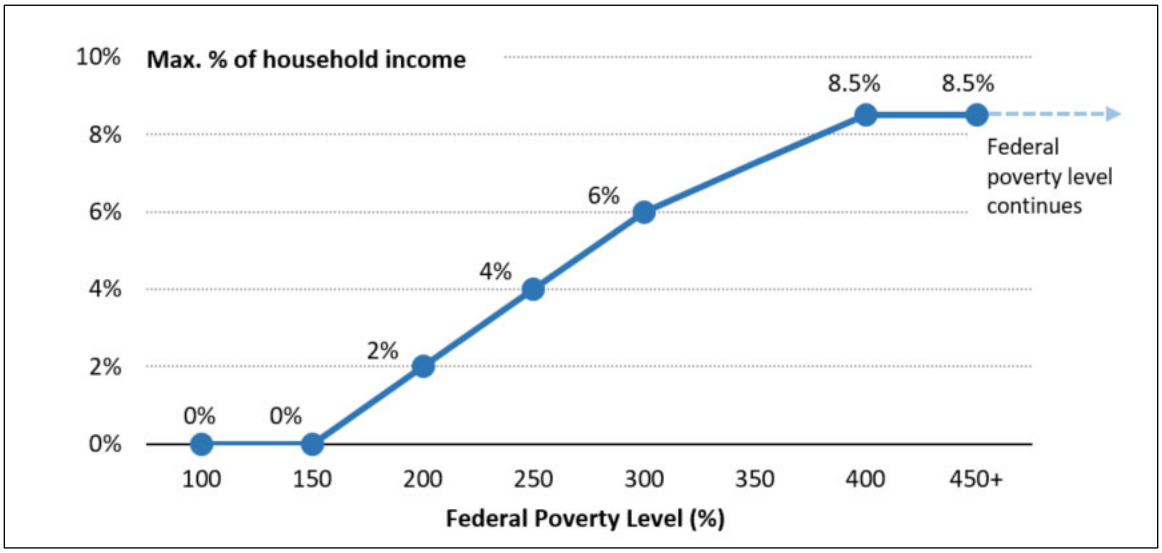
[18] See CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

higher-income individuals. The required premium contribution caps typically are updated through IRS guidance on an annual basis. However, the ARPA temporarily replaces those caps (see **Figure 1**).[19]

The amount of the credit for a given individual is calculated as the difference between the premium of the plan in which the individual enrolls and his or her required contribution. Given that the premium and required contribution vary from person to person, the premium credit amount likewise varies. An extreme example is when the premium for the standard plan is very low, the tax credit may cover the entire premium and the individual may pay nothing toward the premium. The opposite extreme scenario, for some higher-income individuals, is when the required contribution exceeds the premium amount, leading to a credit of zero dollars, meaning the PTC-eligible individual (or family) would pay the entire premium amount.

Figure 1. Cap on Required Premium Contributions for Individuals Who Are Eligible for the Premium Tax Credit in 2022

(cap varies by income, as measured relative to the federal poverty level)



Source: Internal Revenue Service (IRS), Revenue Procedure 2021-36, at https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36.

Notes: The cap assumes that the individual enrolls in the standard plan (second-lowest-cost silver plan) used to calculate premium credit amounts. If the individual enrolls in an exchange plan that is more expensive than the standard plan, the individual would be responsible for paying any premium amount that exceeds the calculated credit amount. Section 9661 of the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) applies these percentages to tax years 2021 and 2022.

To illustrate the premium credit calculation for 2022, consider a premium credit eligible individual living in Lebanon, KS—the geographic center of the continental United States—with household income of $19,320 (150% of FPL, according to applicable regulations). For 2022, such an individual would be required to contribute 0.0% of that income toward the premium for the standard plan in his or her local area (see **Figure 1**). In other words, the individual would have a zero dollar premium if he or she enrolled in the standard plan. In contrast, an individual residing in the same area with income of $32,200 (250% of FPL) would be required to contribute 4.0% of

[19] See ARPA §9661. The new percentages apply to the PTC for tax years 2021 and 2022. Beginning in 2023, the annual update to these percentages would revert to pre-ARPA statute and applicable IRS guidance.

his or her income toward the premium for the same plan. The maximum amount this individual would pay for the standard plan would be $1,288 (that is, $32,200 x 4.0%) for the year or approximately $107 per month.[20]

A similar calculation is used to determine the required premium contribution for a family. For instance, consider a couple and one child residing in Lebanon, KS, who are eligible for the PTC with household income of $32,940 in 2022. For a family of this size, this income is equivalent to 150% of FPL for premium credit purposes. Just as in the example above of the individual with income at 150% of FPL, this family would be required to contribute 0.0% of its annual income toward the premium for the standard plan in its local area. In contrast, a family residing in the same area with income of $54,900 (250% of FPL) would be required to contribute 4.0% of its income toward the premium for the same plan. The maximum amount this family would pay for the standard plan would be $2,196 ($54,900 x 4.0%) for the year (approximately $183 per month).

Generally, the arithmetic difference between the premium and the individual's (or family's) required contribution is the tax credit amount provided to the individual (or family). Therefore, factors that affect either the premium or the required contribution (or both) will change the premium credit amount; such factors include age, family size, and choice of metal plan.

Reconciliation of Advance Premium Tax Credit Payments

As mentioned previously, an eligible individual (or family) may receive advance payments of the premium credit to coincide with when insurance premiums are due. For such an individual, the advance premium tax credit (APTC) is provided on a monthly basis and the amount is calculated using an *estimate* of income. When an individual files his or her tax return for a given year, the total amount of APTC he or she received in that tax year is reconciled with the amount he or she should have received, based on *actual* income, as determined on the tax return.

If an individual's income *decreased* during the year and he or she should have received a larger tax credit, the additional credit amount will be included in the individual's tax refund for the year or used to reduce the amount of taxes owed. If an individual's income *increased* during the year and he or she received too much in APTC payments, the excess amount generally will be repaid in the form of a tax payment.

For individuals with incomes below 400% of FPL, any repayment amount is capped with greater tax relief provided to individuals with lower incomes (see **Table 2**).

Table 2. Annual Limits on Repayment of Excess Premium Tax Credits, 2022

Household Income (Expressed as a Percentage of the Federal Poverty Level)	Applicable Dollar Limit for Unmarried Individuals[a]
<200%	$325
200% to <300%	$825
300% to <400%	$1,400

Source: IRS, Internal Revenue Bulletin 2021-48, at https://www.irs.gov/irb/2021-48_IRB.

Notes: The applicable dollar limit for all other tax filers is twice the limit for unmarried individuals.

a. Does not include surviving spouses or heads of households.

[20] For estimates of premium credit amounts based on factors for which insurance companies are allowed to vary premiums (as described in the "Background" section of this report), see Kaiser Family Foundation, "Health Insurance Marketplace Calculator," at http://kff.org/interactive/subsidy-calculator/.

Preliminary Tax Credit Data

The IRS has published preliminary data about the PTC in its annual "Statistics of Income" (SOI) reports. The most recently published SOI report is for tax year 2019.[21] The following data provide summary statistics about two overlapping populations: tax households that received APTC, and households that claimed the credit on their individual income tax returns.[22]

Tax Year 2019

For tax year 2019, around 5.8 million tax returns indicated receipt of advance payments of the tax credit, totaling to more than $44.4 billion. Of those 5.8 million returns, nearly 2.2 million tax households received advance payments that were less than what they were eligible for, and approximately 3 million tax households received advance payments that were more than what they were eligible for.[23] The remaining difference represents households that received the correct amount in APTC.

The SOI data indicate that approximately 5.2 million tax returns for the 2019 tax year claimed a total of more than $40.5 billion of tax credit. The 5.2 million returns represent the number of tax households that were actually eligible for the credit, based on the information provided in the 2019 tax returns.[24] These eligible households represent those who received advance payments of the credit and those who claimed the credit after the end of the tax year.[25] The IRS also has published limited tax credit data by state, county, and zip code.[26]

Enrollment Data

HHS regularly publishes data on persons selecting and enrolling in exchange plans, including individuals who were determined eligible for the PTC. For plan year 2021, HHS posted reports and public-use files available with national enrollment data, as well as limited data by state, county, and zip code.[27] During the 2021 open enrollment period (OEP), approximately 88% of all exchange enrollees were eligible for the tax credit.[28] In addition to the annual OEP, the Administration provided a special enrollment period (SEP) in response to the ongoing public health emergency caused by the Coronavirus Disease 2019 (COVID-19) pandemic.[29] During the

[21] The data represent tax return information at the time of filing; therefore, the data do not incorporate corrections or amendments made to the tax returns at a later time. IRS, "Affordable Care Act Items," Table 2.7, at https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-complete-report-publication-1304.

[22] The SOI report does not include all estimates of tax credit recipients and claimants necessary to fully describe the overlap of these two taxpayer populations.

[23] The 3 million taxpayers who received excess advanced payments paid back a total of approximately $4.2 billion.

[24] The number of taxpayers who received advance payments exceeded the number who were eligible for the credits, indicating that some taxpayers received unauthorized credits. The IRS did not include, in the SOI report, an estimate of the number of taxpayers who received unauthorized credits.

[25] The IRS did not include, in the SOI report, separate estimates of the number of eligible taxpayers who received advance payments and the number who did not.

[26] See IRS, "ACA Data from Individuals," at https://www.irs.gov/statistics/soi-tax-stats-affordable-care-act-aca-statistics-individual-income-tax-items.

[27] CMS, "2021 Marketplace Open Enrollment Period Public Use Files," at https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files.

[28] See CMS, "Health Insurance Marketplaces 2021 Open Enrollment Report," at https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf.

[29] This SEP was available in all states using the HealthCare.gov enrollment platform from February 15 – August 15,

2021 SEP, approximately 91% of "consumers with New SEP Plan Selections" were eligible for the PTC.[30]

Cost-Sharing Reductions

An individual who qualifies for the PTC, is enrolled in a silver plan (see text box above, "Actuarial Value and Metal Plans"), *and* has annual household income no greater than 250% of FPL is eligible for cost-sharing reductions (CSRs).[31] The purpose of CSRs is to reduce an individual's (or family's) expenses related to cost-sharing requirements under the silver plan; such requirements may include deductibles, co-payments, coinsurance, and annual cost-sharing limits.[32] There are two types of CSRs, and the level of assistance for each varies by income band (see descriptions below). Individuals who are eligible for cost-sharing assistance may receive both types of subsidies, as long as they meet the applicable eligibility requirements.

The ACA requires the HHS Secretary to provide full reimbursements to insurers that provide CSRs. Federal outlays for such reimbursements totaled the following amounts:[33]

- FY2014: $2.111 billion,
- FY2015: $5.382 billion,
- FY2016: $5.652 billion, and
- FY2017: $7.317 billion.

Although the ACA authorized the cost-sharing subsidies and payments to reimburse insurers, it did not address the financing for such payments. The Obama Administration provided CSR payments to insurers using an existing appropriation that finances the PTC (among other tax benefits). The House of Representatives filed suit in 2014, claiming the payments violated the appropriations clause of the U.S. Constitution. After holding that the House has standing to sue the Obama Administration, the U.S. District Court for the District of Columbia concluded that payments for CSRs were unconstitutional for lack of a valid appropriation enacted by Congress. The court barred the Obama Administration from making the payments but stayed its decision pending appeal of the case. Following the November 2016 election, the court delayed the case to allow for nonjudicial resolution, including possible legislative action. Congress did not provide appropriations, and on October 13, 2017, the Trump Administration filed a notice announcing it would terminate payments for these subsidies beginning with the payment that was scheduled for

2021; states with state-based exchanges (SBEs) were "strongly encouraged" to take similar action. All SBEs did so, although the dates of their SEPs varied. CMS, "2021 Special Enrollment Period in Response to the COVID-19 Emergency," at https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency.

[30] This is the share of "unique consumers who didn't have an active enrollment" at the time the SEP began in their respective states, and "made a plan selection" during the SEP, which became "active" (i.e., was not cancelled), as specified. CMS, *2021 Final Marketplace Special Enrollment Period Report*, at https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf. Also see this report for more information about SBEs' SEPs.

[31] ACA §1402.

[32] A *deductible* is the amount an insured consumer pays for covered health care services before the applicable insurer begins to pay for such services (with exceptions). *Coinsurance* is a share of costs, expressed as a percentage, an insured consumer pays for a covered health service. A *co-payment* is a fixed dollar amount an insured consumer pays for a covered health service. An *annual cost-sharing limit* is the total dollar amount an insured consumer would be required to pay out of pocket for use of covered services in a plan year. Once an insured consumer's out-of-pocket spending meets this limit, the insurer generally will pay 100% of covered costs for the remainder of the plan year.

[33] Data provided to CRS by the IRS Budget Office.

October 18, 2017. In response, attorneys general of 18 states and the District of Columbia filed suit in the U.S. District Court for the Northern District of California challenging HHS's decision to terminate CSR payments.[34]

Despite the administrative decision to terminate CSR payments, such decision provides no relief to insurers that continue to be required under federal law to provide CSRs to eligible individuals. In response, health insurers increased premiums to offset this loss in reimbursements (if permitted by state insurance regulators); this practice is referred colloquially as *silver loading*.[35]

As part of the legal challenges related to CSR payments, the Federal Circuit Court of Appeals concluded that insurers were "entitled to recover unpaid cost-sharing reduction (CSR) payments that the Trump Administration withheld, but only to the extent insurers had not recouped their losses through higher premiums."[36]

Reduction in Annual Cost-Sharing Limits

Each metal plan limits the total dollar amount an insured consumer will be required to pay out of pocket for use of covered services in a plan year (referred to as an *annual cost-sharing limit* in this report). In other words, the amount an individual spends in a given year on health care services covered under his or her plan is capped.[37] For 2022, the annual cost-sharing limit for self-only coverage is $8,700; the corresponding limit for family coverage is $17,400.[38] One type of cost-sharing assistance reduces such limits (see **Table 3**). This CSR reduces the annual limit faced by premium credit recipients with incomes up to and including 250% of FPL; greater subsidy amounts are provided to those with lower incomes. In general, this cost-sharing assistance targets individuals and families that use a great deal of health care in a year and, therefore, have high cost-sharing expenses. Enrollees who use little health care may not generate enough cost-sharing expenses to reach the annual limit.

[34] For a discussion of legal considerations related to the termination of CSR payments, see CRS Legal Sidebar LSB10018, *Department of Health and Human Services Halts Cost-Sharing Reduction (CSR) Payments*.

[35] For background on silver loading, see Bipartisan Policy Center, "Stabilizing the Individual Insurance Market: What Happened and What Next?," March 2018, at https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Stabilizing-The-Individual-Health-Insurance-Market.pdf. The practice of silver loading was protected under federal law during plan year 2021; see §609 of the Further Consolidated Appropriations Act, 2020, P.L. 116-94.

[36] Aviva Aron-Dine and Christen Linke Young, "Silver-Loading Likely to Continue Following Federal Circuit Decision on CSRs," *Health Affairs*, October 13, 2020, at https://www.healthaffairs.org/do/10.1377/hblog20201009.845192/full/.

[37] The annual cost-sharing limit applies only to health services that are covered under the health plan and are received within the provider network, if applicable.

[38] See "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards," 86 *Federal Register* 24140, May 5, 2021, at https://www.federalregister.gov/documents/2021/05/05/2021-09102/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and.

Table 3. ACA Cost-Sharing Reductions: Reduced Annual Cost-Sharing Limits, 2022

Household Income Tier, by Federal Poverty Level	Annual Cost-Sharing Limits	
	Self-Only Coverage	*Family Coverage*
100% to 150%	$2,900	$5,800
>150% to 200%	$2,900	$5,800
>200% to 250%	$6,950	$13,900

Source: Department of Health and Human Services (HHS), Table 10, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards," 86 *Federal Register* 24140, May 5, 2021, at https://www.federalregister.gov/documents/2021/05/05/2021-09102/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and.

Note: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

For example, consider the hypothetical individual who resides in Lebanon, KS, and has household income at 150% of FPL (as discussed in the "Required Premium Contribution Examples" section of this report). A person eligible to receive CSRs at that income level would face an annual cost-sharing limit of $2,900, compared to an annual limit of $8,700 for someone also enrolled in a silver plan but does not receive this subsidy. The practical effect of this reduction would occur when this individual spent up to the reduced amount. For additional covered services received by the individual, the insurance company would pay the entire cost. Therefore, by reducing the annual cost-sharing limit, eligible individuals are required to spend less before benefitting from this financial assistance.

Reduction in Cost-Sharing Requirements

The second type of CSR also applies to premium credit recipients with incomes up to and including 250% of FPL. For eligible individuals, the cost-sharing requirements (for the plans in which they have enrolled) are reduced to ensure that the plans cover a certain percentage of allowed health care expenses, on average. The practical effect of this CSR is to increase the actuarial value (AV) of the exchange plan in which the person is enrolled (**Table 4**). In other words, enrollees face lower cost-sharing requirements than they would have without this assistance. Given that this type of CSR directly affects cost-sharing requirements (e.g., lowers a co-payment), both enrollees who use minimal health care and those who use a great deal of services may benefit from this assistance.

Table 4. ACA Cost-Sharing Reductions: Increased Actuarial Values

Household Income Tier, by Federal Poverty Level	New Actuarial Values for Cost-Sharing Subsidy Recipients
100% to150%	94%
>150% to 200%	87%
>200% to 250%	73%

Source: 45 C.F.R. §156.420.

Note: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

To be eligible for cost-sharing subsidies, an individual must be enrolled in a silver plan, which already has an AV of 70% (see text box above, "Actuarial Value and Metal Plans"). For an individual who receives the CSR referred to in **Table 4**, the health plan will impose different cost-sharing requirements so that the silver plan will meet the applicable increased AV. The ACA does

not specify how a plan should reduce cost-sharing requirements to increase the AV from 70% to one of the higher AVs. Through regulations, HHS requires each insurance company that offers a plan subject to this CSR to develop variations of its silver plan; these silver plan variations must comply with the higher levels of actuarial value (73%, 87%, and 94%).[39] When an individual is determined by an exchange to be eligible for CSRs, the person is enrolled in the silver plan variation that corresponds with his or her income.

Consider the same hypothetical individual discussed in the previous section. Since this person's income is at 150% of FPL, if he or she receives this type of subsidy, the silver plan in which he or she is enrolled will have an AV of 94% (as indicated in **Table 4**), instead of the usual 70% AV for silver plans.

Author Information

Bernadette Fernandez
Specialist in Health Care Financing

Acknowledgments

Sylvia L. Bryan, Research Assistant, made contributions to this report.

Disclaimer

[39] See 45 C.F.R. §156.420.

FOR IMMEDIATE RELEASE
January 27, 2022

Contact: HHS Press Office
202-690-6343
media@hhs.gov (mailto:media@hhs.gov)

Biden-Harris Administration Announces 14.5 Million Americans Signed Up for Affordable Health Care During Historic Open Enrollment Period

President Biden's American Rescue Plan subsidies lowered costs and increased enrollment to record levels resulting in 5.8 million people who have newly gained coverage under the Administration.

Today, the Biden-Harris Administration announced a record-breaking 14.5 million people have signed up for 2022 health care coverage through the Marketplaces during the historic Marketplace Open Enrollment Period (OEP) from November 1, 2021 through January 15, 2022 – including 5.8 million people who have newly gained coverage under the Administration. The American Rescue Plan lowered health care costs for most Marketplace consumers and increased enrollment to these records levels: HealthCare.gov consumers saw their average monthly premium fall by 23%, compared to the 2021 enrollment period that ended before the American Rescue Plan passed. The enrollment numbers are a testament to the Biden-Harris Administration's commitment to lowering costs for working families and reaching people where they are through concerted outreach.

"The numbers say it all: We are delivering on our commitment to make health care a right for Americans and to ensure it is accessible and affordable," said Health and Human Services Secretary Xavier Becerra. "We are proud to have completed the Biden-Harris Administration's inaugural Open Enrollment with a record-breaking 14.5 million Americans who now have high-quality, low-cost health coverage, thanks to President Biden's American Rescue Plan and our unprecedented outreach efforts. We will continue to deliver for the American people and work to ensure no one is left behind in getting access to the care they deserve."

Secretary Becerra added, "For people in states and the District of Columbia where enrollment remains open, there is still time to get covered. Don't wait. Sign up today for high-quality, low-cost health coverage."

January 15, 2022, marked the end of the 2022 OEP for the 33 states using HealthCare.gov, as well as many of the State-based Marketplaces. Enrollment remains open in the District of Columbia and five states (California, Kentucky, New Jersey, New York, and Rhode Island) through January 31, 2022. In addition, to date, the District of Columbia, Colorado, Maryland, and New York have established COVID SEPs that allow uninsured consumers to sign up for coverage past the initial OEP end dates.

Of the 14.5 million people who have enrolled in Marketplace coverage through January 15, 2022, 10.3 million people live in the 33 states using HealthCare.gov and 4.2 million people live in the 17 states and the District of Columbia with State-based Marketplaces using their own platforms. To date, three million new consumers that were previously not enrolled in health coverage gained coverage nationwide, a 17% increase compared to the end of the 2021 OEP. Additionally, 32% of HealthCare.gov consumers (3.2 million) selected a plan for $10 or less per month after the additional subsidies provided by the American Rescue Plan. These numbers are likely to grow as enrollment remains open in several State-based Marketplaces.

“We are proud that this Open Enrollment Period and President Biden’s American Rescue Plan enabled a historic 14.5 million people to sign up for quality and affordable health care coverage,” said Centers for Medicare & Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure. “Investing in financial assistance and outreach allows more people to have access to the care that they need.”

This week, HHS’s office of the Assistant Secretary for Planning and Evaluation (ASPE) is also releasing a report analyzing new survey data that showed the uninsured rate fell in 2021 after the American Rescue Plan and outreach efforts took effect. According to the report, the uninsured rate for U.S. population was 8.9% for the third quarter of 2021 (July – September 2021), down from 10.3% for the last quarter of 2020 – corresponding to roughly 4.6 million more people with coverage over that time period. Coverage gains occurred among both children and working age adults, with the largest coverage gains for those with incomes under 200% of the poverty level (roughly $27,000 for a single adult or $56,000 for a family of four).

During the 2022 OEP, the Biden-Harris Administration worked tirelessly to ensure health equity by increasing outreach to communities that have historically been uninsured or underinsured. Through CMS, HHS revamped the Champions for Coverage program and quadrupled the number of Navigators to 1,500 certified Navigators ready to help consumers enroll, and held over 1,800 outreach and education events at accessible areas—such as local libraries, vaccination clinics, food drives, county fairs, and job fairs.

The success of the Biden-Harris Administration’s first OEP affirms the Administration’s commitment to making health care affordable and accessible for consumers and builds on the momentum of the 2021 Special Enrollment Period (SEP). Since the start of the Biden-Harris Administration, through the 2021

SEP and the 2022 OEP, 5.8 million people across the country newly gained access to affordable health care coverage subsidized by the President's American Rescue Plan. That includes 2.8 million during the 2021 SEP and 3 million during the 2022 OEP.

While the OEP has ended in the federal and most State-based Marketplaces, some State-based Marketplace states have extended enrollment deadlines.

Consumers who did not select a plan by the deadline may still have an opportunity to enroll—if they have certain life changes that could qualify them for a special enrollment period or if they qualify for Medicaid or the Children's Health Insurance Program (CHIP). It is important for those who selected a plan during the OEP to make their first monthly payment in order for coverage to begin. More information can be found at HealthCare.gov.

To view the Marketplace 2022 OEP National Snapshot; visit: https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot (https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot)

To view the ASPE report; visit: https://aspe.hhs.gov/reports/health-coverage-changes-2020-2021 (https://aspe.hhs.gov/reports/health-coverage-changes-2020-2021)

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Last revised: January 27, 2022

HHS Headquarters

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free Call Center: 1-877-696-6775

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

DATA POINT

January 27, 2022

HP-2022-05

Health Coverage Changes From 2020-2021

Newly available evidence shows that the uninsured rate in the fall of 2021 fell to levels even lower than before the pandemic.

Rose C. Chu, Aiden Lee, Christie Peters, and Benjamin D. Sommers

KEY POINTS

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

BACKGROUND

The economic impacts of the COVID-19 pandemic have disproportionately affected people of color, young adults, women, parents of young children, and low-income workers.[1] The pandemic's anticipated impacts on employment and income heightened concerns about the loss of coverage during this public health crisis. Legislative and administrative actions were implemented to help stabilize health coverage by maintaining and extending access to affordable coverage.

Efforts to monitor the health insurance dynamics during COVID-19 have been complicated by the fact that the pandemic also created challenges in conducting government-administered surveys that provide the most robust measurement of insurance coverage.[2] The Centers for Disease Control and Prevention's (CDC) National Health Interview Survey (NHIS), for example, experienced a significant drop in response rates during Q2 2020. NHIS response rates have since rebounded, and survey results for the first three quarters of 2021 are now available.[3]

This Data Point examines health coverage trends over time using the newly released NHIS data to assess changes during the pandemic and how they compare to pre-pandemic years, both for the population as a whole, as well as by age and income.

METHODS

We analyzed newly-released survey data from NHIS, employment information from the Department of Labor, and Marketplace enrollment information from the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO).

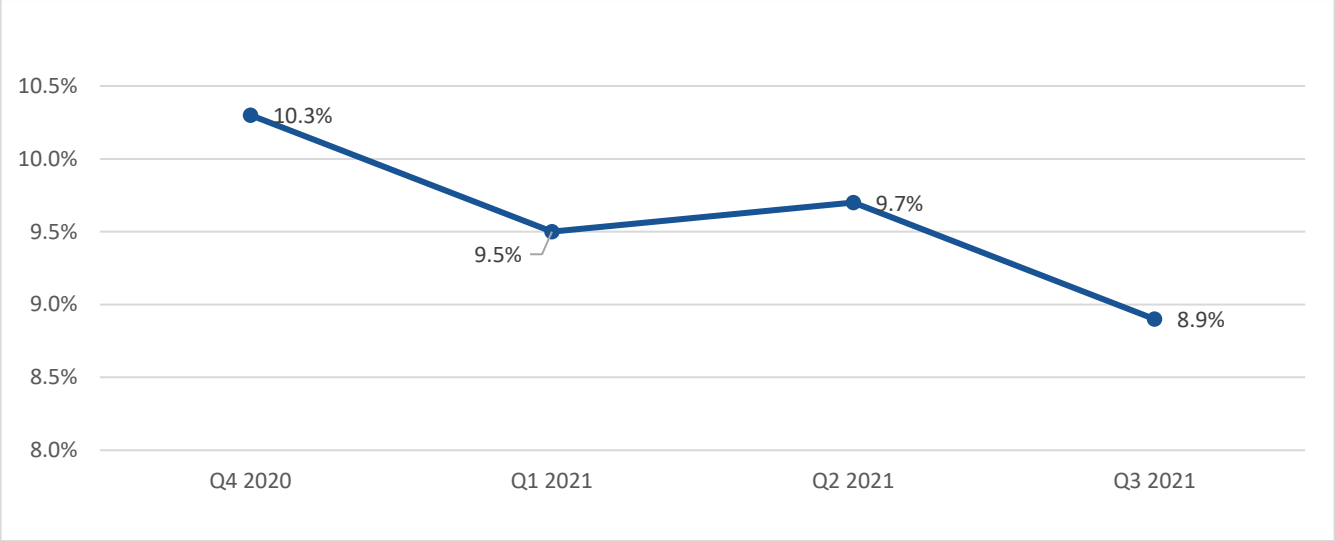
NHIS results during the pandemic may not be as reliable for comparisons to survey results before the pandemic.[4] The CDC suspended in-person visits to conduct the NHIS survey on March 19, 2020 so all NHIS surveys for Q2 2020 were conducted by telephone. Beginning in July 2020 through April 2021, data collection in select areas were opened for in-person visit interviewing. However, NHIS data collection remained predominantly by telephone during this period. Beginning in May 2021, NHIS data collection returned to in-person visits interviewing with Interviewers given discretion based on their own health risk and conditions to complete interviews by phone. Household response rates decreased from 60.0 percent for Q1 2020 to 42.7 percent for Q2 2020. Telephone numbers could not be matched for a number of addresses, especially for renters and those with lower housing tenure (years living at an address). Response rates were lower for groups including those who are younger, have low incomes, Black and Hispanic individuals, non-citizens, and those with lower education attainment. The NHIS weights its data to match U.S. Census Bureau population estimates for age and educational attainment, among other characteristics, and added housing tenure for Q2 2020. Family income could not be adjusted because of the high rate of missing responses. NHIS states that despite these efforts, there is likely to be some non-response bias in the Q2 2020 estimates. NHIS response rates rebounded for the rest of 2020 and 2021.

FINDINGS

Overall Uninsured Rate

Figure 1 shows the most recent National Health Interview Survey estimates, which indicate that the uninsured rate for the total civilian noninstitutionalized U.S. population was 8.9 percent for Q3 2021 (July – September 2021), approaching the lowest uninsured rates ever recorded in the NHIS – similar to results from 2016 and early 2017.[5,6,7] When considered in context of the prior year, the total uninsured rate decreased 1.4 percentage points from 10.3 percent in Q4 2020 to 8.9 percent in Q3 2021. This corresponds to an estimated 4.6 million people gaining health care coverage during this time period (from 33.6 million uninsured in Q4 2020 to 29.0 million in Q3 2021). Alternatively, if we compare the Q3 2021 estimate to the 2020 full year average of 31.6 million uninsured, the estimated number gaining coverage is 2.6 million.[8]

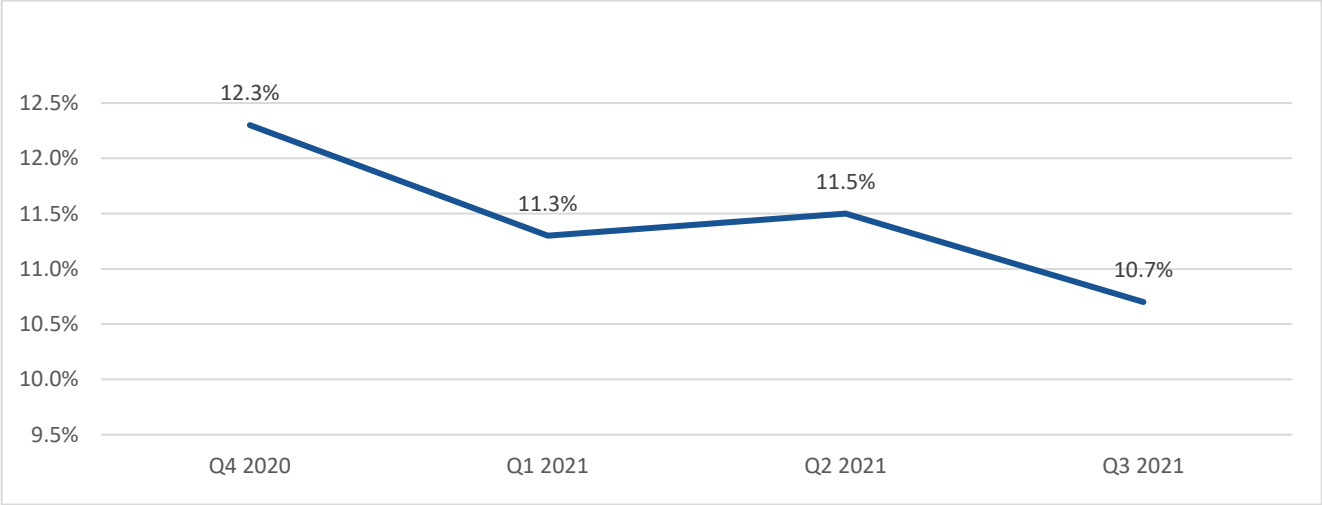
Figure 1. Uninsured Rate by Quarter, All Ages (Q4 2020 – Q3 2021)



Source: Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2021_Q13.pdf

Figure 2 shows that the under 65 population experienced a 1.6 percentage point decrease in uninsurance.

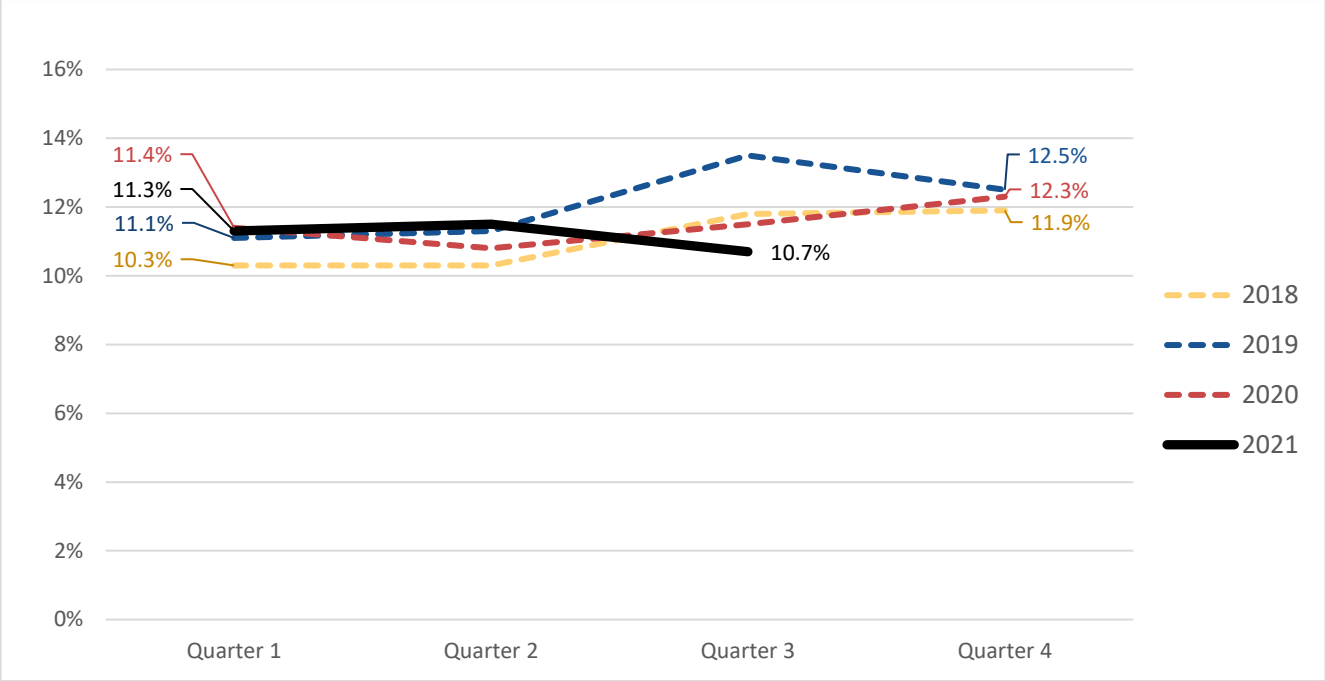
Figure 2. Uninsured Rate by Quarter, Population Under Age 65 (Q4 2020 – Q3 2021)



Source: Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2021_Q13.pdf

Figure 3 shows quarterly changes in the uninsured for the under 65 population for the past 4 years. The solid black line shows the quarterly trends for 2021, in which we see a slight decline in Q3. This is in contrast to the trends in 2018-2020, where the uninsured rate generally rose over the course of the year from Q1 to Q3 and Q4. Many plan years begin in January, and individuals who stop paying premiums during the year may contribute to the rising uninsured rate by quarter; but in 2021, thus far, this trend has reversed.

Figure 3. Uninsured Rate by Quarter, Population Under Age 65 (2018 – 2021)

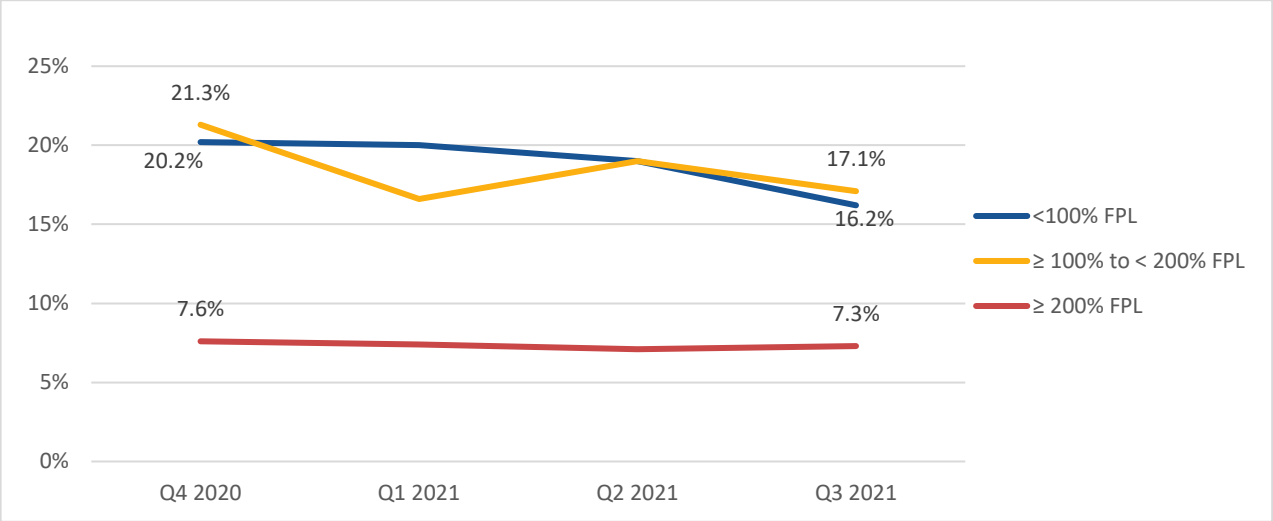


Source: National Health Interview Survey's Supplemental Quarterly Tables on Health Insurance Coverage, 2018-2021. https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm

Uninsured Rates by Income, Age, and Public vs. Private Coverage

Figure 4 shows uninsurance rates among lower income populations decreased the most. Individuals with income between 100-200% of the Federal Poverty Level (FPL) experienced a 4.2 percentage point decrease in uninsurance since Q4 2020. Individuals with income below 100% of the FPL had a 4.0 percentage point decrease in uninsurance in the same timeframe, nearly as much as those in the 100-200% FPL range.

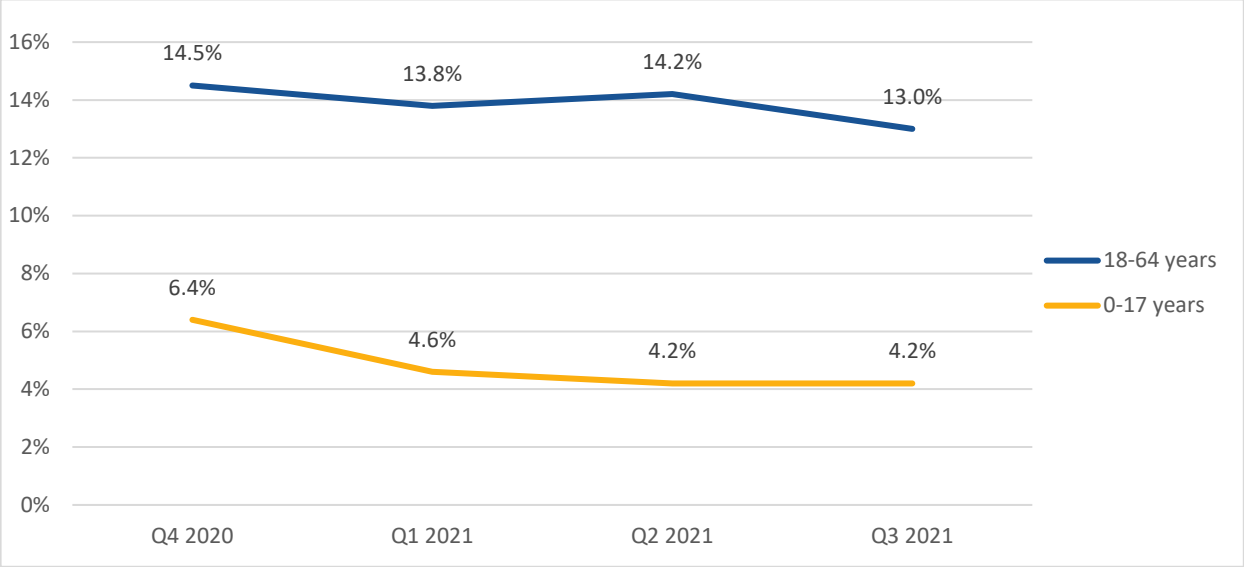
Figure 4. Uninsured Rate by Quarter, Population Under Age 65, by Income (Q4 2020 – Q3 2021)



Source: Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2021_Q13.pdf

The uninsured rate for children decreased more than for working-age adults (18-64). Figure 5 shows children experienced a 2.2 percentage point decrease in uninsurance while working age adults experienced a 1.5 percentage point decrease.

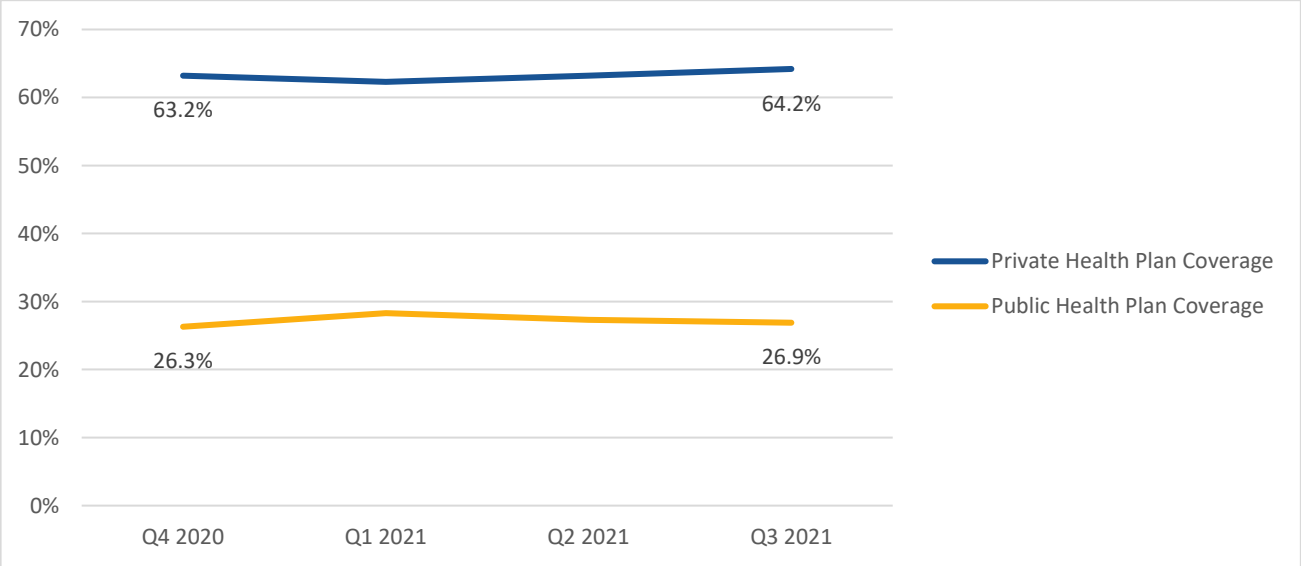
Figure 5. Uninsured Rate by Quarter, by Age (Q4 2020 – Q3 2021)



Source: Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2021_Q13.pdf

Figure 6 shows coverage gains were somewhat larger for private coverage (1.0 percentage-point increase) than public coverage (0.6 percent-point increase), but with increases in both coverage types contributing to the overall decline in the uninsured rate.

Figure 6. Public vs. Private Coverage Rates by Quarter, Population Under Age 65 (Q4 2020 – Q3 2021)

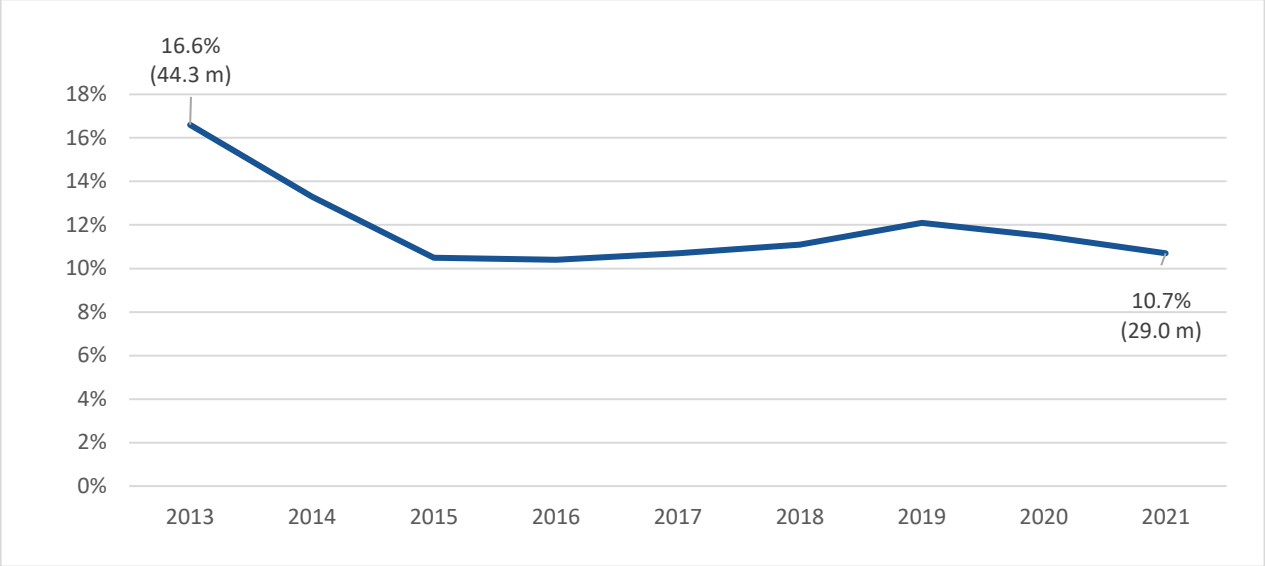


Source: Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2021_Q13.pdf

Longer-Term Trends

Figure 7 places these recent trends in the broader context of the changes in coverage since the implementation of the Affordable Care Act (ACA), when many key coverage provisions took effect beginning in 2014. The uninsured rate declined dramatically between 2013 and 2016, but rose gradually until 2019, before declining in 2020-2021.

Figure 7. Annual Uninsured Rate, Population Under Age 65 (2013 – 2021)



Source: National Health Interview Survey's Health Insurance Coverage Reports, 2013-2020. https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm; Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2021_Q13.pdf

Note: Respondents are those who reported being uninsured at the time of interview. 2021 estimate is Jan-Sept.; other year estimates are Jan-Dec.

DISCUSSION

Despite the COVID-19 pandemic and widespread economic challenges,[9] the U.S. uninsured rate has declined over the last 12 months of available data – due primarily to growth in private coverage and to a lesser extent public coverage. Potential factors contributing to this stability in health coverage during the pandemic include months of strong economic recovery with record job growth, legislative and administrative actions to help Americans maintain and gain affordable coverage, and implementation of Medicaid expansion in additional states.

There are some notable limitations of the most recently-released NHIS data. The recent data report did not distinguish between Marketplace coverage and employer-sponsored insurance in the "private coverage" category, precluding detailed analysis of these coverage types. In addition, while lower NHIS response rates during the first few quarters of the pandemic may have affected the 2020 survey results, response rates in 2021 are close to pre-pandemic levels, resulting in more unbiased estimates of coverage. If anything, the response bias of the 2020 data (with the sample skewed towards people with higher incomes and higher educational attainment, disproportionately White and older respondents) means the 2020 uninsured estimates may have been artificially low – which indicates that the coverage gains in 2021 may even be larger than those observed in the NHIS. Overall, it appears that health coverage has rebounded and stabilized, although health coverage rates for Q4 2021 and for the full year 2021 may be more conclusive.

Economic Recovery

The large job losses during the pandemic that started in March 2020 could have resulted in large losses of health coverage; however, the most recent NHIS data shows this has not happened. Millions of adults lost jobs or were furloughed during the pandemic, but did not lose their employer coverage. A Commonwealth Fund survey in May-June 2020 found that 21 percent of adults lost their jobs or were furloughed because of COVID-19; but among those who originally had employer coverage through work, more than half (53 percent) still maintained that coverage through their furloughed job.[10] Similarly, while the Bureau of Labor Statistics reported that 51.8 percent of private sector establishments (employing 78.3 million workers) told employees not to work in Q3 2020, 41.9 percent of these establishments paid health insurance premiums for some or all furloughed employees.[11] Those who lost their jobs during the pandemic were more likely to have lower incomes, women, and Black and Hispanic workers;[12] economic recovery and the coverage policies discussed below may be particularly likely to benefit these groups. However, the most recent NHIS release did not include information on coverage changes by gender or race and ethnicity.

The American Rescue Plan, Families First Coronavirus Response Act, and Medicaid Expansion

The American Rescue Plan (ARP) provides expanded subsidies to Marketplace consumers by removing the income cap on eligibility for premium tax credits (PTC) and lowering the required premium contribution for all consumers who were already eligible for PTC prior to the ARP. These expanded subsidies began in 2021 and continue through the end of 2022. The ARP substantially increased availability of zero- and low-premium health plans for both current enrollees and uninsured adults.[13] Another ARP provision treats anyone in a household receiving unemployment compensation during 2020 as having income of 133 percent of FPL, which gives them access to zero- or near zero-premium health plans with minimal cost sharing.[14] The ARP also provided for 100 percent reimbursement of COBRA premiums to employers or health plans from April 1, 2021, through September 2021 for employees who lost employer coverage due to job loss or work hours.[15]

The Families First Coronavirus Response Act (FFCRA) of 2020 required states, starting in March 2020, to suspend Medicaid eligibility terminations and maintain coverage for nearly all existing enrollees, in order to receive a 6.2 percentage point increase in their Federal Medical Assistance Percentage (FMAP). This Medicaid continuous coverage requirement accounted for higher Medicaid enrollment during the pandemic.[16] CMS and states also developed numerous strategies and flexibilities to support Medicaid and CHIP operations during this time, often resulting in expedited enrollment and retention (e.g., presumptive eligibility, continuous eligibility, waiving premiums and cost sharing, regulatory authority to apply exceptions to the timeliness standards for application and renewal processing).

Medicaid expansion under the ACA has also made Medicaid available to more families during the pandemic than during previous recessions, and two states implemented recent Medicaid expansions that contributed to increased coverage in late 2020 and the first three quarters of 2021: Nebraska (August 2020) and Oklahoma (June 2021).[*] In addition, as of December 2021, five states have received CMS approval for a section 1115 demonstration that provides extended postpartum Medicaid eligibility to some or most of those enrolled in Medicaid and/or CHIP during pregnancy, and 13 additional states have passed legislation that would extend pregnancy-related Medicaid eligibility.[17]

Outreach and Special Enrollment Period

Outside the Marketplace Open Enrollment Period (OEP), consumers can enroll in a special enrollment period (SEP) due to a life change (such as losing health coverage, moving, getting married, having a baby, or adopting a child) but generally must enroll within 60 days of the life change. In response to the pandemic, the Centers

[*] Coverage for Missouri's Medicaid expansion did not begin until October 2021 and therefore is not reflected in this NHIS data release.

for Medicare & Medicaid Services implemented a February 15 – May 15, 2021 SEP[18] that allowed consumers in the 36 states that used the HealthCare.gov platform in 2021 to enroll without a life change, and later extended the SEP to August 15, 2021.[19] All 15 State-Based Marketplaces (SBMs) also implemented broad SEPs in 2021 with varying start and end dates.

The Department of Health and Human Services (HHS) first announced a $50 million marketing campaign for the 2021 SEP[20] and then another $50 million.[21] HHS also added $2.3 million for Navigator grants to assist consumers during the SEP (a 20 percent increase from the 2021 OEP).[22] The marketing campaigns and Navigator grants helped to inform and encourage enrollment.

Almost half of HealthCare.gov consumers selected a new plan having a monthly premium of $10 or less from February 15 – August 15, 2021, compared to 25 percent during the same period in 2020.[23] A total of 2.8 million consumers enrolled in coverage during the 2021 SEPs, through HealthCare.gov and SBMs.[24] Nearly 209,000 consumers in the 36 HealthCare.gov states, including 84,000 new consumers, benefitted from the unemployment compensation provisions that qualified them for additional subsidies, from July 1 – August 15, 2021.[25]

These policy efforts likely accounted for a substantial portion of the coverage gains in 2021. Since the NHIS data currently only extend through September of 2021, they do not yet reflect the record-breaking enrollment in Marketplace coverage during the 2022 Open Enrollment Period, which likely will reduce the uninsured rate further.[26] Navigator funding increased to $80 million for the 2022 OEP, the largest amount to date.[27] HHS extended the 2022 OEP to November 1, 2021 to January 15, 2022 (a month longer than the 2021 OEP) for the 33 states that use the HealthCare.gov platform in 2022. Most SBMs have similar or longer 2022 OEPs.

CONCLUSION

New national survey results provide timely evidence about the stability of insurance coverage during the pandemic. The findings suggest that 2021 legislative and administrative strategies to extend affordable coverage via the ARP and Marketplace SEP, as well as state Medicaid expansions, have had positive impacts on coverage. These national coverage estimates are encouraging and will inform policy decisions for 2022. As new data become available, we will be able to analyze factors including changes in coverage by race and ethnicity, education, and state of residence. More recent data will be critical to assessing the full effects of the recent Marketplace open enrollment period, the first one to occur with the ARP Marketplace subsidies fully implemented.

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Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D
Washington, D.C. 20201

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ABOUT THE AUTHORS

Rose C. Chu is an Analyst in the Office of Health Policy in ASPE.
Aiden Lee is a Public Health Analyst in the Office of Health Policy in ASPE.
Christie Peters is the Director of the Division of Health Care Access and Coverage for the Office of Health Policy in ASPE.
Benjamin D. Sommers is the Deputy Assistant Secretary for the Office of Health Policy in ASPE.

SUGGESTED CITATION

Chu RC, Lee A, Peters C, and Sommers BD. Health Coverage Changes From 2020-2021. (Data Point No. HP-2022-05). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. January 2022.

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Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Updated Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers

Released: January 20, 2022

Updated: CMS is releasing an updated version of the Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers that was originally released on August 18, 2020.[1] The purpose of releasing this updated report is to describe the impact of the reissued 2018 benefit year HHS-RADV results on 2019 benefit year risk adjustment transfers.[2] The 2018 benefit year HHS-RADV results have been reissued in response to a successful appeal under 45 C.F.R. § 156.1220(a)(1)(viii), which challenged the calculation of the 2018 benefit year error rates under the applicable HHS-RADV error estimation methodology.[3] As a result of this appeal, CMS realigned the application and calculation of 2018 benefit year error rates with the methodology described in the 2019 Payment Notice. The methodological realignment focuses only on the portions of the enrollee EDGE risk score associated with HCCs to conform with the definition of the variable $EdgeRS_{i,e}$ in the applicable rulemaking[4,5] as detailed in the January 20, 2022 memo entitled "Reissuing 2018 Benefit Year HHS Risk Adjustment Data Validation (RADV) Results".[6] Although this methodological realignment did not change the state market risk pools impacted by 2018 benefit year HHS-RADV or the identification of outliers for the benefit year, it did cause changes in the dollar amounts of the 2018 benefit year HHS-RADV adjustments to 2019 benefit year risk adjustment transfers for all issuers with transfer adjustments. The reissued 2018 benefit year HHS-RADV adjustments to 2019 benefit year risk adjustment transfers will be invoiced to issuers in February 2022. Reissued 2018 benefit year HHS-RADV adjustments to 2019 benefit year risk adjustment transfers are reflected in this report.

[1] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018-BY-HHS-RADV-Public-August-18-2020-Report.pdf.

[2] There were no exiting issuers with positive error rates in 2018 benefit year HHS-RADV, in either the original or reissued results. Thus, there will be no adjustments to 2018 benefit year risk scores or transfers as a result of 2018 benefit year HHS-RADV.

[3] This issue did not affect the HHS-RADV Default Data Validation Charge (DDVC) calculations or DDVC allocation payment amounts.

[4] See the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule, 83 FR 16930 at 16963 – 16964 (April 17, 2018) (2019 Payment Notice) (the variable $EdgeRS_{i,e}$ is defined as "the risk score for EDGE HCCs of enrollee *e* of issuer *i*").

[5] The HHS-RADV error estimation methodology applicable beginning with the 2019 benefit year is detailed in the Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program; Final Rule, 85 FR 76979 (December 1, 2020).

[6] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs.

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I. Background

The Patient Protection and Affordable Care Act (ACA) established a permanent risk adjustment program[7] to provide payments to health insurance issuers that attract higher-risk enrollees, such as those with chronic conditions, to reduce the incentives for issuers to avoid those enrollees, and to lessen the potential influence of risk selection on the premiums that issuers charge. The risk adjustment program is designed to support issuers offering a wide range of benefit designs that are available to consumers at an affordable premium. Consistent with section 1321(c)(1) of the ACA, the Department of Health and Human Services (HHS) is responsible for operating the program on behalf of any state that does not elect to do so. HHS-operated risk adjustment in all 50 states and the District of Columbia in the 2018 benefit year.

To ensure the integrity of the HHS-operated risk adjustment program and to validate the accuracy of data submitted by issuers for use in calculations under the state payment transfer formula, the Centers for Medicare & Medicaid Services (CMS) performs risk adjustment data validation in states where the HHS-operated risk adjustment program applies. HHS-operated risk adjustment data validation (HHS-RADV) also ensures that issuers' actual actuarial risk is reflected in transfers and that the HHS-operated program assesses charges to issuers with plans with lower-than-average actuarial risk while making payments to issuers with plans with higher-than-average actuarial risk.

This reissued[8] annual report publishes issuers' HHS-RADV adjustments to risk adjustment transfer results. The reissued 2018 benefit year HHS-RADV results will generally be used to adjust 2019 benefit year plan liability risk scores, resulting in adjustments to 2019 benefit year risk adjustment transfer amounts.[9] The one exception to the prospective application of reissued 2018 benefit year HHS-RADV results is for exiting issuers[10] who are positive error rate outliers. For these exiting issuers, HHS would use 2018 benefit year HHS-RADV results to adjust 2018 benefit year plan liability risk scores, resulting in adjustments to 2018 benefit year risk adjustment transfer amounts, when applicable.[11] We note that all participating exiting issuers had either a negative or zero error rate for 2018 benefit year HHS-RADV; therefore, the reissued 2018 benefit year HHS-RADV results will not be used to modify any 2018 benefit year risk

[7] See section 1343 of the ACA.

[8] The original version of this annual report was published on August 18, 2020 and is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018-BY-HHS-RADV-Public-August-18-2020-Report.pdf. This annual report is being reissued in response to a successful appeal under 45 C.F.R. § 156.1220(a)(1)(viii), which challenged the calculation of the 2018 benefit year error rates under the HHS-RADV error estimation methodology.

[9] 45 C.F.R. § 153.350(b) and (c).

[10] To be an exiting issuer, the issuer has to exit all of the market risk pools in the state (that is, not selling or offering any new plans in the state). If an issuer only exits some market risk pools in the state, but continues to sell or offer plans in others, it is not an exiting issuer. A small group issuer with off-calendar year coverage, who exits the small group market risk pool and only has small group carry-over coverage that ends in the next benefit year, and is not otherwise selling or offering new plans in any market risk pools in the state, would be an exiting issuer. See the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020; Final Rule , 84 FR 17454 at 17503 (April 25, 2019) (2020 Payment Notice).

[11] See the 2020 Payment Notice, 84 FR at 17503 – 17504.

scores or risk adjustment transfers, and will only apply to 2019 benefit year risk scores and risk adjustment transfers.

This report sets forth by HIOS ID and state market risk pool the applicable adjustments to 2019 benefit year risk adjustment transfer amounts based on the reissued 2018 benefit year HHS-RADV results. This report displays the 2019 benefit year risk adjustment transfer amounts that were provided in the summary report,[12] the adjusted transfer amount due to the application of reissued HHS-RADV error rates, and the difference between the amounts that will be invoiced and paid in 2022, pending collections. This report also would generally include information on 2018 benefit year default data validation charges (DDVC) under 45 C.F.R. § 153.630(b)(10) and allocations of those amounts; however, no issuers received a DDVC related to 2018 benefit year HHS-RADV. Issuers will also receive new issuer-specific transfer reports for the 2019 benefit year on January 20, 2022, reflecting any adjustments to transfers as a result of the application of reissued 2018 benefit year HHS-RADV results. The data included in these reports reflect amounts calculated based on the applicable methodologies established through notice with comment rulemaking,[13] prior to the resolution of HHS-RADV discrepancies and related appeals regarding the reissued results, and are provided for informational purposes. These amounts do not constitute specific obligations of Federal funds to any particular issuer or plan.

The HHS-RADV error rate is calculated based on the methodology set forth in the 2019 Payment Notice, and is calculated by using failure rates specific to hierarchical condition category (HCC) groups. HHS adjusts an issuer's risk score when the issuer's failure rate for a group of HCCs is statistically different from the weighted mean failure rate, or total failure rate, for that group of HCCs for all issuers who participated in the HHS-RADV process.[14] The HHS-RADV total error rate represents the percent of an issuer's EDGE risk scores that are estimated to be in error after applying risk score adjustments to sampled enrollees with HCCs in the HCC group(s) in which the issuer was identified as an outlier and extrapolating the impact of those adjustments to the issuer's risk adjustment population.[15]

On June 12, 2020, HHS released the 2018 Benefit Year Risk Adjustment Data Validation (HHS-RADV) Results Report Suite. This included the June 2020 HHS-RADV 2018 Benefit Year Results Memo[16] as well as the release of Issuer-Specific Metrics Reports and Enrollee-Level Metrics Reports to issuers in the HHS-RADV Audit Tool. The June 2020 Results Memo

[12] The Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf.

[13] See, e.g., the 2019 Payment Notice, 83 FR at 16961 – 16965, and the 2020 Payment Notice, 84 FR at 17495 – 17497.

[14] See the 2019 Payment Notice, 83 FR at 16961 – 16965.

[15] For additional detail related to the calculation of the HHS-RADV total error rate, please refer to the Reissuing HHS-RADV 2018 Benefit Year Results Memo, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs. Also see the HHS-RADV 2018 Benefit Year Protocols document, available in the REGTAP Library at: https://www.regtap.info/uploads/library/HRADV_2018Protocols_070319_RETIRED_5CR_070519.pdf.

[16] The June 12, 2020 2018 Benefit Year HHS-RADV Results Memo can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018_BY_RADV_Results_Memo.pdf.

included an overview of the original 2018 benefit year HHS-RADV error rate results by providing national program benchmarks, estimated weighted risk score error rates by state market risk pool, and HCC group definitions.

On January 20, 2022, HHS released the Reissued 2018 Benefit Year Risk Adjustment Data Validation (HHS-RADV) Results Report Suite. This included the Reissuing HHS-RADV 2018 Benefit Year Results Memo[17] as well as the release of reissued Issuer-Specific Metrics Reports and reissued Enrollee-Level Metrics Reports to issuers in the HHS-RADV Audit Tool. The January 2022 Reissuing HHS-RADV 2018 Benefit Year Results Memo included an overview of the reissued 2018 benefit year HHS-RADV error rate results by providing reissued national program benchmarks and estimated weighted risk score error rates by state market risk pool based on reissued results. The HCC failure rates and HCC failure rate group definitions were unaffected by the methodological realignment.

As detailed in the January 2022 Reissuing HHS-RADV 2018 Benefit Year Results Memo, the 2018 HHS-RADV results are being reissued in response to a successful appeal, which challenged the calculation of the 2018 benefit year error rates under the HHS-RADV error estimation methodology. Based on the appeal, a difference was observed between the error rate calculation described in the 2019 Payment Notice[18] and the error rate calculation executed for 2018 benefit year HHS-RADV (as described in the 2018 Benefit Year HHS-RADV Protocols[19]). The reissued results reflect a methodological realignment to apply the error rate only on the portions of the enrollee EDGE risk score associated with HCCs, to conform to the 2019 Payment Notice, rather than applying the error rate to the entire enrollee EDGE risk score, including portions of the enrollee EDGE risk score not associated with HCCs. This report and the reissued results supersede and replace the original 2018 benefit year HHS-RADV results released in June 2020.[20]

II. HHS-RADV Summary Data

For both the original and reissued 2018 benefit year HHS-RADV results, 59 of 146 state market risk pools have 2019 benefit year risk scores and transfers adjusted due to outlier issuers, and zero of the 146 state market risk pools have 2018 benefit year risk scores and transfers adjusted due to exiting outlier issuers.[21] Below we set forth the detailed summary of the application of the reissued 2018 benefit year HHS-RADV results on 2019 benefit year risk adjustment transfers

[17] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs.
[18] See supra note 4.
[19] The 2018 Benefit Year HHS-RADV Protocols are available in the REGTAP Library at: https://www.regtap.info/uploads/library/HRADV_2018Protocols_070319_RETIRED_5CR_070519.pdf.
[20] See, e.g., the 2018 Benefit Year HHS-RADV Results Memo released on June 12, 2020, available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018_BY_RADV_Results_Memo.pdf and the Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers (August 18, 2020), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018-BY-HHS-RADV-Public-August-18-2020-Report.pdf.
[21] For 2018 benefit year HHS-RADV and beyond, only those exiting issuers who are identified as positive error rate outliers will result in HHS-RADV adjustments to risk scores and transfers. See the 2020 Payment Notice, 84 FR at 17503 – 17504. There were no exiting issuers with positive error rates in 2018 benefit year HHS-RADV, in either the original or reissued results. Thus, there will be no adjustments to 2018 benefit year risk scores or transfers as a result of 2018 benefit year HHS-RADV.

(Table 1). For information on the reissued 2018 benefit year HHS-RADV error rate results, please refer to the January 20, 2022 memo entitled "Reissuing 2018 Benefit Year HHS Risk Adjustment Data Validation (RADV) Results".[22] As demonstrated below in Table 1, because the methodological realignments in the reissued 2018 benefit year HHS-RADV results do not change the number or direction of outlier issuers, the number of issuers and states impacted by 2018 benefit year HHS-RADV results are identical between the reissued and original 2018 HHS-RADV results.

Table 1: HHS-RADV Summary Data for Original and Reissued 2018 HHS-RADV Adjustments to 2019 Benefit Year Transfers, Non-Exiting Issuers Only[23]

	Individual, Non-Catastrophic		Small Group		Merged, Non-Catastrophic		Individual, Catastrophic	
	2019 RA with 2018 Original RADV	2019 RA with 2018 Reissued RADV	2019 RA with 2018 Original RADV	2019 RA with 2018 Reissued RADV	2019 RA with 2018 Original RADV	2019 RA with 2018 Reissued RADV	2019 RA with 2018 Original RADV	2019 RA with 2018 Reissued RADV
RADV Adjustment as a percent of premium[24] - All Market Risk Pools	0.36%	0.28%	0.61%	0.47%	0.43%	0.26%	0.23%	0.18%
RADV Adjustment as a percent of premium - Market Risk Pools w/ RADV Adjustment	0.89%	0.69%	1.03%	0.79%	0.47%	0.29%	0.64%	0.50%
Number of States with Risk Adjustment Covered Plans[25]	49		49		2		46	
Number of States with Adjusted Risk Adjustment Transfers Due to 2018 HHS-RADV[26]	18		27		1		13	
Number of States without Adjusted Risk Adjustment Transfers Due to 2018 HHS-RADV	31		22		1		33	
Number of Issuers w/ RADV Adjustment*	129 / 252	129 / 252	293 / 462	292 / 462	13 / 15	13 / 15	61 / 149	61 / 149
Number of Issuers w/RADV Charge*	66	67	121	109	12	12	29	29
Number of Issuers w/RADV Payment*	63	62	172	183	1	1	32	32

*Counts include issuers with greater than $1 in RADV adjustments

[22] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs.

[23] Exiting issuers were excluded from this analysis for ease of comparison because there will be no 2018 benefit year HHS-RADV adjustments to 2018 benefit year transfers since there were no positive error rate outlier exiting issuers in 2018 benefit year HHS-RADV. See supra note 21.

[24] Total Premium is reduced by 14%.

[25] See 45 CFR 153.20 for a definition of "Risk Adjustment Covered Plan".

[26] These numbers exclude single issuer markets in which the single issuer had a non-zero error rate.

For Reissued 2018 benefit year HHS-RADV results, HHS-RADV adjustments as a percent of premiums decreased on average across all four market risk pools compared to original 2018 benefit year HHS-RADV results (Table 1). All risk pools and issuers originally receiving a 2018 benefit year HHS-RADV adjustment to 2019 benefit year transfers will continue to receive a 2018 benefit year HHS-RADV adjustment to 2019 benefit year transfers. The number of issuers receiving a charge or payment remained relatively stable across all risk pools except small group, where there was a decrease in the number of issuers receiving a charge and increase in the number of issuers receiving a payment.

III. Issuer-Specific Adjustments to 2019 Risk Adjustment Transfers Based on the Reissued 2018 Benefit Year HHS-RADV Results

Below we set forth the 2019 benefit year risk adjustment transfer amounts that were provided in the summary report[27] and the 2019 benefit year risk adjustment transfer amounts adjusted for the reissued 2018 benefit year HHS-RADV results by issuer by state market risk pool. We note that a small number of issuers' 2019 benefit year risk adjustment transfer amounts have been updated since the publication of the 2019 RA summary report due to recalculations resulting from late-filed discrepancies.[28] We also provide a comparison of 2018 benefit year HHS-RADV original and reissued issuer-specific HHS-RADV adjustment amounts in Table 4 and Appendix D.

The "Adjustment Amount" represents the difference between issuers' 2019 benefit year risk adjustment transfer and the adjusted transfer amount due to the incorporation of reissued 2018 benefit year HHS-RADV error rates. The Adjustment Amount is the amount that will be collected or paid in calendar year 2022, subject to any changes that may result from successful HHS-RADV discrepancies or related appeals.

If an issuer does not have enrollment in a state market risk pool, and thus, does not have a risk adjustment transfer in that risk pool, the issuer is not included in the applicable risk pool table(s) below. We signify $0.00 for issuers where there is no adjustment being made because there are no error rates in the state market risk pool.

[27] The Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf.

[28] Risk adjustment transfer amounts are subject to change based on late-filed material discrepancies, as well as successful appeals.

Table 2a: Issuer-Specific 2018 HHS-RADV Adjustments to 2019 Risk Adjustment Transfers for Individual, Non-Catastrophic Market Risk Pool *(Appendix A)*

Individual, Non-Catastrophic Market Risk Pool					
HIOS ID	**HIOS INSURANCE COMPANY NAME**	**STATE**	**2019 HHS RISK ADJUSTMENT STATE TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2020)**	**2019 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER STATE TRANSFER AMOUNT (Total Issuer Transfer Amount)**	**ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2022)**
38344	Premera Blue Cross	AK	$0.00	$0.00	$0.00
46944	Blue Cross and Blue Shield of Alabama	AL	$6,135,529.52	$6,135,529.52	$0.00
73301	Bright Health Insurance Company	AL	($6,135,529.53)	($6,135,529.53)	$0.00
37903	Qualchoice Life and Health Insurance Company, Inc.	AR	($4,903,068.38)	($4,903,068.38)	$0.00
62141	Celtic Insurance Company	AR	$19,280,320.16	$19,280,320.16	$0.00
70525	QCA Health Plan INC	AR	($5,716,670.12)	($5,716,670.12)	$0.00
75293	USAble Mutual Insurance Company	AR	($8,660,581.68)	($8,660,581.68)	$0.00
13877	Oscar Health Plan, Inc.	AZ	($173,225.91)	($173,225.91)	$0.00
53901	Blue Cross Blue Shield of Arizona	AZ	($29,869,535.70)	($29,869,535.70)	$0.00
87247	Bright Health Insurance Company	AZ	($22,323,667.50)	($22,323,667.50)	$0.00
91450	Health Net of Arizona, Inc.	AZ	$52,426,035.45	$52,426,035.45	$0.00
97667	Cigna HealthCare of Arizona, Inc	AZ	($59,606.34)	($59,606.34)	$0.00
10544	Oscar Health Plan of California	CA	($58,857,783.05)	($58,857,783.05)	$0.00
18126	Molina Healthcare of California	CA	($83,340,593.78)	($83,340,593.78)	$0.00
27603	Blue Cross of California (Anthem BC)	CA	($72,336,362.27)	($72,336,362.27)	$0.00
40513	Kaiser Foundation Health Plan, Inc.	CA	($438,619,234.59)	($438,619,234.59)	$0.00
47579	Chinese Community Health Plan	CA	($28,899,311.23)	($28,899,311.23)	$0.00
64210	Sutter Health Plan	CA	$460,498.42	$460,498.42	$0.00
67138	Health Net of California, Inc.	CA	($64,006,735.25)	($64,006,735.25)	$0.00
70285	CA Physician's Service dba Blue Shield of CA	CA	$873,847,666.64	$873,847,666.64	$0.00
84014	Valley Health Plan	CA	($33,600,113.92)	($33,600,113.92)	$0.00
92499	Sharp Health Plan	CA	$16,891,987.26	$16,891,987.26	$0.00
92815	Local Initiative Health Authority for Los Angeles County	CA	($110,959,376.79)	($110,959,376.79)	$0.00
93689	Western Health Advantage	CA	($7,102,955.68)	($7,102,955.68)	$0.00
99110	Health Net Life Insurance Company	CA	$6,522,314.19	$6,522,314.19	$0.00

Individual, Non-Catastrophic Market Risk Pool					
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21032	Kaiser Foundation Health Plan of Colorado	CO	($53,911,319.83)	($57,691,733.60)	($3,780,413.77)
31070	Bright Health Insurance Company	CO	($27,330,657.35)	($16,662,829.85)	$10,667,827.50
49375	Cigna Health and Life Insurance Company	CO	$9,646,287.06	$8,045,617.30	($1,600,669.76)
63312	Friday Health Plans of Colorado, Inc	CO	$610,315.04	$282,651.88	($327,663.16)
66699	Denver Health Medical Plan, Inc.	CO	$20,458,696.15	$20,211,436.61	($247,259.54)
76680	HMO Colorado Inc(Anthem BCBS)	CO	$46,766,103.25	$42,194,147.19	($4,571,956.06)
97879	Rocky Mountain Health Maintenance Organization Inc	CO	$3,760,575.65	$3,620,710.45	($139,865.20)
75091	ConnectiCare, Inc.	CT	($309,293.79)	($290,314.86)	$18,978.93
76962	ConnectiCare Benefits, Inc.	CT	($24,631,704.33)	($21,007,492.07)	$3,624,212.26
86545	Anthem Health Plans Inc(Anthem BCBS)	CT	$10,886,668.43	$12,456,338.11	$1,569,669.68
94815	ConnectiCare Insurance Company, Inc.	CT	$14,054,329.72	$8,841,468.77	($5,212,860.95)
78079	Group Hospitalization and Medical Services	DC	$7,257,963.81	$7,257,963.81	$0.00
86052	CareFirst BlueChoice	DC	($4,436,756.67)	($4,436,756.67)	$0.00
94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	DC	($2,821,207.15)	($2,821,207.15)	$0.00
76168	Highmark BCBSD Inc.	DE	$0.00	$0.00	$0.00
16842	Blue Cross Blue Shield of FL Inc.	FL	$746,793,212.63	$746,793,212.63	$0.00
19898	AvMed, Inc	FL	$10,224,798.08	$10,224,798.08	$0.00
21663	Celtic Insurance Company	FL	($606,010,942.06)	($606,010,942.06)	$0.00
30252	Health Options, Inc.	FL	($44,553,431.59)	($44,553,431.59)	$0.00
36194	Health First Commercial Plans, Inc.	FL	$10,181,183.39	$10,181,183.39	$0.00
40572	Oscar Insurance Company of Florida	FL	($53,361,390.38)	($53,361,390.38)	$0.00
48121	Cigna Health and Life Insurance Company	FL	$2,965,200.80	$2,965,200.80	$0.00
54172	Molina Healthcare of Florida, Inc.	FL	($72,011,329.54)	($72,011,329.54)	$0.00
56503	Florida Health Care Plan, Inc	FL	$5,772,698.63	$5,772,698.63	$0.00
49046	Blue Cross and Blue Shield of GA, Inc	GA	($93,861,961.78)	($93,861,961.78)	$0.00
70893	Ambetter of Peach State	GA	$71,362,342.56	$71,362,342.56	$0.00
83761	Alliant Health Plans	GA	($5,548,653.43)	($5,548,653.43)	$0.00

Individual, Non-Catastrophic Market Risk Pool					
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89942	Kaiser Foundation Health Plan of Georgia, Inc.	GA	$28,048,272.69	$28,048,272.69	$0.00
18350	Hawaii Medical Service Association	HI	$10,038,939.54	$10,038,939.54	$0.00
60612	Kaiser Foundation Health Plan, Inc.	HI	($10,038,939.56)	($10,038,939.56)	$0.00
25896	Wellmark Health Plan of Iowa, Inc	IA	$624,411.74	$624,411.74	$0.00
74406	Wellmark Value Health Plan, Inc.	IA	($864,286.88)	($864,286.88)	$0.00
93078	Medica Insurance Company	IA	$239,875.11	$239,875.11	$0.00
26002	SelectHealth	ID	($2,769,678.62)	($12,571,410.44)	($9,801,731.82)
38128	Montana Health Cooperative	ID	$5,336,231.10	$1,769,506.93	($3,566,724.17)
44648	Regence Blue Shield of Idaho	ID	$2,174,961.07	$1,703,409.61	($471,551.46)
60597	PacificSource Health Plans	ID	$2,349,602.98	$2,143,972.33	($205,630.65)
61589	Blue Cross of Idaho	ID	($7,091,116.62)	$6,954,521.55	$14,045,638.17
20129	Health Alliance Medical Plans, Inc.	IL	$4,163,320.03	($7,099,889.40)	($11,263,209.43)
27833	Celtic Insurance Company	IL	($42,977,352.61)	($50,441,253.67)	($7,463,901.06)
33235	Gundersen Health Plan, Inc.	IL	($500,246.90)	($794,923.53)	($294,676.63)
36096	Blue Cross Blue Shield of Illinois	IL	$72,889,926.76	$95,476,949.24	$22,587,022.48
53882	Cigna HealthCare of Illinois, Inc.	IL	($33,575,647.34)	($37,140,882.71)	($3,565,235.37)
54192	CareSource Indiana, Inc	IN	($5,557,169.70)	($5,557,169.70)	$0.00
76179	Celtic Insurance Company	IN	$5,557,169.62	$5,557,169.62	$0.00
18558	Blue Cross and Blue Shield of Kansas, Inc	KS	($11,382,632.92)	($11,382,632.92)	$0.00
39520	Medica Insurance Company	KS	($4,377,748.22)	($4,377,748.22)	$0.00
80065	Sunflower State Health Plan, Inc	KS	$15,760,381.15	$15,760,381.15	$0.00
36239	Anthem Health Plans of KY (Anthem BCBS)	KY	($22,469,935.19)	($22,469,935.19)	$0.00
45636	CareSource Kentucky Co.	KY	$22,469,935.13	$22,469,935.13	$0.00
19636	HMO Louisiana, Inc.	LA	($70,632,972.01)	($70,632,972.01)	$0.00
67243	Vantage Health Plan	LA	($101,182.48)	($101,182.48)	$0.00
97176	Louisiana Health Service & Indemnity Company	LA	$70,734,154.54	$70,734,154.54	$0.00
28137	CareFirst BlueChoice	MD	$20,728,871.49	$24,906,378.88	$4,177,507.39
45532	CareFirst of Maryland	MD	$46,524,596.24	$44,115,884.85	($2,408,711.39)
90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	MD	($103,425,767.23)	($103,629,223.94)	($203,456.71)

Individual, Non-Catastrophic Market Risk Pool					
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94084	Group Hospitalization and Medical Services	MD	$36,172,299.52	$34,606,960.18	($1,565,339.34)
33653	Maine Community Health Options	ME	($6,790,154.66)	($6,790,154.66)	$0.00
48396	Anthem Health Plans of ME (Anthem BCBS)	ME	($15,289,459.93)	($15,289,459.93)	$0.00
96667	Harvard Pilgrim Health Care Inc.	ME	$22,079,614.55	$22,079,614.55	$0.00
15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	MI	$98,831,397.13	$98,961,633.52	$130,236.39
29698	Priority Health	MI	($49,282,318.16)	($49,146,981.12)	$135,337.04
37651	Health Alliance Plan of Michigan	MI	($496,529.62)	($491,316.26)	$5,213.36
40047	Molina Healthcare of Michigan, Inc.	MI	$276,329.18	$289,235.94	$12,906.76
58594	Meridian Health Plan of Michigan, Inc.	MI	($8,989,225.33)	($8,980,693.26)	$8,532.07
60829	Physicians Health Plan	MI	($4,553,266.98)	($4,539,788.93)	$13,478.05
67183	Total Health Care	MI	($11,144,964.96)	($11,119,012.97)	$25,951.99
67577	Alliance Health & Life Insurance Co	MI	$9,931.39	$13,506.36	$3,574.97
74917	McLaren Health Plan	MI	$2,638,993.13	$2,031,393.66	($607,599.47)
77739	Oscar Insurance Company	MI	($734,281.99)	($733,354.45)	$927.54
98185	Blue Care Network of Michigan	MI	($26,556,063.76)	($26,284,622.57)	$271,441.19
31616	Medica Insurance Company	MN	$17,712,617.25	$17,712,617.25	$0.00
34102	Group Health Plan Inc	MN	($29,194,791.23)	($29,194,791.23)	$0.00
57129	HMO Minnesota	MN	$10,890,713.24	$10,890,713.24	$0.00
85736	UCare Minnesota	MN	($871,084.37)	($871,084.37)	$0.00
88102	PreferredOne Insurance Company	MN	$1,462,545.09	$1,462,545.09	$0.00
32753	Healthy Alliance Life Co (Anthem BCBS)	MO	($15,489,291.86)	($15,489,291.86)	$0.00
53461	Medica Insurance Company	MO	($1,803,457.04)	($1,803,457.04)	$0.00
74483	Cigna Health and Life Insurance Company	MO	($4,299,009.52)	($4,299,009.52)	$0.00
99723	Celtic Insurance Company	MO	$21,591,758.40	$21,591,758.40	$0.00
11721	Blue Cross Blue Shield of Mississippi	MS	($4,815,693.88)	($4,815,693.88)	$0.00
90714	Ambetter of Magnolia	MS	$4,815,693.86	$4,815,693.86	$0.00
23603	PacificSource Health Plans	MT	($2,100,399.66)	($2,100,399.66)	$0.00
30751	Blue Cross and Blue Shield of Montana	MT	$25,247,517.21	$25,247,517.21	$0.00

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32225	Montana Health Cooperative	MT	($23,147,117.59)	($23,147,117.59)	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	($25,631,412.70)	($22,712,879.53)	$2,918,533.17
73943	Cigna HealthCare of North Carolina, Inc.	NC	$3,308,010.94	$2,388,797.82	($919,213.12)
77264	Ambetter of North Carolina Inc.	NC	$22,323,401.76	$20,324,081.70	($1,999,320.06)
37160	Blue Cross Blue Shield of North Dakota	ND	$3,958,619.23	$3,958,619.23	$0.00
73751	Medica Health Plans	ND	$245,893.97	$245,893.97	$0.00
89364	Sanford Health Plan	ND	($4,204,513.13)	($4,204,513.13)	$0.00
20305	Medica Insurance Company	NE	$0.01	$0.01	$0.00
59025	Harvard Pilgrim Health Care of NE	NH	$13,031,908.10	$13,031,908.10	$0.00
75841	Celtic Insurance Company	NH	$4,342,274.90	$4,342,274.90	$0.00
96751	Matthew Thornton Hlth Plan(Anthem BCBS)	NH	($17,374,183.01)	($17,374,183.01)	$0.00
13953	Horizon Healthcare of New Jersey, Inc.	NJ	($4,183.44)	($4,182.93)	$0.51
23818	Oscar Garden State Insurance Corporation	NJ	($10,437,260.14)	($10,418,618.18)	$18,641.96
77263	Oxford Health Insurance, Inc.	NJ	$15,914,020.15	$15,252,421.38	($661,598.77)
77606	AmeriHealth HMO	NJ	($3,729,523.11)	($3,696,576.72)	$32,946.39
91661	Horizon Healthcare Services, Inc.	NJ	$116,869,072.22	$117,286,994.63	$417,922.41
91762	AmeriHealth Ins Company of New Jersey	NJ	($118,612,125.67)	($118,420,038.18)	$192,087.49
19722	Molina Healthcare of New Mexico, Inc.	NM	($8,187,021.52)	($8,399,442.97)	($212,421.45)
57173	Presbyterian Health Plan	NM	$230,991.28	$153,155.40	($77,835.88)
72034	CHRISTUS Health Plan	NM	($158,822.93)	($170,284.70)	($11,461.77)
75605	Blue Cross Blue Shield of New Mexico	NM	$6,124,274.62	$6,623,064.04	$498,789.42
93091	New Mexico Health Connections	NM	$1,990,578.59	$1,793,508.24	($197,070.35)
41094	Hometown Health Plan Inc	NV	($4,923,282.50)	($4,675,068.42)	$248,214.08
45142	SilverSummit Healthplan, Inc.	NV	$11,426,343.56	$17,069,911.38	$5,643,567.82
83198	Sierra Health and Life Insurance Company, Inc.	NV	$4,490,041.47	($453,893.81)	($4,943,935.28)
85266	Hometown Health Providers Insurance Company, Inc	NV	$3,409,205.83	$4,418,759.62	$1,009,553.79
95865	Health Plan of Nevada, Inc.	NV	($14,402,308.33)	($16,359,708.80)	($1,957,400.47)
11177	Metro Plus Health Plan	NY	($1,576.76)	$143,389.96	$144,966.72

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17210	Aetna Life Insurance Company	NY	($88,930.97)	($88,673.31)	$257.66
18029	Independent Health Benefits Corporation	NY	$6,787,319.38	$6,841,582.28	$54,262.90
25303	New York State Catholic Health Plan, Inc.	NY	($74,587,617.01)	($73,666,956.45)	$920,660.56
36346	BlueShield of Northeastern New York	NY	($569,784.22)	($535,779.05)	$34,005.17
44113	Empire HealthChoice Assurance, Inc.	NY	$59,298,388.91	$59,638,212.99	$339,824.08
49526	BlueCross BlueShield of Western New York	NY	$7,463,911.68	$7,530,089.62	$66,177.94
54235	UnitedHealthcare of New York, Inc	NY	$16,239,167.32	$13,157,138.24	($3,082,029.08)
54297	UnitedHealthcare Insurance Company of New York	NY	$502,336.74	$503,822.16	$1,485.42
56184	MVP Health Care Inc.	NY	($1,150,702.34)	($842,689.94)	$308,012.40
61405	Healthfirst Insurance Company, Inc.	NY	$289,906.48	$292,145.00	$2,238.52
73886	Crystal Run Health Plan, LLC	NY	$39,683.78	$40,604.67	$920.89
74289	Oscar Insurance Corporation	NY	($50,577,257.94)	($50,329,620.12)	$247,637.82
78124	Excellus Health Plan, Inc.	NY	$27,470,155.57	$27,763,289.68	$293,134.11
88582	Health Insurance Plan of Greater New York	NY	$11,992,734.83	$12,223,829.76	$231,094.93
91237	Healthfirst PHSP Inc.	NY	($8,070,558.64)	($7,696,729.46)	$373,829.18
94788	Capital District Physicians' Health Plan, Inc.	NY	$4,962,823.20	$5,026,343.90	$63,520.70
28162	AultCare Insurance Company	OH	$4,398,259.27	$4,398,259.27	$0.00
29276	Community Insurance Company (Anthem BCBS)	OH	($4,782,200.72)	($4,782,200.72)	$0.00
29341	Oscar Buckeye State Insurance Corp.	OH	($9,214,115.73)	($9,214,115.73)	$0.00
41047	Buckeye Community Health Plan	OH	$6,122,731.47	$6,122,731.47	$0.00
45845	Oscar Insurance Corporation of Ohio	OH	$25,310,834.99	$25,310,834.99	$0.00
52664	Summa Insurance Company Inc.	OH	$388,559.80	$388,559.80	$0.00
64353	Molina Healthcare of Ohio, Inc.	OH	$15,638,148.09	$15,638,148.09	$0.00
74313	Paramount Insurance Company	OH	($1,489,000.57)	($1,489,000.57)	$0.00
77552	CareSource	OH	$23,400,871.96	$23,400,871.96	$0.00
83396	The Health Plan of the Upper Ohio Valley	OH	$451,484.26	$451,484.26	$0.00

Individual, Non-Catastrophic Market Risk Pool					
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99969	Medical Mutual of Ohio	OH	($60,225,572.84)	($60,225,572.84)	$0.00
21333	Medica Insurance Company	OK	($3,733,974.05)	($4,651,308.50)	($917,334.45)
87571	Blue Cross Blue Shield of Oklahoma	OK	$2,849,313.77	$4,114,798.45	$1,265,484.68
98905	CommunityCare HMO Inc.	OK	$884,660.28	$536,510.05	($348,150.23)
10091	PacificSource Health Plans	OR	($10,327,072.85)	($13,932,250.87)	($3,605,178.02)
10940	Health Net Plan of Oregon, Inc.	OR	$1,371,638.07	$1,290,346.09	($81,291.98)
39424	Moda Health Plan Inc	OR	$25,965,472.70	$37,312,354.16	$11,346,881.46
56707	Providence Health Plan	OR	$19,970,029.47	$9,764,010.85	($10,206,018.62)
63474	BridgeSpan Health Company (OR)	OR	$4,496,150.22	$4,243,687.31	($252,462.91)
71287	Kaiser Foundation Health Plan of the Northwest	OR	($40,642,661.28)	($37,835,300.00)	$2,807,361.28
77969	Regence BlueCross BlueShield of Oregon	OR	($833,556.34)	($842,847.52)	($9,291.18)
16322	UPMC Health Options	PA	($17,912,033.11)	($17,912,033.11)	$0.00
22444	Geisinger Health Plan	PA	$9,959,399.18	$9,959,399.18	$0.00
31609	Independence Blue Cross (QCC Ins Co.)	PA	$29,723,298.44	$29,723,298.44	$0.00
33709	Highmark Inc.	PA	$1,991,896.68	$1,991,896.68	$0.00
33871	Keystone Health Plan East	PA	($63,884,997.90)	($63,884,997.90)	$0.00
38949	Keystone Health Plan West	PA	$5,299,682.02	$5,299,682.02	$0.00
45127	Capital Advantage Assurance Company	PA	$38,088,900.26	$38,088,900.26	$0.00
53789	Keystone Health Plan Central	PA	($2,121,668.26)	($2,121,668.26)	$0.00
55957	First Priority Life Insurance Company	PA	($87,689.95)	($87,689.95)	$0.00
62560	UPMC Health Coverage	PA	($7,086.68)	($7,086.68)	$0.00
70194	Highmark Health Insurance Company	PA	$6,416,129.43	$6,416,129.43	$0.00
75729	Geisinger Quality Options	PA	($4,933,655.31)	($4,933,655.31)	$0.00
83731	First Priority Health	PA	($82,830.07)	($82,830.07)	$0.00
86199	Pennsylvania Health & Wellness, Inc.	PA	($2,449,344.72)	($2,449,344.72)	$0.00
15287	Blue Cross & Blue Shield of Rhode Island	RI	$3,359,773.25	$3,359,773.25	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	($3,359,773.25)	($3,359,773.25)	$0.00
26065	Blue Cross and Blue Shield of South Carolina	SC	$7,716,429.78	$7,716,429.78	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($7,839,380.14)	($7,839,380.14)	$0.00
79222	Absolute Total Care, Inc	SC	$122,950.22	$122,950.22	$0.00

Individual, Non-Catastrophic Market Risk Pool					
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31195	Sanford Health Plan	SD	($978,822.51)	($978,822.51)	$0.00
60536	Avera Health Plans, Inc.	SD	$978,822.49	$978,822.49	$0.00
14002	BlueCross BlueShield of Tennessee	TN	$7,249,119.76	($1,614,575.59)	($8,863,695.35)
23552	Oscar Insurance Company of Texas	TN	($4,062,361.30)	($4,734,199.71)	($671,838.41)
70111	Celtic Insurance Company	TN	($7,050,757.56)	($7,533,612.94)	($482,855.38)
97906	Bright Health Insurance Company of Tennessee	TN	($35,022,995.02)	($35,674,032.77)	($651,037.75)
99248	Cigna Health and Life Insurance Company	TN	$38,886,994.16	$49,556,421.02	$10,669,426.86
20069	Oscar Insurance Company of Texas	TX	($59,086,662.79)	($62,661,552.41)	($3,574,889.62)
26539	SHA, LLC	TX	$16,651,888.30	$14,812,150.98	($1,839,737.32)
27248	Community Health Choice, Inc.	TX	$82,793,636.63	$72,639,629.84	($10,154,006.79)
29418	Celtic Insurance Company	TX	($273,849,395.19)	($300,127,031.74)	($26,277,636.55)
33602	Blue Cross Blue Shield of Texas	TX	$395,619,366.62	$450,894,468.60	$55,275,101.98
37755	Insurance Company of Scott & White	TX	$1,761,574.69	$1,708,837.62	($52,737.07)
40788	Scott and White Health Plan	TX	$6,988,778.45	$6,778,586.92	($210,191.53)
45786	Molina Healthcare of Texas, Inc.	TX	($168,389,681.43)	($178,394,079.14)	($10,004,397.71)
66252	CHRISTUS Health Plan	TX	($7,109,436.40)	($9,073,477.18)	($1,964,040.78)
71837	Sendero Health Plans, Inc.	TX	$4,619,931.11	$3,422,466.50	($1,197,464.61)
18167	Molina Healthcare of Utah, Inc.	UT	$1,345,353.72	$1,345,353.72	$0.00
22013	Regence BlueCross BlueShield of Utah	UT	$15,267,324.76	$15,267,324.76	$0.00
34541	BridgeSpan Health Company	UT	($1,755.03)	($1,755.03)	$0.00
42261	University of Utah Health Insurance Plans	UT	$31,857,143.04	$31,857,143.04	$0.00
68781	SelectHealth	UT	($48,468,066.52)	($48,468,066.52)	$0.00
10207	CareFirst BlueChoice	VA	$25,596,234.11	$25,030,407.50	($565,826.61)
20507	Optima Health	VA	$60,405,440.11	$58,466,411.17	($1,939,028.94)
37204	Piedmont Community HealthCare HMO, Inc.	VA	$7,372,212.74	$6,896,910.28	($475,302.46)
40308	Group Hospitalization and Medical Services	VA	$28,921,368.30	$28,532,542.70	($388,825.60)
41921	Cigna Health and Life Insurance Company	VA	($107,873,117.62)	($95,130,561.71)	$12,742,555.91
80352	Virginia Premier Health Plan, Inc.	VA	($5,007,798.20)	($5,229,706.62)	($221,908.42)

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88380	HealthKeepers, Inc (Anthem BCBS)	VA	$2,637,787.41	($4,594,266.78)	($7,232,054.19)
95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	VA	($12,052,126.91)	($13,971,736.48)	($1,919,609.57)
23371	Kaiser Foundation Health Plan of the Northwest	WA	($19,630,091.16)	($16,524,875.61)	$3,105,215.55
38229	Health Alliance Northwest Health Plan Inc.	WA	($10,427.60)	($10,236.65)	$190.95
38498	Lifewise Health Plan of Washington	WA	$6,797,186.01	$7,121,375.60	$324,189.59
49831	Premera Blue Cross	WA	$89,051,917.24	$82,057,867.98	($6,994,049.26)
53732	BridgeSpan Health Company (WA)	WA	($230,548.27)	($214,163.72)	$16,384.55
61836	Coordinated Care Corporation	WA	($19,281,049.20)	($18,126,240.71)	$1,154,808.49
69364	Asuris Northwest Health	WA	($71,440.38)	($40,128.96)	$31,311.42
71281	Regence BlueCross BlueShield Of Oregon (Clark County)	WA	$1,546,576.88	$1,612,330.17	$65,753.29
80473	Kaiser Foundation Health Plan of Washington	WA	($93,704,098.55)	($92,081,603.78)	$1,622,494.77
84481	Molina Healthcare of Washington, Inc.	WA	$34,912,249.66	$35,563,026.18	$650,776.52
87718	Regence BlueShield	WA	$619,725.34	$642,649.55	$22,924.21
14630	Children's Community Health Plan	WI	$18,597,587.74	$22,584,790.82	$3,987,203.08
20173	HealthPartners Insurance Company	WI	($5,797,000.07)	($5,473,411.06)	$323,589.01
37833	Unity Health Plans Insurance Corporation	WI	$7,535,775.86	$22,259,246.35	$14,723,470.49
38166	Security Health Plan of Wisconsin, Inc.	WI	($17,017,753.26)	($13,173,000.11)	$3,844,753.15
38345	Dean Health Plan	WI	($26,642,325.03)	($30,778,648.45)	($4,136,323.42)
52697	Molina Healthcare of Wisconsin, Inc.	WI	$11,043,268.57	$9,515,855.49	($1,527,413.08)
57845	Medica Health Plans of Wisconsin	WI	$6,334,385.93	$4,837,806.93	($1,496,579.00)
58326	MercyCare HMO, Inc.	WI	($1,802,556.41)	($2,521,077.17)	($718,520.76)
81413	Network Health Plan	WI	$8,469,145.51	$6,989,826.59	($1,479,318.92)
81974	Wisconsin Physicians Svc Insurance Corp - WI	WI	$1,059,128.02	$984,411.06	($74,716.96)
84670	WPS Health Plan, Inc. - WI	WI	$2,243,184.11	$1,983,677.85	($259,506.26)
86584	Aspirus Arise Health Plan of Wisconsin, Inc.	WI	($3,662,581.17)	($5,421,841.37)	($1,759,260.20)

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87416	Common Ground Healthcare Cooperative	WI	($3,958,243.08)	($14,924,579.56)	($10,966,336.48)
94529	Group Health Cooperative of South Central Wisconsin	WI	$3,597,983.35	$3,136,942.70	($461,040.65)
31274	Highmark Blue Cross Blue Shield West Virginia	WV	$9,243,514.64	$9,243,514.64	$0.00
50328	CareSource West Virginia Co.	WV	($9,017,560.75)	($9,017,560.75)	$0.00
72982	The Health Plan of the Upper Ohio Valley	WV	($225,953.90)	($225,953.90)	$0.00
11269	Blue Cross Blue Shield of Wyoming	WY	$0.00	$0.00	$0.00

Table 2b: Issuer-Specific 2018 HHS-RADV Adjustments to 2019 Risk Adjustment Transfers for Individual, Catastrophic Market Risk Pool *(Appendix A)*

Individual, Catastrophic Market Risk Pool					
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46944	Blue Cross and Blue Shield of Alabama	AL	($47,856.32)	($47,856.32)	$0.00
73301	Bright Health Insurance Company	AL	$47,856.31	$47,856.31	$0.00
70525	QCA Health Plan INC	AR	$0.00	$0.00	$0.00
13877	Oscar Health Plan, Inc.	AZ	$269,245.20	$269,245.20	$0.00
53901	Blue Cross Blue Shield of Arizona	AZ	($269,245.21)	($269,245.21)	$0.00
10544	Oscar Health Plan of California	CA	($2,458,249.53)	($2,458,249.53)	$0.00
18126	Molina Healthcare of California	CA	$20,907.55	$20,907.55	$0.00
27603	Blue Cross of California(Anthem BC)	CA	($257,027.13)	($257,027.13)	$0.00
40513	Kaiser Foundation Health Plan, Inc.	CA	$6,976.47	$6,976.47	$0.00
47579	Chinese Community Health Plan	CA	($16,613.06)	($16,613.06)	$0.00
67138	Health Net of California, Inc.	CA	($165,543.30)	($165,543.30)	$0.00
70285	CA Physician's Service dba Blue Shield of CA	CA	$4,133,386.90	$4,133,386.90	$0.00
84014	Valley Health Plan	CA	($47,472.23)	($47,472.23)	$0.00
92499	Sharp Health Plan	CA	($680,198.21)	($680,198.21)	$0.00
92815	Local Initiative Health Authority for Los Angeles County	CA	$33,348.76	$33,348.76	$0.00
93689	Western Health Advantage	CA	($80,981.29)	($80,981.29)	$0.00
99110	Health Net Life Insurance Company	CA	($488,534.95)	($488,534.95)	$0.00
21032	Kaiser Foundation Health Plan of Colorado	CO	($404,507.83)	($414,275.19)	($9,767.36)
31070	Bright Health Insurance Company	CO	($643,841.94)	($519,603.35)	$124,238.59
63312	Friday Health Plans of Colorado, Inc	CO	($1,202,360.80)	($1,223,672.99)	($21,312.19)
76680	HMO Colorado Inc(Anthem BCBS)	CO	$948,540.08	$880,726.85	($67,813.23)
87269	Rocky Mountain Hos&Med Svc(Anthem BCBS)	CO	$1,302,170.49	$1,276,824.71	($25,345.78)
76962	ConnectiCare Benefits, Inc.	CT	$81,962.12	$81,962.12	$0.00

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86545	Anthem Health Plans Inc (Anthem BCBS)	CT	($81,962.11)	($81,962.11)	$0.00
86052	CareFirst BlueChoice	DC	($92,899.07)	($92,899.07)	$0.00
94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	DC	$92,899.07	$92,899.07	$0.00
76168	Highmark BCBSD Inc.	DE	$0.00	$0.00	$0.00
36194	Health First Commercial Plans, Inc.	FL	$67,289.00	$67,289.00	$0.00
40572	Oscar Insurance Company of Florida	FL	$10,977.04	$10,977.04	$0.00
56503	Florida Health Care Plan, Inc	FL	($78,266.02)	($78,266.02)	$0.00
49046	Blue Cross and Blue Shield of GA, Inc	GA	($241,243.60)	($241,243.60)	$0.00
89942	Kaiser Foundation Health Plan of Georgia, Inc.	GA	$241,243.59	$241,243.59	$0.00
18350	Hawaii Medical Service Association	HI	$0.00	$0.00	$0.00
93078	Medica Insurance Company	IA	($0.02)	($0.02)	$0.00
26002	SelectHealth	ID	($159,248.39)	($199,407.37)	($40,158.98)
38128	Montana Health Cooperative	ID	($48,816.64)	($56,350.06)	($7,533.42)
60597	PacificSource Health Plans	ID	($49,295.76)	($53,797.75)	($4,501.99)
61589	Blue Cross of Idaho	ID	$257,360.77	$309,555.17	$52,194.40
20129	Health Alliance Medical Plans, Inc.	IL	($47,379.30)	($72,225.06)	($24,845.76)
33235	Gundersen Health Plan, Inc.	IL	($19,228.93)	($19,609.29)	($380.36)
36096	Blue Cross Blue Shield of Illinois	IL	$66,608.23	$91,834.37	$25,226.14
17575	Anthem Ins Companies Inc (Anthem BCBS)	IN	$0.00	$0.00	$0.00
39520	Medica Insurance Company	KS	($0.01)	($0.01)	$0.00
36239	Anthem Health Plans of KY (Anthem BCBS)	KY	$1,458.94	$1,458.94	$0.00
45636	CareSource Kentucky Co.	KY	($1,458.95)	($1,458.95)	$0.00
42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	MA	($326,947.02)	($326,947.02)	$0.00
59763	Tufts Health Public Plans, Inc.	MA	$291,686.91	$291,686.91	$0.00
88806	Fallon Community Health Plan	MA	$35,260.12	$35,260.12	$0.00
28137	CareFirst BlueChoice	MD	$40,856.09	$42,418.88	$1,562.79

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90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	MD	($40,856.09)	($42,418.87)	($1,562.78)
33653	Maine Community Health Options	ME	$1,139.56	$1,139.56	$0.00
48396	Anthem Health Plans of ME (Anthem BCBS)	ME	($1,139.57)	($1,139.57)	$0.00
15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	MI	$1,592,506.43	$1,592,963.96	$457.53
37651	Health Alliance Plan of Michigan	MI	($40,629.36)	($40,548.01)	$81.35
58594	Meridian Health Plan of Michigan, Inc.	MI	($156,721.56)	($156,692.61)	$28.95
60829	Physicians Health Plan	MI	($13,722.54)	($13,722.31)	$0.23
67577	Alliance Health & Life Insurance Co	MI	($50,439.83)	($50,427.19)	$12.64
74917	McLaren Health Plan	MI	($51,360.18)	($52,462.77)	($1,102.59)
77739	Oscar Insurance Company	MI	($5,788.69)	($5,786.45)	$2.24
98185	Blue Care Network of Michigan	MI	($1,273,844.27)	($1,273,324.64)	$519.63
31616	Medica Insurance Company	MN	($187,513.69)	($187,513.69)	$0.00
34102	Group Health Plan Inc	MN	$77,369.27	$77,369.27	$0.00
85736	UCare Minnesota	MN	$110,144.43	$110,144.43	$0.00
32753	Healthy Alliance Life Co (Anthem BCBS)	MO	($120,303.33)	($120,303.33)	$0.00
53461	Medica Insurance Company	MO	$120,303.34	$120,303.34	$0.00
30751	Blue Cross and Blue Shield of Montana	MT	$203,712.86	$203,712.86	$0.00
32225	Montana Health Cooperative	MT	($203,712.86)	($203,712.86)	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	$0.01	$0.01	$0.00
37160	Blue Cross Blue Shield of North Dakota	ND	$29,492.02	$29,492.02	$0.00
73751	Medica Health Plans	ND	($3,109.76)	($3,109.76)	$0.00
89364	Sanford Health Plan	ND	($26,382.27)	($26,382.27)	$0.00
20305	Medica Insurance Company	NE	$0.00	$0.00	$0.00
59025	Harvard Pilgrim Health Care of NE	NH	$59,729.36	$59,729.36	$0.00
96751	Matthew Thornton Hlth Plan (Anthem BCBS)	NH	($59,729.36)	($59,729.36)	$0.00

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23818	Oscar Garden State Insurance Corporation	NJ	($839,335.33)	($839,335.33)	$0.00
91661	Horizon Healthcare Services, Inc.	NJ	$294,853.37	$294,853.37	$0.00
91762	AmeriHealth Ins Company of New Jersey	NJ	$544,481.95	$544,481.95	$0.00
57173	Presbyterian Health Plan	NM	$52,132.76	$51,374.88	($757.88)
72034	CHRISTUS Health Plan	NM	($20,553.22)	($20,560.39)	($7.17)
75605	Blue Cross Blue Shield of New Mexico	NM	($31,579.52)	($30,814.50)	$765.02
33670	Rocky Mountain Hos&Med Svc(Anthem BCBS)	NV	$131,444.11	$140,745.67	$9,301.56
41094	Hometown Health Plan Inc	NV	($78,772.34)	($77,643.85)	$1,128.49
60156	HMO Colorado Inc(Anthem BCBS)	NV	($78,464.23)	($76,135.32)	$2,328.91
83198	Sierra Health and Life Insurance Company, Inc.	NV	($155,245.39)	($166,640.32)	($11,394.93)
85266	Hometown Health Providers Insurance Company, Inc	NV	$291,611.67	$298,535.28	$6,923.61
95865	Health Plan of Nevada, Inc.	NV	($110,573.79)	($118,861.47)	($8,287.68)
11177	Metro Plus Health Plan	NY	($6,830.96)	($6,830.23)	$0.73
18029	Independent Health Benefits Corporation	NY	($12,223.83)	($12,216.25)	$7.58
25303	New York State Catholic Health Plan, Inc.	NY	$447,725.78	$448,115.80	$390.02
44113	Empire HealthChoice Assurance, Inc.	NY	$181,548.32	$181,686.27	$137.95
54235	UnitedHealthcare of New York, Inc	NY	($1,766.62)	($4,403.15)	($2,636.53)
56184	MVP Health Care Inc.	NY	$119,507.59	$119,548.53	$40.94
73886	Crystal Run Health Plan, LLC	NY	($1,980.12)	($1,979.89)	$0.23
74289	Oscar Insurance Corporation	NY	($1,089,530.26)	($1,087,683.49)	$1,846.77
78124	Excellus Health Plan, Inc.	NY	($116,172.18)	($116,078.95)	$93.23
88582	Health Insurance Plan of Greater New York	NY	$187,694.89	$187,746.79	$51.90
91237	Healthfirst PHSP Inc.	NY	$300,580.07	$300,644.97	$64.90
94788	Capital District Physicians' Health Plan, Inc.	NY	($8,552.66)	($8,550.42)	$2.24
28162	AultCare Insurance Company	OH	($71,992.12)	($71,992.12)	$0.00
29276	Community Insurance Company(Anthem BCBS)	OH	($18,550.27)	($18,550.27)	$0.00

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29341	Oscar Buckeye State Insurance Corp.	OH	$208,485.37	$208,485.37	$0.00
45845	Oscar Insurance Corporation of Ohio	OH	($11,936.62)	($11,936.62)	$0.00
52664	Summa Insurance Company Inc.	OH	($60,238.04)	($60,238.04)	$0.00
99969	Medical Mutual of Ohio	OH	($45,768.32)	($45,768.32)	$0.00
21333	Medica Insurance Company	OK	$37,881.49	$26,405.74	($11,475.75)
87571	Blue Cross Blue Shield of Oklahoma	OK	$129,187.49	$146,052.74	$16,865.25
98905	CommunityCare HMO Inc.	OK	($167,068.98)	($172,458.49)	($5,389.51)
10091	PacificSource Health Plans	OR	$46,678.93	$41,411.80	($5,267.13)
71287	Kaiser Foundation Health Plan of the Northwest	OR	($46,678.93)	($41,411.80)	$5,267.13
16322	UPMC Health Options	PA	($262,544.66)	($262,544.66)	$0.00
22444	Geisinger Health Plan	PA	$311,838.31	$311,838.31	$0.00
31609	Independence Blue Cross (QCC Ins Co.)	PA	($2,129.77)	($2,129.77)	$0.00
33709	Highmark Inc.	PA	$160,527.96	$160,527.96	$0.00
36247	Highmark Select Resources Inc.	PA	$62,844.81	$62,844.81	$0.00
53789	Keystone Health Plan Central	PA	($48,276.09)	($48,276.09)	$0.00
70194	Highmark Health Insurance Company	PA	($196,683.77)	($196,683.77)	$0.00
82795	Capital Advantage Insurance Company CAIC	PA	($28,001.90)	($28,001.90)	$0.00
83731	First Priority Health	PA	$2,425.15	$2,425.15	$0.00
26065	Blue Cross and Blue Shield of South Carolina	SC	$282,718.12	$282,718.12	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($282,718.11)	($282,718.11)	$0.00
31195	Sanford Health Plan	SD	$87,662.40	$87,662.40	$0.00
60536	Avera Health Plans, Inc.	SD	($87,662.38)	($87,662.38)	$0.00
23552	Oscar Insurance Company of Texas	TN	$212,542.11	$212,542.11	$0.00
97906	Bright Health Insurance Company of Tennessee	TN	($212,542.11)	($212,542.11)	$0.00
20069	Oscar Insurance Company of Texas	TX	($1,917,829.84)	($2,014,010.63)	($96,180.79)
33602	Blue Cross Blue Shield of Texas	TX	$1,698,919.82	$1,808,475.89	$109,556.07

Individual, Catastrophic Market Risk Pool					
HIOS ID	**HIOS INSURANCE COMPANY NAME**	**STATE**	**2019 HHS RISK ADJUSTMENT STATE TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2020)**	**2019 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER STATE TRANSFER AMOUNT (Total Issuer Transfer Amount)**	**ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2022)**
66252	CHRISTUS Health Plan	TX	$218,910.04	$205,534.73	($13,375.31)
68781	SelectHealth	UT	$0.00	$0.00	$0.00
10207	CareFirst BlueChoice	VA	($283,919.23)	($283,919.23)	$0.00
20507	Optima Health	VA	$389,622.74	$389,622.74	$0.00
37204	Piedmont Community HealthCare HMO, Inc.	VA	$241,917.86	$241,917.86	$0.00
88380	HealthKeepers, Inc(Anthem BCBS)	VA	($271,775.13)	($271,775.13)	$0.00
95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	VA	($75,846.23)	($75,846.23)	$0.00
13627	Blue Cross Blue Shield of Vermont	VT	$15,358.39	$15,358.39	$0.00
77566	MVP Health Care Inc.	VT	($15,358.39)	($15,358.39)	$0.00
23371	Kaiser Foundation Health Plan of the Northwest	WA	$350,724.53	$367,865.24	$17,140.71
80473	Kaiser Foundation Health Plan of Washington	WA	($350,724.52)	($367,865.24)	($17,140.72)
14630	Children's Community Health Plan	WI	$445,512.84	$468,944.11	$23,431.27
20173	HealthPartners Insurance Company	WI	($43,983.32)	($43,480.42)	$502.90
37833	Unity Health Plans Insurance Corporation	WI	$109,029.73	$144,832.65	$35,802.92
38166	Security Health Plan of Wisconsin, Inc.	WI	($78,584.46)	($72,016.31)	$6,568.15
38345	Dean Health Plan	WI	($257,616.30)	($277,658.41)	($20,042.11)
57845	Medica Health Plans of Wisconsin	WI	($135,657.65)	($139,691.27)	($4,033.62)
81974	Wisconsin Physicians Svc Insurance Corp - WI	WI	($3,959.26)	($3,985.59)	($26.33)
84670	WPS Health Plan, Inc. - WI	WI	($38,081.92)	($38,559.25)	($477.33)
86584	Aspirus Arise Health Plan of Wisconsin, Inc.	WI	($47,328.56)	($48,190.94)	($862.38)
87416	Common Ground Healthcare Cooperative	WI	$59,631.92	$19,781.48	($39,850.44)
94529	Group Health Cooperative of South Central Wisconsin	WI	($8,963.04)	($9,976.06)	($1,013.02)
31274	Highmark Blue Cross Blue Shield West Virginia	WV	$0.00	$0.00	$0.00

Table 2c: Issuer-Specific 2018 HHS-RADV Adjustments to 2019 Risk Adjustment Transfers for Small Group Market Risk Pool *(Appendix A)*

Small Group Market Risk Pool					
HIOS ID	**HIOS INSURANCE COMPANY NAME**	**STATE**	**2019 HHS RISK ADJUSTMENT STATE TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collectedin August 2020)**	**2019 HHS RISK ADJUSTMENT RADV ADJUSTMENT ISSUER STATE TRANSFER AMOUNT (Total Issuer Transfer Amount)**	**ADJUSTMENT AMOUNT (Charges Collectedin Calendar Year 2022)**
11082	Aetna Life Insurance Company	AK	($52,517.14)	($52,517.14)	$0.00
38344	Premera Blue Cross	AK	($159,372.00)	($159,372.00)	$0.00
73836	Moda Health Plan Inc	AK	$162,757.41	$162,757.41	$0.00
80049	UnitedHealthcare Insurance Company	AK	$49,131.73	$49,131.73	$0.00
46944	Blue Cross and Blue Shield of Alabama	AL	$2,173,185.19	$2,173,185.19	$0.00
68259	UnitedHealthcare of Alabama, Inc.	AL	($1,960,117.65)	($1,960,117.65)	$0.00
69461	UnitedHealthcare Insurance Company	AL	$154,617.72	$154,617.72	$0.00
93018	Viva Health, Inc.	AL	($367,685.30)	($367,685.30)	$0.00
13262	USAble Mutual Insurance Company	AR	$121,860.69	$121,860.69	$0.00
22732	UnitedHealthcare Insurance Company of the River Valley	AR	($324,815.85)	($324,815.85)	$0.00
37903	Qualchoice Life and Health Insurance Company, Inc.	AR	($361,203.31)	($361,203.31)	$0.00
65817	UnitedHealthcare of Arkansas, Inc.	AR	($549,647.02)	($549,647.02)	$0.00
70525	QCA Health Plan INC	AR	($552,747.83)	($552,747.83)	$0.00
75293	USAble Mutual Insurance Company	AR	$2,034,166.81	$2,034,166.81	$0.00
81392	UnitedHealthcare Insurance Company	AR	($367,613.60)	($367,613.60)	$0.00
23307	Humana Health Plan, Inc.	AZ	($269,587.68)	($252,959.60)	$16,628.08
23435	Banner Health and Aetna Health Plan Inc.	AZ	($69,485.73)	($69,442.08)	$43.65
40702	UnitedHealthcare of Arizona, Inc.	AZ	($5,800,768.71)	($6,059,749.47)	($258,980.76)
51485	Health Net Life Insurance Company	AZ	($133,851.39)	($132,498.08)	$1,353.31
53901	Blue Cross Blue Shield of Arizona	AZ	($827,536.07)	($750,627.38)	$76,908.69
66105	Humana Insurance Company	AZ	$817,738.60	$819,760.83	$2,022.23
70904	WMI Mutual Insurance Company	AZ	($27,060.44)	($27,057.13)	$3.31
77349	Banner Health and Aetna Health Insurance Company	AZ	($2,353,253.13)	($2,325,545.69)	$27,707.44

Small Group Market Risk Pool					
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78611	Aetna Health Inc. (a PA corp.)	AZ	($63,593.35)	($63,498.23)	$95.12
82011	UnitedHealthcare Insurance Company	AZ	$8,265,184.10	$8,397,150.01	$131,965.91
84251	Aetna Life Insurance Company	AZ	$328,164.06	$330,082.07	$1,918.01
86830	Cigna Health and Life Insurance Company	AZ	($15,771.87)	($15,771.03)	$0.84
91450	Health Net of Arizona, Inc.	AZ	$16,011.52	$16,231.42	$219.90
97667	Cigna HealthCare of Arizona, Inc	AZ	$88,949.33	$89,041.13	$91.80
98971	All Savers Insurance Company	AZ	$44,860.76	$44,883.30	$22.54
10544	Oscar Health Plan of California	CA	($402,719.71)	($402,719.71)	$0.00
20523	Aetna Health of California Inc.	CA	($10,132,177.38)	($10,132,177.38)	$0.00
27330	Kaiser Permanente Insurance Company	CA	$648,379.37	$648,379.37	$0.00
27603	Blue Cross of California(Anthem BC)	CA	$227,415,933.77	$227,415,933.77	$0.00
40513	Kaiser Foundation Health Plan, Inc.	CA	($357,963,401.04)	($357,963,401.04)	$0.00
40733	Aetna Life Insurance Company	CA	$12,166,038.89	$12,166,038.89	$0.00
47579	Chinese Community Health Plan	CA	($2,300,124.71)	($2,300,124.71)	$0.00
49116	UHC of California	CA	($32,023,673.23)	($32,023,673.23)	$0.00
56887	Ventura County Health Care Plan	CA	$180,761.04	$180,761.04	$0.00
64210	Sutter Health Plan	CA	($13,536,034.29)	($13,536,034.29)	$0.00
64618	National Health Insurance Company	CA	$118,805.40	$118,805.40	$0.00
67138	Health Net of California, Inc.	CA	($20,526,605.45)	($20,526,605.45)	$0.00
70285	CA Physician's Service dba Blue Shield of CA	CA	$160,918,949.65	$160,918,949.65	$0.00
92499	Sharp Health Plan	CA	($5,784,926.27)	($5,784,926.27)	$0.00
93689	Western Health Advantage	CA	$1,229,919.26	$1,229,919.26	$0.00
95677	UnitedHealthcare Insurance Company	CA	$13,769,293.79	$13,769,293.79	$0.00
99110	Health Net Life Insurance Company	CA	$26,221,580.95	$26,221,580.95	$0.00

Small Group Market Risk Pool					
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21032	Kaiser Foundation Health Plan of Colorado	CO	($21,301,984.66)	($17,915,252.43)	$3,386,732.23
35944	Kaiser Permanente Insurance Company	CO	($231,078.93)	($221,499.18)	$9,579.75
39041	Aetna Life Insurance Company	CO	($35,999.05)	($33,480.30)	$2,518.75
39670	Aetna Health Inc. (a PA corp.)	CO	($2,052.28)	($2,031.80)	$20.48
59036	UnitedHealthcare of Colorado, Inc.	CO	($11,888,359.53)	($10,942,369.36)	$945,990.17
63312	Friday Health Plans of Colorado, Inc	CO	($940,955.51)	($861,858.29)	$79,097.22
67879	UnitedHealthcare Insurance Company	CO	$22,469,748.45	$13,203,600.24	($9,266,148.21)
74320	Humana Health Plan	CO	($1,126,286.76)	$333,924.48	$1,460,211.24
76680	HMO Colorado Inc(Anthem BCBS)	CO	($7,780,138.27)	($7,435,182.77)	$344,955.50
79509	Humana Insurance Company	CO	$175,453.02	$208,340.43	$32,887.41
87269	Rocky Mountain Hos&Med Svc(Anthem BCBS)	CO	$20,628,922.97	$23,104,076.62	$2,475,153.65
97879	Rocky Mountain Health Maintenance Organization Inc	CO	$32,730.46	$561,732.21	$529,001.75
29462	Oxford Health Insurance, Inc.	CT	($8,679,773.61)	($10,355,380.09)	($1,675,606.48)
39159	Aetna Life Insurance Company	CT	$1,236,450.94	$1,335,976.05	$99,525.11
49650	UnitedHealthcare Insurance Company	CT	$165,516.98	$337,674.91	$172,157.93
71179	Oxford Health Plans (CT), Inc.	CT	($3,658,062.50)	($3,235,980.12)	$422,082.38
75091	ConnectiCare, Inc.	CT	($109,710.31)	($103,812.22)	$5,898.09
76962	ConnectiCare Benefits, Inc.	CT	($316,161.25)	($295,842.39)	$20,318.86
86545	Anthem Health Plans Inc(Anthem BCBS)	CT	$20,756,784.02	$27,211,206.72	$6,454,422.70
89130	HPHC Insurance Company, Inc.	CT	($2,978,889.80)	($1,693,240.48)	$1,285,649.32
94815	ConnectiCare Insurance Company, Inc.	CT	($3,313,233.23)	($10,779,115.49)	($7,465,882.26)
95882	Harvard Pilgrim Health Care of Connecticut, Inc.	CT	($3,102,921.26)	($2,421,486.87)	$681,434.39
21066	UnitedHealthcare of the Mid-Atlantic, Inc.	DC	($1,262,062.35)	($1,253,222.66)	$8,839.69
41842	UnitedHealthcare Insurance Company	DC	($1,598,092.93)	($3,685,235.63)	($2,087,142.70)

Small Group Market Risk Pool					
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73987	Aetna Health Inc. (a PA corp.)	DC	$53,928.14	$58,785.60	$4,857.46
75753	Optimum Choice, Inc.	DC	($881,254.13)	($862,875.30)	$18,378.83
77422	Aetna Life Insurance Company	DC	$839,114.49	$850,473.72	$11,359.23
78079	Group Hospitalization and Medical Services	DC	$13,354,185.70	$14,170,256.41	$816,070.71
86052	CareFirst BlueChoice	DC	($7,016,390.37)	($5,896,103.70)	$1,120,286.67
94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	DC	($3,489,428.52)	($3,382,078.46)	$107,350.06
29497	Aetna Life Insurance Company	DE	$219,171.38	$219,171.38	$0.00
61021	UnitedHealthcare Insurance Company	DE	($848,526.23)	($848,526.23)	$0.00
67190	Aetna Health Inc. (a PA corp.)	DE	$10,477.31	$10,477.31	$0.00
76168	Highmark BCBSD Inc.	DE	$674,998.41	$674,998.41	$0.00
97569	Optimum Choice, Inc.	DE	($56,120.87)	($56,120.87)	$0.00
16842	Blue Cross Blue Shield of FL Inc.	FL	$27,119,844.70	$27,748,375.13	$628,530.43
18628	Aetna Health Inc. (a FL corp.)	FL	$5,544,619.05	$5,589,996.62	$45,377.57
19898	AvMed, Inc	FL	$862,637.59	$974,242.87	$111,605.28
23841	Aetna Life Insurance Company	FL	$1,444,453.33	$1,451,885.26	$7,431.93
30252	Health Options, Inc.	FL	($16,397,574.72)	($16,094,458.72)	$303,116.00
35783	Humana Medical Plan, Inc.	FL	($1,709,565.83)	$5,179,860.44	$6,889,426.27
36194	Health First Commercial Plans, Inc.	FL	($435,793.03)	($366,030.92)	$69,762.11
42204	All Savers Insurance Company	FL	($215,654.33)	($214,406.59)	$1,247.74
43839	UnitedHealthcare Insurance Company	FL	$15,006,700.92	$15,543,608.09	$536,907.17
56503	Florida Health Care Plan, Inc	FL	($1,037,145.94)	($1,005,087.00)	$32,058.94
66966	Capital Health Plan	FL	($5,667,767.21)	($5,549,064.52)	$118,702.69
68398	UnitedHealthcare of Florida, Inc.	FL	$1,761,939.65	$2,378,064.13	$616,124.48
80779	Neighborhood Health Partnership, Inc.	FL	($25,852,652.50)	($35,223,463.57)	($9,370,811.07)
99308	Humana Health Insurance Co of FL, Inc.	FL	($424,041.74)	($413,520.85)	$10,520.89
13535	UnitedHealthcare Insurance Company	GA	$1,630,188.81	$1,630,188.81	$0.00

Small Group Market Risk Pool					
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30552	UnitedHealthcare Insurance Company of the River Valley	GA	($10,737,916.98)	($10,737,916.98)	$0.00
37001	Humana Insurance Company	GA	$397,824.09	$397,824.09	$0.00
43802	UnitedHealthcare of Georgia, Inc.	GA	($2,328,524.93)	($2,328,524.93)	$0.00
49046	Blue Cross and Blue Shield of GA, Inc	GA	$22,803,452.63	$22,803,452.63	$0.00
82302	Kaiser Permanente Insurance Company	GA	($234,560.20)	($234,560.20)	$0.00
82824	Aetna Health Inc. (a GA corp.)	GA	$135,470.24	$135,470.24	$0.00
83761	Alliant Health Plans	GA	($2,619,705.21)	($2,619,705.21)	$0.00
83978	Aetna Life Insurance Company	GA	$1,897,333.79	$1,897,333.79	$0.00
89942	Kaiser Foundation Health Plan of Georgia, Inc.	GA	($7,081,706.08)	($7,081,706.08)	$0.00
93332	Humana Employers Health Plan of Georgia, Inc.	GA	($3,861,855.93)	($3,861,855.93)	$0.00
18350	Hawaii Medical Service Association	HI	$15,423,516.52	$14,733,912.90	($689,603.62)
54179	UnitedHealthcare Insurance Company	HI	$155,881.62	$153,017.39	($2,864.23)
56682	Hawaii Medical Assurance Association	HI	($23,121.86)	($26,707.66)	($3,585.80)
60612	Kaiser Foundation Health Plan, Inc.	HI	($14,598,237.73)	($15,096,381.85)	($498,144.12)
95366	University Health Alliance	HI	($958,038.55)	$236,159.24	$1,194,197.79
18973	Aetna Health Inc. (a IA corp.)	IA	$30,704.93	$30,704.93	$0.00
25896	Wellmark Health Plan of Iowa, Inc	IA	($8,897,355.58)	($8,897,355.58)	$0.00
27651	Gundersen Health Plan, Inc.	IA	($61,525.31)	($61,525.31)	$0.00
50735	Medical Associates Health Plans	IA	$71,639.07	$71,639.07	$0.00
56610	UnitedHealthcare Plan of the River Valley, Inc.	IA	($1,823,531.14)	($1,823,531.14)	$0.00
72160	Wellmark, Inc	IA	$17,126,135.06	$17,126,135.06	$0.00
74406	Wellmark Value Health Plan, Inc.	IA	($482,386.47)	($482,386.47)	$0.00
74980	Avera Health Plans, Inc.	IA	($100,797.44)	($100,797.44)	$0.00
77638	Health Alliance Midwest, Inc.	IA	($28,982.12)	($28,982.12)	$0.00
78252	Aetna Life Insurance Company	IA	($41,178.25)	($41,178.25)	$0.00

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85930	Sanford Health Plan	IA	$11,491.93	$11,491.93	$0.00
88678	UnitedHealthcare Insurance Company	IA	($5,804,214.68)	($5,804,214.68)	$0.00
26002	SelectHealth	ID	($87,637.66)	($2,349,945.25)	($2,262,307.59)
38128	Montana Health Cooperative	ID	$38,309.71	$9,424.40	($28,885.31)
43541	National Health Insurance Company	ID	($200,586.17)	($232,827.27)	($32,241.10)
44648	Regence Blue Shield of Idaho	ID	($2,822,325.31)	($6,046,725.61)	($3,224,400.30)
45059	Aetna Life Insurance Company	ID	($75,920.70)	($79,521.00)	($3,600.30)
50118	UnitedHealthcare Insurance Company	ID	($412,441.79)	($488,772.82)	($76,331.03)
60597	PacificSource Health Plans	ID	$148,783.19	($977,439.44)	($1,126,222.63)
61589	Blue Cross of Idaho	ID	$3,411,818.67	$10,165,806.93	$6,753,988.26
20129	Health Alliance Medical Plans, Inc.	IL	($319,170.03)	($1,858,339.52)	($1,539,169.49)
24301	Medical Associates Health Plans	IL	($818,666.61)	($875,679.40)	($57,012.79)
33235	Gundersen Health Plan, Inc.	IL	($78,087.37)	($96,035.01)	($17,947.64)
34446	UnitedHealthcare Insurance Company of the River Valley	IL	$1,521,632.53	($1,832,062.75)	($3,353,695.28)
36096	Blue Cross Blue Shield of Illinois	IL	$2,684,192.27	$26,438,744.10	$23,754,551.83
42529	UnitedHealthcare of Illinois, Inc.	IL	($3,731,769.14)	($4,622,470.91)	($890,701.77)
54322	MercyCare HMO	IL	($387,239.87)	($485,629.90)	($98,390.03)
58239	UnitedHealthcare Plan of the River Valley, Inc.	IL	($330,762.38)	($999,056.39)	($668,294.01)
58288	Humana Health Plan, Inc.	IL	($946,670.37)	($1,470,457.42)	($523,787.05)
68303	Humana Insurance Company	IL	($434,952.91)	($1,149,761.70)	($714,808.79)
72547	Aetna Life Insurance Company	IL	$92,103.67	($20,495.59)	($112,599.26)
92476	UnitedHealthcare Insurance Company of Illinois	IL	$2,627,703.10	($13,140,573.69)	($15,768,276.79)
99129	Aetna Health Inc. (a PA corp.)	IL	$121,687.04	$111,818.21	($9,868.83)
17575	Anthem Ins Companies Inc(Anthem BCBS)	IN	$11,907,700.97	$11,907,700.97	$0.00
32378	Aetna Life Insurance Company	IN	($1,387.63)	($1,387.63)	$0.00
33380	Indiana University Health Plans, Inc	IN	($510,330.80)	($510,330.80)	$0.00

Small Group Market Risk Pool					
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36373	All Savers Insurance Company	IN	$110,302.76	$110,302.76	$0.00
43442	Humana Health Plan	IN	($318,354.35)	($318,354.35)	$0.00
50816	Physicians Health Plan of Northern Indiana, Inc.	IN	($4,028,263.84)	($4,028,263.84)	$0.00
67920	Southeastern Indiana Health Organization	IN	($317,807.61)	($317,807.61)	$0.00
72850	UnitedHealthcare Insurance Company	IN	($6,805,549.16)	($6,805,549.16)	$0.00
99791	Humana Insurance Company	IN	($36,310.54)	($36,310.54)	$0.00
18558	Blue Cross and Blue Shield of Kansas, Inc	KS	($7,398,709.25)	($7,398,709.25)	$0.00
19968	Humana Insurance Company	KS	$3,439,024.63	$3,439,024.63	$0.00
49857	Humana Health Plan, Inc.	KS	($269,003.03)	($269,003.03)	$0.00
57850	Aetna Health Inc. (a PA corp.)	KS	$67,359.24	$67,359.24	$0.00
84600	Aetna Life Insurance Company	KS	$35,904.36	$35,904.36	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	$3,390,457.74	$3,390,457.74	$0.00
94968	UnitedHealthcare Insurance Company	KS	$734,966.34	$734,966.34	$0.00
15411	Humana Health Plan, Inc.	KY	($3,561,355.21)	($3,561,355.21)	$0.00
23671	UnitedHealthcare of Kentucky, Ltd.	KY	($3,648,340.63)	($3,648,340.63)	$0.00
28773	UnitedHealthcare Insurance Company	KY	$34,364.09	$34,364.09	$0.00
34822	Aetna Health Inc. (a PA corp.)	KY	($10,172.43)	($10,172.43)	$0.00
36239	Anthem Health Plans of KY(Anthem BCBS)	KY	$6,198,550.60	$6,198,550.60	$0.00
45920	UnitedHealthcare of Ohio, Inc.	KY	$986,953.65	$986,953.65	$0.00
14030	Aetna Life Insurance Company	LA	($16,695.72)	($16,712.05)	($16.33)
19636	HMO Louisiana, Inc.	LA	($8,245,580.27)	($8,736,301.91)	($490,721.64)
38499	UnitedHealthcare of Louisiana, Inc.	LA	($112,244.80)	($113,634.10)	($1,389.30)
44965	Humana Health Benefit Plan of Louisiana, Inc.	LA	($509,946.82)	$1,140,515.52	$1,650,462.34
53946	UnitedHealthcare Insurance Company of the River Va	LA	($295,236.17)	($338,886.37)	($43,650.20)
67243	Vantage Health Plan	LA	($209,855.79)	($224,565.72)	($14,709.93)

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69842	UnitedHealthcare Insurance Company	LA	$63,494.97	($49,007.11)	($112,502.08)
81941	Aetna Health Inc. (a LA corp.)	LA	($3,442.74)	($3,447.36)	($4.62)
97176	Louisiana Health Service & Indemnity Company	LA	$9,329,507.22	$8,342,039.03	($987,468.19)
23620	UnitedHealthcare Insurance Company	MD	($1,361,559.61)	($8,448,666.07)	($7,087,106.46)
28137	CareFirst BlueChoice	MD	($4,796,178.18)	$7,992,210.43	$12,788,388.61
31112	UnitedHealthcare of the Mid-Atlantic, Inc.	MD	($3,396,778.55)	($4,195,801.76)	($799,023.21)
45532	CareFirst of Maryland	MD	$9,842,323.56	$9,061,840.90	($780,482.66)
65635	MAMSI Life and Health Insurance Company	MD	$314,937.49	($1,425,387.83)	($1,740,325.32)
66516	Aetna Health Inc. (a PA corp.)	MD	$182,462.64	$165,413.05	($17,049.59)
70767	Aetna Life Insurance Company	MD	($216,161.10)	($258,433.18)	($42,272.08)
72375	Optimum Choice, Inc.	MD	($8,101,893.51)	($9,392,514.52)	($1,290,621.01)
90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	MD	($6,752,769.90)	($6,307,540.67)	$445,229.23
94084	Group Hospitalization and Medical Services	MD	$14,285,617.14	$12,808,879.69	($1,476,737.45)
11593	HPHC Insurance Company Inc.	ME	$2,579,433.12	$2,579,433.12	$0.00
33653	Maine Community Health Options	ME	($670,993.21)	($670,993.21)	$0.00
48396	Anthem Health Plans of ME (Anthem BCBS)	ME	$913,742.73	$913,742.73	$0.00
53357	Aetna Life Insurance Company	ME	$2,107,962.02	$2,107,962.02	$0.00
73250	Aetna Health Inc. (a ME corp.)	ME	$164,277.01	$164,277.01	$0.00
90214	UnitedHealthcare Insurance Company	ME	($796,464.38)	($796,464.38)	$0.00
96667	Harvard Pilgrim Health Care Inc.	ME	($4,297,957.36)	($4,297,957.36)	$0.00
15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	MI	$11,235,971.36	$11,363,013.16	$127,041.80
20662	PHP Insurance Company	MI	$862,380.35	$863,328.43	$948.08
29241	Priority Health	MI	$1,146,521.52	$1,148,681.54	$2,160.02
29698	Priority Health	MI	$402,629.20	$429,555.85	$26,926.65

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37651	Health Alliance Plan of Michigan	MI	$1,489,181.69	$1,497,461.50	$8,279.81
52670	All Savers Insurance Company	MI	($26,002.04)	($26,000.74)	$1.30
60829	Physicians Health Plan	MI	($823,544.10)	($821,115.59)	$2,428.51
62294	Humana Insurance Company	MI	$129,986.63	$130,236.55	$249.92
63631	UnitedHealthcare Insurance Company	MI	($2,278,635.68)	($2,267,485.91)	$11,149.77
67183	Total Health Care	MI	$1,207,909.94	$1,212,194.41	$4,284.47
67577	Alliance Health & Life Insurance Co	MI	$2,269,521.21	$2,278,650.20	$9,128.99
71667	UnitedHealthcare Community Plan, Inc.	MI	($322,014.01)	($321,572.18)	$441.83
74917	McLaren Health Plan	MI	$415,441.57	$156,291.69	($259,149.88)
95233	Paramount Insurance Company	MI	$232,070.61	$232,278.49	$207.88
98185	Blue Care Network of Michigan	MI	($15,941,418.25)	($15,875,517.08)	$65,901.17
25198	UnitedHealthcare Insurance Company	MN	$109,542.93	$109,542.93	$0.00
31616	Medica Insurance Company	MN	$10,169,174.56	$10,169,174.56	$0.00
49316	BCBSMN INC	MN	$15,059,752.59	$15,059,752.59	$0.00
52346	Sanford Health Plan of Minnesota	MN	($68,409.98)	($68,409.98)	$0.00
57129	HMO Minnesota	MN	($7,897,302.21)	($7,897,302.21)	$0.00
70373	Gundersen Health Plan Minnesota, Inc.	MN	($523,565.92)	($523,565.92)	$0.00
79888	HealthPartners, Inc	MN	($16,525,912.61)	($16,525,912.61)	$0.00
85654	HealthPartners Insurance Company	MN	$333,832.61	$333,832.61	$0.00
88102	PreferredOne Insurance Company	MN	($608,955.20)	($608,955.20)	$0.00
97624	PreferredOne Community Health Plan	MN	($48,156.90)	($48,156.90)	$0.00
30613	Humana Insurance Company	MO	$1,497,426.21	$1,497,426.21	$0.00
32753	Healthy Alliance Life Co(Anthem BCBS)	MO	$5,993,468.17	$5,993,468.17	$0.00
32898	Aetna Health Inc. (a PA corp.)	MO	$99,749.57	$99,749.57	$0.00
34762	Blue Cross and Blue Shield of Kansas City	MO	$257,346.51	$257,346.51	$0.00

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48161	Aetna Life Insurance Company	MO	$69,459.64	$69,459.64	$0.00
95426	UnitedHealthcare Insurance Company	MO	($8,176,684.01)	($8,176,684.01)	$0.00
96384	Cox HealthPlans	MO	$259,234.00	$259,234.00	$0.00
11721	Blue Cross Blue Shield of Mississippi	MS	($244,468.80)	($244,468.80)	$0.00
26781	All Savers Insurance Company	MS	($106,561.13)	($106,561.13)	$0.00
48963	Humana Insurance Company	MS	($452,669.00)	($452,669.00)	$0.00
97560	UnitedHealthcare of Mississippi, Inc.	MS	($113,094.17)	($113,094.17)	$0.00
98805	UnitedHealthcare Insurance Company	MS	$916,793.10	$916,793.10	$0.00
23603	PacificSource Health Plans	MT	($2,260,031.75)	($2,260,031.75)	$0.00
30751	Blue Cross and Blue Shield of Montana	MT	$2,104,795.56	$2,104,795.56	$0.00
32225	Montana Health Cooperative	MT	($61,884.82)	($61,884.82)	$0.00
46621	UnitedHealthcare Insurance Company	MT	$217,121.00	$217,121.00	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	$27,675,049.24	$44,914,458.74	$17,239,409.50
43283	FirstCarolinaCare Insurance Company	NC	$62,043.30	$86,001.95	$23,958.65
54332	UnitedHealthcare of North Carolina, Inc.	NC	($14,956,628.97)	($34,052,601.43)	($19,095,972.46)
58658	UnitedHealthcare Insurance Company of the River Valley	NC	($3,228,717.01)	($2,594,972.93)	$633,744.08
61644	Aetna Life Insurance Company	NC	($239,821.73)	($214,449.27)	$25,372.46
61671	Aetna Health Inc. (a PA corp.)	NC	($15,543.71)	($14,752.26)	$791.45
69347	UnitedHealthcare Insurance Company	NC	($9,249,712.39)	($8,077,377.38)	$1,172,335.01
72487	All Savers Insurance Company	NC	($46,668.66)	($46,307.61)	$361.05
37160	Blue Cross Blue Shield of North Dakota	ND	($1,870,344.91)	($1,870,344.91)	$0.00
39364	Medica Insurance Company	ND	$2,009,594.93	$2,009,594.93	$0.00
73751	Medica Health Plans	ND	($35,949.73)	($35,949.73)	$0.00
76311	UnitedHealthcare Insurance Company	ND	($228,555.87)	($228,555.87)	$0.00
89364	Sanford Health Plan	ND	$125,255.52	$125,255.52	$0.00

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29678	Blue Cross and Blue Shield of Nebraska	NE	($1,525,660.88)	($1,525,660.88)	$0.00
44751	UnitedHealthcare of the Midlands, Inc.	NE	$161,104.00	$161,104.00	$0.00
59699	Aetna Life Insurance Company	NE	$47,198.74	$47,198.74	$0.00
73102	UnitedHealthcare Insurance Company	NE	$1,317,358.16	$1,317,358.16	$0.00
51889	UnitedHealthcare Insurance Company	NH	($665,003.08)	($660,316.02)	$4,687.06
57601	Anthem Health Plans of NH(Anthem BCBS)	NH	$655,269.83	$115,364.16	($539,905.67)
59025	Harvard Pilgrim Health Care of NE	NH	($2,655,453.09)	($2,445,946.56)	$209,506.53
71616	HPHC Insurance Company, Inc	NH	$4,198,889.34	$4,236,167.70	$37,278.36
86365	Tufts Health Freedom Insurance Company	NH	($4,031,432.02)	($3,899,171.04)	$132,260.98
96751	Matthew Thornton Hlth Plan(Anthem BCBS)	NH	$2,497,729.01	$2,653,901.70	$156,172.69
13953	Horizon Healthcare of New Jersey, Inc.	NJ	$347,309.41	$407,600.65	$60,291.24
23458	Cigna Health and Life Insurance Company	NJ	$91,847.72	$93,040.62	$1,192.90
23818	Oscar Garden State Insurance Corporation	NJ	($1,477,648.15)	($1,410,298.21)	$67,349.94
41014	Cigna HealthCare of New Jersey, Inc.	NJ	($3,402.55)	($3,342.80)	$59.75
48834	Oxford Health Plans (NJ), Inc.	NJ	$287,721.88	$312,780.99	$25,059.11
77263	Oxford Health Insurance, Inc.	NJ	$22,866,708.78	$9,888,471.91	($12,978,236.87)
77606	AmeriHealth HMO	NJ	($7,387,471.96)	($7,076,995.14)	$310,476.82
91661	Horizon Healthcare Services, Inc.	NJ	($15,273,253.75)	($4,340,955.66)	$10,932,298.09
91762	AmeriHealth Ins Company of New Jersey	NJ	$548,188.56	$2,129,697.65	$1,581,509.09
42776	True Health New Mexico, Inc.	NM	($1,656,427.16)	($2,071,122.13)	($414,694.97)
52744	Presbyterian Insurance Company	NM	$1,245,823.71	$943,923.28	($301,900.43)
57173	Presbyterian Health Plan	NM	($6,175,984.57)	($6,575,688.07)	($399,703.50)
75605	Blue Cross Blue Shield of New Mexico	NM	$6,745,307.29	$8,200,073.32	$1,454,766.03
90762	UnitedHealthcare Insurance Company	NM	($158,719.13)	($497,186.34)	($338,467.21)

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16698	Prominence HealthFirst	NV	$336,889.99	$860,043.04	$523,153.05
19298	Aetna Health Inc. (a PA corp.)	NV	$98,998.96	$150,720.10	$51,721.14
27990	Aetna Life Insurance Company	NV	($1,612,695.03)	($1,173,004.76)	$439,690.27
33670	Rocky Mountain Hos&Med Svc(Anthem BCBS)	NV	$6,926,547.64	$9,315,544.02	$2,388,996.38
41094	Hometown Health Plan Inc	NV	($1,394,315.89)	($1,200,773.24)	$193,542.65
42313	WMI Mutual Insurance Company	NV	($11,341.52)	($10,854.94)	$486.58
60156	HMO Colorado Inc(Anthem BCBS)	NV	($22,934.12)	$87,059.49	$109,993.61
68524	Prominence Preferred Health Insurance Company, Inc.	NV	$246,726.17	$272,027.46	$25,301.29
74222	UnitedHealthcare Insurance Company	NV	($1,609,307.16)	$994,764.13	$2,604,071.29
83198	Sierra Health and Life Insurance Company, Inc.	NV	$2,071,484.37	($5,196,715.11)	($7,268,199.48)
85266	Hometown Health Providers Insurance Company, Inc	NV	($1,362,260.52)	($230,276.68)	$1,131,983.84
95865	Health Plan of Nevada, Inc.	NV	($3,667,792.96)	($3,868,533.46)	($200,740.50)
11177	Metro Plus Health Plan	NY	($2,809,572.50)	($2,684,652.99)	$124,919.51
17210	Aetna Life Insurance Company	NY	($4,355,032.12)	($614,644.05)	$3,740,388.07
18029	Independent Health Benefits Corporation	NY	$7,745,623.36	$11,211,248.92	$3,465,625.56
36346	BlueShield of Northeastern New York	NY	$1,626,133.86	$4,960,369.49	$3,334,235.63
43477	Crystal Run Health Insurance Company, Inc.	NY	($3,799,145.39)	($3,434,649.34)	$364,496.05
44113	Empire HealthChoice Assurance, Inc.	NY	($8,022,666.12)	($3,251,675.09)	$4,770,991.03
49526	BlueCross BlueShield of Western New York	NY	$13,575,156.17	$23,110,931.35	$9,535,775.18
54297	UnitedHealthcare Insurance Company of New York	NY	($459,872.66)	($363,025.35)	$96,847.31
56184	MVP Health Care Inc.	NY	($2,176,105.51)	($1,541,796.14)	$634,309.37
61405	Healthfirst Insurance Company, Inc.	NY	($14,989,660.68)	($13,616,197.60)	$1,373,463.08
73886	Crystal Run Health Plan, LLC	NY	($2,552,147.56)	($2,391,409.99)	$160,737.57
74289	Oscar Insurance Corporation	NY	($40,900,639.76)	($39,125,057.59)	$1,775,582.17
78124	Excellus Health Plan, Inc.	NY	($44,043,931.37)	($18,436,900.82)	$25,607,030.55

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80519	Empire HealthChoice HMO, Inc.	NY	($2,441,078.80)	($2,218,191.65)	$222,887.15
85629	Oxford Health Insurance, Inc.	NY	$129,708,438.73	$55,296,585.17	($74,411,853.56)
88582	Health Insurance Plan of Greater New York	NY	($24,210,632.58)	($19,901,260.44)	$4,309,372.14
89846	MVP Health Care Inc.	NY	$1,593,033.84	$11,272,610.86	$9,679,577.02
92551	CDPHP, Universal Benefits Inc.	NY	$5,576,476.84	$9,852,590.22	$4,276,113.38
94788	Capital District Physicians' Health Plan, Inc.	NY	($9,064,377.83)	($8,124,875.16)	$939,502.67
28162	AultCare Insurance Company	OH	($386,024.54)	($363,042.77)	$22,981.77
29276	Community Insurance Company(Anthem BCBS)	OH	$9,087,626.10	$9,830,780.64	$743,154.54
33232	UnitedHealthcare Insurance Company of the River Valley	OH	($661,399.86)	($638,466.67)	$22,933.19
33931	UnitedHealthcare of Ohio, Inc.	OH	$297,150.64	$336,580.04	$39,429.40
52664	Summa Insurance Company Inc.	OH	$863,424.89	$900,375.04	$36,950.15
56726	UnitedHealthcare Insurance Company	OH	($428,766.64)	($371,610.61)	$57,156.03
61724	UnitedHealthcare Life Insurance Company	OH	($15,214,335.70)	($14,527,907.87)	$686,427.83
66083	Humana Health Plan of Ohio, Inc.	OH	($2,465,124.89)	($4,452,468.84)	($1,987,343.95)
67129	Aetna Life Insurance Company	OH	$92,941.78	$103,921.54	$10,979.76
74313	Paramount Insurance Company	OH	$466,695.32	$498,916.20	$32,220.88
80627	Medical Mutual of Ohio	OH	$9,109,301.61	$9,426,558.62	$317,257.01
83396	The Health Plan of the Upper Ohio Valley	OH	($303,939.63)	($299,073.18)	$4,866.45
84867	Aetna Health Inc. (a PA corp.)	OH	($124,341.24)	($118,889.96)	$5,451.28
97596	Humana Insurance Company	OH	($298,801.23)	($292,906.00)	$5,895.23
98810	THP Insurance Company	OH	($34,406.41)	($32,766.26)	$1,640.15
45480	UnitedHealthcare of Oklahoma, Inc.	OK	($327,904.90)	($780,434.49)	($452,529.59)
66946	Aetna Life Insurance Company	OK	$214,668.99	$194,013.40	($20,655.59)
76275	Aetna Health Inc. (a PA corp.)	OK	($11,815.93)	($12,395.38)	($579.45)
85757	UnitedHealthcare Insurance Company	OK	($1,211,855.09)	($3,718,128.98)	($2,506,273.89)

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87571	Blue Cross Blue Shield of Oklahoma	OK	$6,732,119.84	$12,670,199.17	$5,938,079.33
87698	CommunityCare Life & Health Insurance Co	OK	$259,837.17	($76,483.38)	($336,320.55)
98905	CommunityCare HMO Inc.	OK	($5,655,050.04)	($8,276,770.24)	($2,621,720.20)
10091	PacificSource Health Plans	OR	$646,583.99	($318,416.16)	($965,000.15)
10940	Health Net Plan of Oregon, Inc.	OR	$2,112,598.38	$1,834,998.30	($277,600.08)
33375	Samaritan Health Plans	OR	$101,919.74	$72,862.29	($29,057.45)
39424	Moda Health Plan Inc	OR	$1,187,867.00	$2,901,171.57	$1,713,304.57
56707	Providence Health Plan	OR	$7,524,957.25	$2,878,941.57	($4,646,015.68)
71287	Kaiser Foundation Health Plan of the Northwest	OR	($8,476,422.62)	($5,294,091.05)	$3,182,331.57
77969	Regence BlueCross BlueShield of Oregon	OR	($1,843,925.92)	$537,878.63	$2,381,804.55
90175	UnitedHealthcare Insurance Company	OR	($1,253,577.65)	($2,613,345.15)	($1,359,767.50)
16322	UPMC Health Options	PA	$4,151,868.93	$4,151,868.93	$0.00
18939	Aetna HealthAssurance Pennsylvania, Inc.	PA	$566,873.69	$566,873.69	$0.00
22444	Geisinger Health Plan	PA	($401,409.93)	($401,409.93)	$0.00
23489	UnitedHealthcare Insurance Company	PA	($10,093,662.00)	($10,093,662.00)	$0.00
24872	UnitedHealthcare of PA, Inc.	PA	($1,088,898.13)	($1,088,898.13)	$0.00
31609	Independence Blue Cross (QCC Ins Co.)	PA	$11,298,288.50	$11,298,288.50	$0.00
33709	Highmark Inc.	PA	$712,097.65	$712,097.65	$0.00
33871	Keystone Health Plan East	PA	($28,490,127.37)	($28,490,127.37)	$0.00
33906	Aetna Life Insurance Company	PA	($132,950.87)	($132,950.87)	$0.00
38949	Keystone Health Plan West	PA	($51,280.07)	($51,280.07)	$0.00
45127	Capital Advantage Assurance Company	PA	$16,350,609.62	$16,350,609.62	$0.00
53789	Keystone Health Plan Central	PA	($149,357.82)	($149,357.82)	$0.00
55957	First Priority Life Insurance Company	PA	$4,147,631.12	$4,147,631.12	$0.00
62560	UPMC Health Coverage	PA	($708,881.33)	($708,881.33)	$0.00
64844	Aetna Health Inc. (a PA corp.)	PA	$553,231.49	$553,231.49	$0.00
67430	UPMC Health Benefits, Inc.	PA	($1,212,038.34)	($1,212,038.34)	$0.00

Small Group Market Risk Pool					
HIOS ID	**HIOS INSURANCE COMPANY NAME**	**STATE**	**2019 HHS RISK ADJUSTMENT STATE TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collectedin August 2020)**	**2019 HHS RISK ADJUSTMENT RADV ADJUSTMENT ISSUER STATE TRANSFER AMOUNT (Total Issuer Transfer Amount)**	**ADJUSTMENT AMOUNT (Charges Collectedin Calendar Year 2022)**
70194	Highmark Health Insurance Company	PA	$202,651.05	$202,651.05	$0.00
75729	Geisinger Quality Options	PA	($113,079.27)	($113,079.27)	$0.00
79279	Highmark Coverage Advantage Inc.	PA	$1,270,632.61	$1,270,632.61	$0.00
79962	Highmark Benefits Group Inc.	PA	$3,130,205.43	$3,130,205.43	$0.00
82795	Capital Advantage Insurance Company CAIC	PA	$57,595.15	$57,595.15	$0.00
15287	Blue Cross & Blue Shield of Rhode Island	RI	$5,023,880.25	$5,023,880.25	$0.00
26322	Tufts Associated Health Maintenance Organization Inc.	RI	($1,413,930.38)	($1,413,930.38)	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	($1,447,128.45)	($1,447,128.45)	$0.00
79881	UnitedHealthcare of New England, Inc.	RI	($482,078.76)	($482,078.76)	$0.00
90010	Tufts Associated Health Maintenance Organization Inc.	RI	($1,717,988.80)	($1,717,988.80)	$0.00
90117	UnitedHealthcare Insurance Company	RI	$37,246.18	$37,246.18	$0.00
22369	Aetna Life Insurance Company	SC	($55,162.34)	($55,162.34)	$0.00
26065	Blue Cross and Blue Shield of South Carolina	SC	$3,396,831.82	$3,396,831.82	$0.00
38408	Aetna Health Inc. (a PA corp.)	SC	$25,308.99	$25,308.99	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($606,627.84)	($606,627.84)	$0.00
57860	UnitedHealthcare Insurance Company	SC	($286,290.36)	($286,290.36)	$0.00
64146	UnitedHealthcare Insurance Company of the River Valley	SC	($2,474,060.35)	($2,474,060.35)	$0.00
31195	Sanford Health Plan	SD	($168,247.60)	($168,247.60)	$0.00
50305	Wellmark of South Dakota, Inc	SD	$4,613,155.94	$4,613,155.94	$0.00
60536	Avera Health Plans, Inc.	SD	($4,322,311.36)	($4,322,311.36)	$0.00
62210	South Dakota State Medical Holding Company, Inc.	SD	($8,426.36)	($8,426.36)	$0.00
76458	UnitedHealthcare Insurance Company	SD	($143,066.65)	($143,066.65)	$0.00
96594	Medica Insurance Company	SD	$28,896.02	$28,896.02	$0.00
10958	UnitedHealthcare Insurance Company of the River Valley	TN	($7,208,320.90)	($7,208,320.90)	$0.00

Small Group Market Risk Pool					
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14002	BlueCross BlueShield of Tennessee	TN	$8,391,253.31	$8,391,253.31	$0.00
23552	Oscar Insurance Company of Texas	TN	($302,447.82)	($302,447.82)	$0.00
31552	Aetna Life Insurance Company	TN	$243,111.09	$243,111.09	$0.00
69443	UnitedHealthcare Insurance Company	TN	$1,125,787.13	$1,125,787.13	$0.00
82120	Humana Insurance Company	TN	($2,249,382.87)	($2,249,382.87)	$0.00
26539	SHA, LLC	TX	($229,737.71)	($854,898.85)	($625,161.14)
30609	Memorial Hermann Health Insurance Company	TX	$881,217.93	$782,169.08	($99,048.85)
32673	Humana Health Plan of Texas, Inc.	TX	$3,156,848.28	($2,646,366.80)	($5,803,215.08)
33602	Blue Cross Blue Shield of Texas	TX	($2,779,511.73)	$18,642,374.45	$21,421,886.18
37392	Prominence HealthFirst of Texas, Inc.	TX	$29,632.04	$27,334.50	($2,297.54)
37755	Insurance Company of Scott & White	TX	($1,455,901.31)	($1,868,703.33)	($412,802.02)
40220	UnitedHealthcare of Texas, Inc.	TX	($2,592,793.24)	($3,132,816.55)	($540,023.31)
40788	Scott and White Health Plan	TX	($3,871,149.81)	($4,887,011.14)	($1,015,861.33)
41549	Southwest Life and Health	TX	$112,495.58	$89,469.27	($23,026.31)
58840	Aetna Health Inc. (a TX corp.)	TX	($16,064.49)	($16,285.92)	($221.43)
63141	Humana Insurance Company	TX	$2,977,436.53	$2,095,047.20	($882,389.33)
75394	Texas Health + Aetna Health Insurance Company	TX	$179,719.44	$171,486.51	($8,232.93)
75655	MemorialHermann Commercial Health Plan	TX	($1,741,458.25)	($1,915,780.35)	($174,322.10)
91716	Aetna Life Insurance Company	TX	$1,597,171.53	$1,480,049.97	($117,121.56)
98809	UnitedHealthcare Insurance Company	TX	$3,752,094.84	($7,966,067.87)	($11,718,162.71)
22013	Regence BlueCross BlueShield of Utah	UT	$395,222.13	$526,292.88	$131,070.75
29031	National Health Insurance Company	UT	($42,462.68)	($37,369.53)	$5,093.15
38927	Altius Health Plans Inc.	UT	$84,131.24	$84,609.88	$478.64
46958	Humana Insurance Company	UT	$444,477.34	$446,811.63	$2,334.29

Small Group Market Risk Pool					
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48588	Aetna Life Insurance Company	UT	$69,587.35	$69,819.45	$232.10
66413	UnitedHealthcare of Utah, Inc.	UT	($488,336.67)	($487,438.41)	$898.26
68781	SelectHealth	UT	$1,166,958.47	$1,608,137.96	$441,179.49
80043	WMI Mutual Insurance Company	UT	($28,651.06)	($28,345.86)	$305.20
97462	UnitedHealthcare Insurance Company	UT	($1,600,926.09)	($2,182,518.06)	($581,591.97)
10207	CareFirst BlueChoice	VA	($16,992,039.04)	($16,867,374.95)	$124,664.09
12028	Innovation Health Insurance Company	VA	($246,907.95)	($239,948.63)	$6,959.32
16064	Anthem Health Plans of VA (Anthem BCBS)	VA	$42,134,668.11	$42,451,692.84	$317,024.73
20507	Optima Health	VA	($6,949,186.92)	($6,802,790.81)	$146,396.11
24251	Optimum Choice, Inc.	VA	($3,034,619.59)	($3,011,345.49)	$23,274.10
25978	UnitedHealthcare Insurance Company	VA	($19,914,350.42)	($19,681,839.73)	$232,510.69
37204	Piedmont Community HealthCare HMO, Inc.	VA	$1,618,444.01	$1,624,395.39	$5,951.38
38234	Aetna Life Insurance Company	VA	($279,201.44)	($278,367.43)	$834.01
38599	UnitedHealthcare of the Mid-Atlantic Inc	VA	($2,228,455.58)	($3,457,902.58)	($1,229,447.00)
40308	Group Hospitalization and Medical Services	VA	$8,112,275.85	$8,174,328.60	$62,052.75
86443	Innovation Health Plan, Inc.	VA	$455,454.20	$457,896.69	$2,442.49
88380	HealthKeepers, Inc (Anthem BCBS)	VA	$5,661,522.37	$5,908,640.33	$247,117.96
89242	Optima Health	VA	$1,567,955.60	$1,574,623.45	$6,667.85
89498	UnitedHealthcare Plan of the River Valley, Inc.	VA	($75,652.34)	($66,670.14)	$8,982.20
93187	Aetna Health Inc. (a PA corp.)	VA	$104,318.29	$105,381.43	$1,063.14
95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	VA	($9,934,225.25)	($9,890,719.16)	$43,506.09
18699	UnitedHealthcare Insurance Company	WA	($4,771,724.70)	($4,388,453.73)	$383,270.97
23371	Kaiser Foundation Health Plan of the Northwest	WA	($2,462,350.03)	($157,104.61)	$2,305,245.42
25768	Kaiser Foundation Health Plan of Washington Options	WA	($5,941,736.50)	($5,349,019.03)	$592,717.47

Small Group Market Risk Pool					
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34673	Aetna Life Insurance Company	WA	($73,083.79)	($24,231.13)	$48,852.66
36026	Health Net Plan of Oregon, Inc.	WA	$126,400.48	$137,508.15	$11,107.67
38229	Health Alliance Northwest Health Plan Inc.	WA	($36,354.10)	($36,280.85)	$73.25
43861	UnitedHealthcare of Washington, Inc.	WA	$292,527.93	$294,226.17	$1,698.24
49831	Premera Blue Cross	WA	$17,080,378.95	$11,064,896.63	($6,015,482.32)
69364	Asuris Northwest Health	WA	$953,802.30	$1,109,915.66	$156,113.36
71281	Regence BlueCross BlueShield Of Oregon (Clark County)	WA	$93,217.98	$181,762.85	$88,544.87
80473	Kaiser Foundation Health Plan of Washington	WA	($11,057,713.42)	($10,626,865.71)	$430,847.71
87718	Regence BlueShield	WA	$5,796,634.84	$7,793,645.47	$1,997,010.63
16245	Group Health Cooperative of Eau Claire	WI	($768,452.65)	($843,907.49)	($75,454.84)
20173	HealthPartners Insurance Company	WI	($850,241.16)	($701,978.61)	$148,262.55
35334	MercyCare Insurance Co	WI	$23,863.57	$20,052.91	($3,810.66)
37833	Unity Health Plans Insurance Corporation	WI	($8,835,031.35)	($359,682.77)	$8,475,348.58
38166	Security Health Plan of Wisconsin, Inc.	WI	($1,859,467.21)	($1,119,303.28)	$740,163.93
38345	Dean Health Plan	WI	($4,867,122.40)	($5,785,935.94)	($918,813.54)
38752	Aetna Life Insurance Company	WI	($43,341.25)	($45,101.05)	($1,759.80)
39924	All Savers Insurance Company	WI	($76,258.62)	($77,364.65)	($1,106.03)
47342	Health Tradition Health Plan	WI	$53,314.61	($16,815.29)	($70,129.90)
55103	Humana Wisconsin Health Org. Ins. Copr	WI	$1,409,621.09	$1,145,818.88	($263,802.21)
57637	Medica Insurance Company	WI	($1,257,454.95)	($1,634,049.33)	($376,594.38)
58326	MercyCare HMO, Inc.	WI	($677,002.32)	($874,318.71)	($197,316.39)
58564	Physicians Plus	WI	($22,596.86)	($23,321.18)	($724.32)
59158	UnitedHealthcare Insurance Company	WI	$11,431,172.12	$7,379,120.96	($4,052,051.16)
64772	Medical Associates Health Plans	WI	$75,292.73	$46,383.36	($28,909.37)
79475	Compcare Health Serv Ins Co(Anthem BCBS)	WI	$4,542,042.85	$2,743,152.66	($1,798,890.19)

Small Group Market Risk Pool					
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80180	UnitedHealthcare of Wisconsin, Inc.	WI	($519,328.47)	($811,824.11)	($292,495.64)
81413	Network Health Plan	WI	$91,572.41	$89,090.27	($2,482.14)
81974	Wisconsin Physicians Svc Insurance Corp – WI	WI	$2,243,694.09	$2,031,147.25	($212,546.84)
84670	WPS Health Plan, Inc. – WI	WI	$824,799.55	$652,818.46	($171,981.09)
86584	Aspirus Arise Health Plan of Wisconsin, Inc.	WI	($1,182,552.96)	($1,301,884.03)	($119,331.07)
87416	Common Ground Healthcare Cooperative	WI	($7,314.84)	($42,755.05)	($35,440.21)
90028	BCBS of Wisconsin(Anthem BCBS)	WI	($950,054.29)	($1,004,637.42)	($54,583.13)
91604	Humana Insurance Company	WI	$1,570,967.36	$973,427.09	($597,540.27)
94529	Group Health Cooperative of South Central Wisconsin	WI	($350,120.82)	($438,132.76)	($88,011.94)
31274	Highmark Blue Cross Blue Shield West Virginia	WV	$1,876,021.03	$2,439,182.74	$563,161.71
50318	Aetna Life Insurance Company	WV	$242,393.08	$246,089.38	$3,696.30
59772	THP Insurance Company	WV	($23,456.78)	$1,605.48	$25,062.26
72982	The Health Plan of the Upper Ohio Valley	WV	($460,667.41)	($430,305.37)	$30,362.04
77060	UnitedHealthcare Insurance Company	WV	($1,325,564.99)	($1,950,108.32)	($624,543.33)
95628	Optimum Choice, Inc.	WV	($308,724.99)	($306,463.98)	$2,261.01
11269	Blue Cross Blue Shield of Wyoming	WY	($1,416,840.06)	($2,327,062.60)	($910,222.54)
49714	UnitedHealthcare Insurance Company	WY	$1,416,840.07	$2,327,062.56	$910,222.49

IV. Issuer-Specific 2018 HHS-RADV Adjustments to 2019 Risk Adjustment Transfers for Merged Market States

For the 2018 and 2019 benefit years, Vermont and Massachusetts were the only states considered to have merged markets for purposes of the HHS-operated risk adjustment program.[29]

We signify $0.00 for issuers where there is no adjustment being made because there are no error rates in the state market risk pool.

Table 3: Issuer-Specific 2018 HHS-RADV Adjustments to 2019 Risk Adjustment Transfers for Merged Market Risk Pool *(Appendix B)*[30]

Merged Market Risk Pool					
HIOS ID	**HIOS INSURANCE COMPANY NAME**	**STATE**	**2019 HHS RISK ADJUSTMENT STATE TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2020)**	**2019 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER STATE TRANSFER AMOUNT (Total Issuer Transfer Amount)**	**ADJUSTMENT AMOUNT (Charges Collectedin Calendar Year 2022)**
29125	Tufts Associated Health Maintenance Organization Inc.	MA	($3,183,254.20)	($4,529,255.75)	($1,346,001.55)
31779	UnitedHealthcare Insurance Company	MA	($9,134,411.48)	($9,310,115.18)	($175,703.70)
34484	Health New England	MA	($4,321,853.45)	($4,759,864.94)	($438,011.49)
36046	Harvard Pilgrim Health Care Inc.	MA	$18,363,994.18	$17,458,215.12	($905,779.06)
38712	Tufts Associated Health Maintenance Organization Inc.	MA	$1,245,167.24	$1,169,422.50	($75,744.74)
41304	AllWays Health Partners	MA	$51,012,613.95	$62,415,133.00	$11,402,519.05
42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	MA	$47,671,125.55	$43,558,320.71	($4,112,804.84)
52710	Fallon Life and Health Assurance Co	MA	$125,626.12	$123,006.54	($2,619.58)
59763	Tufts Health Public Plans, Inc.	MA	($89,297,368.18)	($91,950,849.37)	($2,653,481.19)
82569	Boston Medical Center Health Plan, Inc.	MA	($16,684,744.22)	($18,021,417.45)	($1,336,673.23)
88806	Fallon Community Health Plan	MA	$3,973,653.92	$3,638,457.88	($335,196.04)
88950	ConnectiCare of Massachusetts Inc.	MA	$552,384.80	$546,262.09	($6,122.71)
95878	HPHC Insurance Company Inc.	MA	($322,934.23)	($337,315.53)	($14,381.30)
13627	Blue Cross Blue Shield of Vermont	VT	$20,258,361.68	$20,258,361.68	$0.00
77566	MVP Health Care Inc.	VT	($20,258,361.65)	($20,258,361.65)	$0.00

[29] See https://www.regtap.info/uploads/library/RA_GuidanceMergedMarkets2018_030118_5CR_030118.pdf.
[30] Massachusetts and Vermont were considered to have a merged market for purposes of the risk adjustment program for the 2018 and 2019 benefit years. See https://www.regtap.info/uploads/library/RA_GuidanceMergedMarkets2018_030118_5CR_030118.pdf.

V. Exiting Issuers and Issuer-Specific Adjustments to 2018 Benefit Year Risk Adjustment Transfers Based on Reissued 2018 Benefit Year HHS-RADV Results

There were no exiting issuers with a positive error rate in 2018 benefit year HHS-RADV and therefore no adjustments are being made to 2018 benefit year risk adjustment transfers as a result of 2018 benefit year HHS-RADV.

VI. Default Data Validation Charge

For 2018 benefit year HHS-RADV, no issuers were assessed a default data validation charge (DDVC).[31] As such, we do not provide any issuer specific tables related to the HHS Default Data Validation Charge (Charge and Allocation) as there were no issuers assessed a DDVC for 2018 benefit year HHS-RADV.

VII. HHS-Operated Risk Adjustment Program State-Specific Data *(Appendix C)*

In *Appendix C*, we set forth the risk adjustment state averages after application of the reissued 2018 benefit year HHS-RADV error rates with billable member months for the 2019 benefit year. *Appendix C* includes the following data elements after application of the reissued 2018 benefit year HHS-RADV error rates: state average monthly premiums by state market risk pool (catastrophic, individual non-catastrophic, small group, and merged), the state average plan liability risk score by state market risk pool, state average allowable rating factor by state market risk pool, state average actuarial value by state market risk pool, state average induced demand factor by state market risk pool, and billable member months for each respective benefit year. We note that some data elements in *Appendix C* have been updated to reflect material late-filed discrepancies after the original publication of 2019 benefit year risk adjustment transfers and state averages.[32,33] We also provide a description below of the calculations for state average premium, state average plan liability risk score, state average allowable rating factor, state average actuarial value, state average induced demand factor, and billable member months.

DATA ELEMENT	DESCRIPTION
State Average Monthly Premium	The state average premium for state market risk pool is the weighted average monthly premium for the state market risk pool, weighted by plan share of statewide enrollment in the state market risk pool. Beginning in the 2018 benefit year, a 14 percent administrative cost adjustment is applied to the state average monthly premium. This value is used in the state payment transfer formula calculations for risk adjustment payments and charges.

[31] Pursuant to 45 C.F.R. § 153.630(b)(10), HHS will assess a DDVC if an issuer of a risk adjustment covered plan fails to engage an initial validation auditor (IVA) or submit IVA results to HHS. See the 2020 Payment Notice, 84 FR at 17495 – 17497, for details on the calculation and allocation of DDVCs.

[32] The Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf.

[33] State risk pool averages are subject to change based on late-filed material discrepancies, as well as successful appeals.

DATA ELEMENT	DESCRIPTION
State Average Monthly Premium Before Adjustment	The state average premium for state market risk pool is the weighted average monthly premium for the state market risk pool, weighted by plan share of statewide enrollment in the state market risk pool before the 14 percent administrative cost adjustment is applied. This value is for informational purposes only and not used in the calculation of risk adjustment payments and charges.
State Average Plan Liability Risk Score (PLRS)	The state average PLRS is calculated as the summed products of PLRS and billable member months for all plans within the state market risk pool divided by total billable months for all plans within the state market risk pool.
State Average Plan Liability Risk Score After RADV	The state average PLRS after RADV is calculated as the summed products of PLRS with RADV error rates applied and billable member months for all plans within the state market risk pool divided by total billable months for all plans within the state market risk pool.
State Average Allowable Rating Factor (ARF)	The state average ARF is calculated as the summed products of ARF and billable member months for the plans within the state market risk pool divided by total billable member months for all plans in the state market risk pool.
State Average Actuarial Value (AV)	The state average AV is calculated as the summed products of AV and billable member months for the plans within the state market risk pool divided by the total billable member months within the state market risk pool. AV corresponds with metal and catastrophic tiers as follows: * Catastrophic: 0.57 * Bronze: 0.60 * Silver: 0.70 * Gold: 0.80 * Platinum: 0.90
State Average Induced Demand Factor (IDF)	The state average IDF is calculated as the summed products of IDF and billable member months for the plans within the state market risk pool divided by the total billable member months within the state market risk pool. IDF corresponds with metal and catastrophic tiers as follows: *Catastrophic: 1.00 *Bronze: 1.00 *Silver: 1.03 *Gold: 1.08 *Platinum: 1.15
Billable Member Months	Billable member months are the member months of an individual or family policy that are included when setting the policy's premium rate.

VIII. HHS-Operated Risk Adjustment Program Original and Reissued 2018 Benefit Year HHS-RADV Adjustment Amount Comparison

Below we set forth the original and reissued 2018 benefit year HHS-RADV adjustments to 2019 risk adjustment transfer amounts.[34] "Reissued Adjustment Amount" represents the amount that issuers will be charged or paid as a result of the reissued 2018 benefit year HHS-RADV results being applied to the issuers' 2019 benefit year risk adjustment transfers.

We signify $0.00 for issuers where there is no adjustment being made because there are no error rates in the state market risk pool.

Table 4: Issuer-Specific Comparison of Original and Reissued 2018 Benefit Year HHS-RADV Adjustments to 2019 Benefit Year Risk Adjustment Transfers Amounts *(Appendix D)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	Original ADJUSTMENT AMOUNT Individual, Non-Catastrophic Market Risk Pool	Reissued ADJUSTMENT AMOUNT Individual, Non-Catastrophic Market Risk Pool	Original ADJUSTMENT AMOUNT Individual, Catastrophic Risk Pool	Reissued ADJUSTMENT AMOUNT Individual, Catastrophic Risk Pool	Original ADJUSTMENT AMOUNT Small Group Market Risk Pool	Reissued ADJUSTMENT AMOUNT Small Group Market Risk Pool	Original ADJUSTMENT AMOUNT Merged Market Risk Pool	Reissued ADJUSTMENT AMOUNT Merged Market Risk Pool
11082	Aetna Life Insurance Company	AK	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
38344	Premera Blue Cross	AK	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
73836	Moda Health Plan Inc	AK	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
80049	UnitedHealthcare Insurance Company	AK	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
46944	Blue Cross and Blue Shield of Alabama	AL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
68259	UnitedHealthcare of Alabama, Inc.	AL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
69461	UnitedHealthcare Insurance Company	AL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
73301	Bright Health Insurance Company	AL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

[34] There were no exiting issuers with positive error rates in 2018 benefit year HHS-RADV, in either the original or reissued results. Thus, there will be no adjustments to 2018 benefit year risk scores or transfers as a result of 2018 benefit year HHS-RADV and there is nothing to compare between the original and reissued 2018 benefit year HHS-RADV results.

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93018	Viva Health, Inc.	AL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
13262	USAble Mutual Insurance Company	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
22732	UnitedHealthcare Insurance Company of the River Valley	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
37903	Qualchoice Life and Health Insurance Company, Inc.	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
62141	Celtic Insurance Company	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
65817	UnitedHealthcare of Arkansas, Inc.	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
70525	QCA Health Plan INC	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
75293	USAble Mutual Insurance Company	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
81392	UnitedHealthcare Insurance Company	AR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
13877	Oscar Health Plan, Inc.	AZ	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23307	Humana Health Plan, Inc.	AZ	$0.00	$0.00	$0.00	$0.00	$28,592.65	$16,628.08	$0.00	$0.00
23435	Banner Health and Aetna Health Plan Inc.	AZ	$0.00	$0.00	$0.00	$0.00	$75.06	$43.65	$0.00	$0.00
40702	UnitedHealthcare of Arizona, Inc.	AZ	$0.00	$0.00	$0.00	$0.00	($445,329.07)	($258,980.76)	$0.00	$0.00
51485	Health Net Life Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$2,327.05	$1,353.31	$0.00	$0.00
53901	Blue Cross Blue Shield of Arizona	AZ	$0.00	$0.00	$0.00	$0.00	$132,248.07	$76,908.69	$0.00	$0.00
66105	Humana Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$3,477.28	$2,022.23	$0.00	$0.00
70904	WMI Mutual Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$5.69	$3.31	$0.00	$0.00

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77349	Banner Health and Aetna Health Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$47,644.17	$27,707.44	$0.00	$0.00
78611	Aetna Health Inc. (a PA corp.)	AZ	$0.00	$0.00	$0.00	$0.00	$163.56	$95.12	$0.00	$0.00
82011	UnitedHealthcare Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$226,921.29	$131,965.91	$0.00	$0.00
84251	Aetna Life Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$3,298.13	$1,918.01	$0.00	$0.00
86830	Cigna Health and Life Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$1.44	$0.84	$0.00	$0.00
87247	Bright Health Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
91450	Health Net of Arizona, Inc.	AZ	$0.00	$0.00	$0.00	$0.00	$378.11	$219.90	$0.00	$0.00
97667	Cigna HealthCare of Arizona, Inc	AZ	$0.00	$0.00	$0.00	$0.00	$157.86	$91.80	$0.00	$0.00
98971	All Savers Insurance Company	AZ	$0.00	$0.00	$0.00	$0.00	$38.75	$22.54	$0.00	$0.00
10544	Oscar Health Plan of California	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18126	Molina Healthcare of California	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
20523	Aetna Health of California Inc.	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
27330	Kaiser Permanente Insurance Company	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
27603	Blue Cross of California (Anthem BC)	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
40513	Kaiser Foundation Health Plan, Inc.	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
40733	Aetna Life Insurance Company	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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47579	Chinese Community Health Plan	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
49116	UHC of California	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
56887	Ventura County Health Care Plan	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
64210	Sutter Health Plan	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
64618	National Health Insurance Company	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
67138	Health Net of California, Inc.	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
70285	CA Physician's Service dba Blue Shield of CA	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
84014	Valley Health Plan	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
92499	Sharp Health Plan	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
92815	Local Initiative Health Authority for Los Angeles County	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
93689	Western Health Advantage	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
95677	UnitedHealthcare Insurance Company	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99110	Health Net Life Insurance Company	CA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
21032	Kaiser Foundation Health Plan of Colorado	CO	($4,815,560.36)	($3,780,413.77)	($12,435.96)	($9,767.36)	$5,805,731.64	$3,386,732.23	$0.00	$0.00
31070	Bright Health Insurance Company	CO	$13,588,874.13	$10,667,827.50	$158,182.63	$124,238.59	$0.00	$0.00	$0.00	$0.00
35944	Kaiser Permanente Insurance Company	CO	$0.00	$0.00	$0.00	$0.00	$16,422.15	$9,579.75	$0.00	$0.00
39041	Aetna Life Insurance Company	CO	$0.00	$0.00	$0.00	$0.00	$4,317.80	$2,518.75	$0.00	$0.00

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39670	Aetna Health Inc. (a PA corp.)	CO	$0.00	$0.00	$0.00	$0.00	$35.10	$20.48	$0.00	$0.00
49375	Cigna Health and Life Insurance Company	CO	($2,038,962.48)	($1,600,669.76)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
59036	UnitedHealthcare of Colorado, Inc.	CO	$0.00	$0.00	$0.00	$0.00	$1,621,670.93	$945,990.17	$0.00	$0.00
63312	Friday Health Plans of Colorado, Inc	CO	($417,383.30)	($327,663.16)	($27,135.07)	($21,312.19)	$135,593.01	$79,097.22	$0.00	$0.00
66699	Denver Health Medical Plan, Inc.	CO	($314,963.72)	($247,259.54)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
67879	UnitedHealthcare Insurance Company	CO	$0.00	$0.00	$0.00	$0.00	($15,891,011.79)	($9,266,148.21)	$0.00	$0.00
74320	Humana Health Plan	CO	$0.00	$0.00	$0.00	$0.00	$2,509,624.62	$1,460,211.24	$0.00	$0.00
76680	HMO Colorado Inc(Anthem BCBS)	CO	($5,823,841.40)	($4,571,956.06)	($86,340.97)	($67,813.23)	$591,342.74	$344,955.50	$0.00	$0.00
79509	Humana Insurance Company	CO	$0.00	$0.00	$0.00	$0.00	$56,377.67	$32,887.41	$0.00	$0.00
87269	Rocky Mountain Hos&Med Svc(Anthem BCBS)	CO	$0.00	$0.00	($32,270.65)	($25,345.78)	$4,243,050.94	$2,475,153.65	$0.00	$0.00
97879	Rocky Mountain Health Maintenance Organization Inc	CO	($178,162.88)	($139,865.20)	$0.00	$0.00	$906,845.35	$529,001.75	$0.00	$0.00
29462	Oxford Health Insurance, Inc.	CT	$0.00	$0.00	$0.00	$0.00	($4,473,690.32)	($1,675,606.48)	$0.00	$0.00
39159	Aetna Life Insurance Company	CT	$0.00	$0.00	$0.00	$0.00	$136,199.16	$99,525.11	$0.00	$0.00
49650	UnitedHealthcare Insurance Company	CT	$0.00	$0.00	$0.00	$0.00	$235,596.49	$172,157.93	$0.00	$0.00
71179	Oxford Health Plans (CT), Inc.	CT	$0.00	$0.00	$0.00	$0.00	$577,615.76	$422,082.38	$0.00	$0.00
75091	ConnectiCare, Inc.	CT	$21,718.12	$18,978.93	$0.00	$0.00	$8,071.47	$5,898.09	$0.00	$0.00
76962	ConnectiCare Benefits, Inc.	CT	$4,147,288.73	$3,624,212.26	$0.00	$0.00	$27,806.16	$20,318.86	$0.00	$0.00

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86545	Anthem Health Plans Inc(Anthem BCBS)	CT	$1,796,217.47	$1,569,669.68	$0.00	$0.00	$8,832,816.95	$6,454,422.70	$0.00	$0.00
89130	HPHC Insurance Company, Inc.	CT	$0.00	$0.00	$0.00	$0.00	$1,759,399.05	$1,285,649.32	$0.00	$0.00
94815	ConnectiCare Insurance Company, Inc.	CT	($5,965,224.35)	($5,212,860.95)	$0.00	$0.00	($8,036,351.20)	($7,465,882.26)	$0.00	$0.00
95882	Harvard Pilgrim Health Care of Connecticut, Inc.	CT	$0.00	$0.00	$0.00	$0.00	$932,536.58	$681,434.39	$0.00	$0.00
21066	UnitedHealthcare of the Mid-Atlantic, Inc.	DC	$0.00	$0.00	$0.00	$0.00	$10,439.26	$8,839.69	$0.00	$0.00
41842	UnitedHealthcare Insurance Company	DC	$0.00	$0.00	$0.00	$0.00	($2,464,817.66)	($2,087,142.70)	$0.00	$0.00
73987	Aetna Health Inc. (a PA corp.)	DC	$0.00	$0.00	$0.00	$0.00	$5,736.44	$4,857.46	$0.00	$0.00
75753	Optimum Choice, Inc.	DC	$0.00	$0.00	$0.00	$0.00	$21,704.52	$18,378.83	$0.00	$0.00
77422	Aetna Life Insurance Company	DC	$0.00	$0.00	$0.00	$0.00	$13,414.70	$11,359.23	$0.00	$0.00
78079	Group Hospitalization and Medical Services	DC	$0.00	$0.00	$0.00	$0.00	$963,741.25	$816,070.71	$0.00	$0.00
86052	CareFirst BlueChoice	DC	$0.00	$0.00	$0.00	$0.00	$1,323,006.05	$1,120,286.67	$0.00	$0.00
94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	DC	$0.00	$0.00	$0.00	$0.00	$126,775.39	$107,350.06	$0.00	$0.00
29497	Aetna Life Insurance Company	DE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
61021	UnitedHealthcare Insurance Company	DE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
67190	Aetna Health Inc. (a PA corp.)	DE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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76168	Highmark BCBSD Inc.	DE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
97569	Optimum Choice, Inc.	DE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
16842	Blue Cross Blue Shield of FL Inc.	FL	$0.00	$0.00	$0.00	$0.00	($317,828.27)	$628,530.43	$0.00	$0.00
18628	Aetna Health Inc. (a FL corp.)	FL	$0.00	$0.00	$0.00	$0.00	($22,946.01)	$45,377.57	$0.00	$0.00
19898	AvMed, Inc	FL	$0.00	$0.00	$0.00	$0.00	($56,435.43)	$111,605.28	$0.00	$0.00
21663	Celtic Insurance Company	FL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23841	Aetna Life Insurance Company	FL	$0.00	$0.00	$0.00	$0.00	($3,758.11)	$7,431.93	$0.00	$0.00
30252	Health Options, Inc.	FL	$0.00	$0.00	$0.00	$0.00	($153,276.01)	$303,116.00	$0.00	$0.00
35783	Humana Medical Plan, Inc.	FL	$0.00	$0.00	$0.00	$0.00	$12,582,637.24	$6,889,426.27	$0.00	$0.00
36194	Health First Commercial Plans, Inc.	FL	$0.00	$0.00	$0.00	$0.00	($35,276.43)	$69,762.11	$0.00	$0.00
40572	Oscar Insurance Company of Florida	FL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
42204	All Savers Insurance Company	FL	$0.00	$0.00	$0.00	$0.00	($630.93)	$1,247.74	$0.00	$0.00
43839	UnitedHealthcare Insurance Company	FL	$0.00	$0.00	$0.00	$0.00	($271,497.40)	$536,907.17	$0.00	$0.00
48121	Cigna Health and Life Insurance Company	FL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
54172	Molina Healthcare of Florida, Inc.	FL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
56503	Florida Health Care Plan, Inc	FL	$0.00	$0.00	$0.00	$0.00	($16,211.20)	$32,058.94	$0.00	$0.00
66966	Capital Health Plan	FL	$0.00	$0.00	$0.00	$0.00	($60,024.25)	$118,702.69	$0.00	$0.00
68398	UnitedHealthcare of Florida, Inc.	FL	$0.00	$0.00	$0.00	$0.00	($311,555.26)	$616,124.48	$0.00	$0.00

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80779	Neighborhood Health Partnership, Inc.	FL	$0.00	$0.00	$0.00	$0.00	($11,327,877.85)	($9,370,811.07)	$0.00	$0.00
99308	Humana Health Insurance Co of FL, Inc.	FL	$0.00	$0.00	$0.00	$0.00	($5,320.08)	$10,520.89	$0.00	$0.00
13535	UnitedHealthcare Insurance Company	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
30552	UnitedHealthcare Insurance Company of the River Valley	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
37001	Humana Insurance Company	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
43802	UnitedHealthcare of Georgia, Inc.	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
49046	Blue Cross and Blue Shield of GA, Inc	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
70893	Ambetter of Peach State	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
82302	Kaiser Permanente Insurance Company	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
82824	Aetna Health Inc. (a GA corp.)	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
83761	Alliant Health Plans	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
83978	Aetna Life Insurance Company	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
89942	Kaiser Foundation Health Plan of Georgia, Inc.	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
93332	Humana Employers Health Plan of Georgia, Inc.	GA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18350	Hawaii Medical Service Association	HI	$0.00	$0.00	$0.00	$0.00	($938,458.62)	($689,603.62)	$0.00	$0.00

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54179	UnitedHealthcare Insurance Company	HI	$0.00	$0.00	$0.00	$0.00	($3,897.83)	($2,864.23)	$0.00	$0.00
56682	Hawaii Medical Assurance Association	HI	$0.00	$0.00	$0.00	$0.00	($4,879.80)	($3,585.80)	$0.00	$0.00
60612	Kaiser Foundation Health Plan, Inc.	HI	$0.00	$0.00	$0.00	$0.00	($677,907.78)	($498,144.12)	$0.00	$0.00
95366	University Health Alliance	HI	$0.00	$0.00	$0.00	$0.00	$1,625,144.04	$1,194,197.79	$0.00	$0.00
18973	Aetna Health Inc. (a IA corp.)	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
25896	Wellmark Health Plan of Iowa, Inc	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
27651	Gundersen Health Plan, Inc.	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
50735	Medical Associates Health Plans	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
56610	UnitedHealthcare Plan of the River Valley, Inc.	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
72160	Wellmark, Inc	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
74406	Wellmark Value Health Plan, Inc.	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
74980	Avera Health Plans, Inc.	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
77638	Health Alliance Midwest, Inc.	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
78252	Aetna Life Insurance Company	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
85930	Sanford Health Plan	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
88678	UnitedHealthcare Insurance Company	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
93078	Medica Insurance Company	IA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
26002	SelectHealth	ID	($12,756,479.59)	($9,801,731.82)	($52,037.92)	($40,158.98)	($2,937,794.68)	($2,262,307.59)	$0.00	$0.00
38128	Montana Health Cooperative	ID	($4,641,918.92)	($3,566,724.17)	($9,761.79)	($7,533.42)	($37,509.99)	($28,885.31)	$0.00	$0.00

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43541	National Health Insurance Company	ID	$0.00	$0.00	$0.00	$0.00	($41,867.76)	($32,241.10)	$0.00	$0.00
44648	Regence Blue Shield of Idaho	ID	($613,701.42)	($471,551.46)	$0.00	$0.00	($4,187,152.13)	($3,224,400.30)	$0.00	$0.00
45059	Aetna Life Insurance Company	ID	$0.00	$0.00	$0.00	$0.00	($4,675.29)	($3,600.30)	$0.00	$0.00
50118	UnitedHealthcare Insurance Company	ID	$0.00	$0.00	$0.00	$0.00	($99,122.26)	($76,331.03)	$0.00	$0.00
60597	PacificSource Health Plans	ID	($267,618.32)	($205,630.65)	($5,833.66)	($4,501.99)	($1,462,493.81)	($1,126,222.63)	$0.00	$0.00
61589	Blue Cross of Idaho	ID	$18,279,718.36	$14,045,638.17	$67,633.40	$52,194.40	$8,770,615.95	$6,753,988.26	$0.00	$0.00
20129	Health Alliance Medical Plans, Inc.	IL	($16,552,388.09)	($11,263,209.43)	($36,393.22)	($24,845.76)	($2,263,092.65)	($1,539,169.49)	$0.00	$0.00
24301	Medical Associates Health Plans	IL	$0.00	$0.00	$0.00	$0.00	($83,827.85)	($57,012.79)	$0.00	$0.00
27833	Celtic Insurance Company	IL	($10,968,932.84)	($7,463,901.06)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
33235	Gundersen Health Plan, Inc.	IL	($433,056.11)	($294,676.63)	($557.14)	($380.36)	($26,389.03)	($17,947.64)	$0.00	$0.00
34446	UnitedHealthcare Insurance Company of the River Valley	IL	$0.00	$0.00	$0.00	$0.00	($4,931,050.78)	($3,353,695.28)	$0.00	$0.00
36096	Blue Cross Blue Shield of Illinois	IL	$33,193,839.38	$22,587,022.48	$36,950.37	$25,226.14	$34,927,115.54	$23,754,551.83	$0.00	$0.00
42529	UnitedHealthcare of Illinois, Inc.	IL	$0.00	$0.00	$0.00	$0.00	($1,309,628.74)	($890,701.77)	$0.00	$0.00
53882	Cigna HealthCare of Illinois, Inc.	IL	($5,239,462.16)	($3,565,235.37)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
54322	MercyCare HMO	IL	$0.00	$0.00	$0.00	$0.00	($144,666.19)	($98,390.03)	$0.00	$0.00
58239	UnitedHealthcare Plan of the River Valley, Inc.	IL	$0.00	$0.00	$0.00	$0.00	($982,615.17)	($668,294.01)	$0.00	$0.00
58288	Humana Health Plan, Inc.	IL	$0.00	$0.00	$0.00	$0.00	($770,141.74)	($523,787.05)	$0.00	$0.00
68303	Humana Insurance Company	IL	$0.00	$0.00	$0.00	$0.00	($1,051,007.40)	($714,808.79)	$0.00	$0.00

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72547	Aetna Life Insurance Company	IL	$0.00	$0.00	$0.00	$0.00	($165,558.48)	($112,599.26)	$0.00	$0.00
92476	UnitedHealthcare Insurance Company of Illinois	IL	$0.00	$0.00	$0.00	$0.00	($23,184,627.05)	($15,768,276.79)	$0.00	$0.00
99129	Aetna Health Inc. (a PA corp.)	IL	$0.00	$0.00	$0.00	$0.00	($14,510.47)	($9,868.83)	$0.00	$0.00
17575	Anthem Ins Companies Inc(Anthem BCBS)	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
32378	Aetna Life Insurance Company	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
33380	Indiana University Health Plans, Inc	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
36373	All Savers Insurance Company	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
43442	Humana Health Plan	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
50816	Physicians Health Plan of Northern Indiana, Inc.	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
54192	CareSource Indiana, Inc	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
67920	Southeastern Indiana Health Organization	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
72850	UnitedHealthcare Insurance Company	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
76179	Celtic Insurance Company	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99791	Humana Insurance Company	IN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18558	Blue Cross and Blue Shield of Kansas, Inc	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
19968	Humana Insurance Company	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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39520	Medica Insurance Company	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
49857	Humana Health Plan, Inc.	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
57850	Aetna Health Inc. (a PA corp.)	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
80065	Sunflower State Health Plan, Inc	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
84600	Aetna Life Insurance Company	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
94968	UnitedHealthcare Insurance Company	KS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
15411	Humana Health Plan, Inc.	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23671	UnitedHealthcare of Kentucky, Ltd.	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
28773	UnitedHealthcare Insurance Company	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
34822	Aetna Health Inc. (a PA corp.)	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
36239	Anthem Health Plans of KY(Anthem BCBS)	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
45636	CareSource Kentucky Co.	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
45920	UnitedHealthcare of Ohio, Inc.	KY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
14030	Aetna Life Insurance Company	LA	$0.00	$0.00	$0.00	$0.00	($26.76)	($16.33)	$0.00	$0.00
19636	HMO Louisiana, Inc.	LA	$0.00	$0.00	$0.00	$0.00	($804,166.88)	($490,721.64)	$0.00	$0.00
38499	UnitedHealthcare of Louisiana, Inc.	LA	$0.00	$0.00	$0.00	$0.00	($2,276.69)	($1,389.30)	$0.00	$0.00

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44965	Humana Health Benefit Plan of Louisiana, Inc.	LA	$0.00	$0.00	$0.00	$0.00	$2,704,684.47	$1,650,462.34	$0.00	$0.00
53946	UnitedHealthcare Insurance Company of the River Va	LA	$0.00	$0.00	$0.00	$0.00	($71,531.49)	($43,650.20)	$0.00	$0.00
67243	Vantage Health Plan	LA	$0.00	$0.00	$0.00	$0.00	($24,105.80)	($14,709.93)	$0.00	$0.00
69842	UnitedHealthcare Insurance Company	LA	$0.00	$0.00	$0.00	$0.00	($184,362.22)	($112,502.08)	$0.00	$0.00
81941	Aetna Health Inc. (a LA corp.)	LA	$0.00	$0.00	$0.00	$0.00	($7.58)	($4.62)	$0.00	$0.00
97176	Louisiana Health Service & Indemnity Company	LA	$0.00	$0.00	$0.00	$0.00	($1,618,207.06)	($987,468.19)	$0.00	$0.00
29125	Tufts Associated Health Maintenance Organization Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($2,152,664.27)	($1,346,001.55)
31779	UnitedHealthcare Insurance Company	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($282,073.04)	($175,703.70)
34484	Health New England	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($703,415.52)	($438,011.49)
36046	Harvard Pilgrim Health Care Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($1,454,427.19)	($905,779.06)
38712	Tufts Associated Health Maintenance Organization Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($121,622.32)	($75,744.74)
41304	AllWays Health Partners	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$18,300,144.72	$11,402,519.05
42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($6,603,963.23)	($4,112,804.84)
52710	Fallon Life and Health Assurance Co	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($4,206.03)	($2,619.58)

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59763	Tufts Health Public Plans, Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($4,260,506.23)	($2,653,481.19)
82569	Boston Medical Center Health Plan, Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($2,145,937.92)	($1,336,673.23)
88806	Fallon Community Health Plan	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($538,404.48)	($335,196.04)
88950	ConnectiCare of Massachusetts Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($9,832.55)	($6,122.71)
95878	HPHC Insurance Company Inc.	MA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($23,092.10)	($14,381.30)
23620	UnitedHealthcare Insurance Company	MD	$0.00	$0.00	$0.00	$0.00	($9,128,032.70)	($7,087,106.46)	$0.00	$0.00
28137	CareFirst BlueChoice	MD	$8,107,961.62	$4,177,507.39	$4,533.34	$1,562.79	$18,708,043.58	$12,788,388.61	$0.00	$0.00
31112	UnitedHealthcare of the Mid-Atlantic, Inc.	MD	$0.00	$0.00	$0.00	$0.00	($1,104,383.38)	($799,023.21)	$0.00	$0.00
45532	CareFirst of Maryland	MD	($3,435,890.45)	($2,408,711.39)	$0.00	$0.00	($1,253,780.55)	($780,482.66)	$0.00	$0.00
65635	MAMSI Life and Health Insurance Company	MD	$0.00	$0.00	$0.00	$0.00	($2,795,687.98)	($1,740,325.32)	$0.00	$0.00
66516	Aetna Health Inc. (a PA corp.)	MD	$0.00	$0.00	$0.00	$0.00	($27,388.73)	($17,049.59)	$0.00	$0.00
70767	Aetna Life Insurance Company	MD	$0.00	$0.00	$0.00	$0.00	($67,906.63)	($42,272.08)	$0.00	$0.00
72375	Optimum Choice, Inc.	MD	$0.00	$0.00	$0.00	$0.00	($2,073,275.29)	($1,290,621.01)	$0.00	$0.00
90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	MD	($2,439,203.23)	($203,456.71)	($4,533.36)	($1,562.78)	$114,667.64	$445,229.23	$0.00	$0.00
94084	Group Hospitalization and Medical Services	MD	($2,232,867.95)	($1,565,339.34)	$0.00	$0.00	($2,372,255.98)	($1,476,737.45)	$0.00	$0.00
11593	HPHC Insurance Company Inc.	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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33653	Maine Community Health Options	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
48396	Anthem Health Plans of ME(Anthem BCBS)	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
53357	Aetna Life Insurance Company	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
73250	Aetna Health Inc. (a ME corp.)	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90214	UnitedHealthcare Insurance Company	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
96667	Harvard Pilgrim Health Care Inc.	ME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	MI	$156,560.24	$130,236.39	$549.99	$457.53	$152,712.94	$127,041.80	$0.00	$0.00
20662	PHP Insurance Company	MI	$0.00	$0.00	$0.00	$0.00	$1,139.64	$948.08	$0.00	$0.00
29241	Priority Health	MI	$0.00	$0.00	$0.00	$0.00	$2,596.38	$2,160.02	$0.00	$0.00
29698	Priority Health	MI	$162,691.86	$135,337.04	$0.00	$0.00	$32,367.69	$26,926.65	$0.00	$0.00
37651	Health Alliance Plan of Michigan	MI	$6,267.10	$5,213.36	$97.79	$81.35	$9,952.90	$8,279.81	$0.00	$0.00
40047	Molina Healthcare of Michigan, Inc.	MI	$15,515.50	$12,906.76	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
52670	All Savers Insurance Company	MI	$0.00	$0.00	$0.00	$0.00	$1.57	$1.30	$0.00	$0.00
58594	Meridian Health Plan of Michigan, Inc.	MI	$10,256.54	$8,532.07	$34.80	$28.95	$0.00	$0.00	$0.00	$0.00
60829	Physicians Health Plan	MI	$16,202.25	$13,478.05	$0.28	$0.23	$2,919.23	$2,428.51	$0.00	$0.00
62294	Humana Insurance Company	MI	$0.00	$0.00	$0.00	$0.00	$300.41	$249.92	$0.00	$0.00

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63631	UnitedHealthcare Insurance Company	MI	$0.00	$0.00	$0.00	$0.00	$13,402.83	$11,149.77	$0.00	$0.00
67183	Total Health Care	MI	$31,197.49	$25,951.99	$0.00	$0.00	$5,150.23	$4,284.47	$0.00	$0.00
67577	Alliance Health & Life Insurance Co	MI	$4,297.55	$3,574.97	$15.19	$12.64	$10,973.59	$9,128.99	$0.00	$0.00
71667	UnitedHealthcare Community Plan, Inc.	MI	$0.00	$0.00	$0.00	$0.00	$531.09	$441.83	$0.00	$0.00
74917	McLaren Health Plan	MI	($730,409.45)	($607,599.47)	($1,325.36)	($1,102.59)	($311,515.82)	($259,149.88)	$0.00	$0.00
77739	Oscar Insurance Company	MI	$1,115.05	$927.54	$2.70	$2.24	$0.00	$0.00	$0.00	$0.00
95233	Paramount Insurance Company	MI	$0.00	$0.00	$0.00	$0.00	$249.86	$207.88	$0.00	$0.00
98185	Blue Care Network of Michigan	MI	$326,305.84	$271,441.19	$624.62	$519.63	$79,217.58	$65,901.17	$0.00	$0.00
25198	UnitedHealthcare Insurance Company	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
31616	Medica Insurance Company	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
34102	Group Health Plan Inc	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
49316	BCBSMN INC	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
52346	Sanford Health Plan of Minnesota	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
57129	HMO Minnesota	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
70373	Gundersen Health Plan Minnesota, Inc.	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
79888	HealthPartners, Inc	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
85654	HealthPartners Insurance Company	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
85736	UCare Minnesota	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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88102	PreferredOne Insurance Company	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
97624	PreferredOne Community Health Plan	MN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
30613	Humana Insurance Company	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
32753	Healthy Alliance Life Co(Anthem BCBS)	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
32898	Aetna Health Inc. (a PA corp.)	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
34762	Blue Cross and Blue Shield of Kansas City	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
48161	Aetna Life Insurance Company	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
53461	Medica Insurance Company	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
74483	Cigna Health and Life Insurance Company	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
95426	UnitedHealthcare Insurance Company	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
96384	Cox HealthPlans	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99723	Celtic Insurance Company	MO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11721	Blue Cross Blue Shield of Mississippi	MS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
26781	All Savers Insurance Company	MS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
48963	Humana Insurance Company	MS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90714	Ambetter of Magnolia	MS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
97560	UnitedHealthcare of Mississippi, Inc.	MS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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98805	UnitedHealthcare Insurance Company	MS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23603	PacificSource Health Plans	MT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
30751	Blue Cross and Blue Shield of Montana	MT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
32225	Montana Health Cooperative	MT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
46621	UnitedHealthcare Insurance Company	MT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	$4,257,564.73	$2,918,533.17	$0.00	$0.00	$23,049,205.81	$17,239,409.50	$0.00	$0.00
43283	FirstCarolinaCare Insurance Company	NC	$0.00	$0.00	$0.00	$0.00	$17,019.39	$23,958.65	$0.00	$0.00
54332	UnitedHealthcare of North Carolina, Inc.	NC	$0.00	$0.00	$0.00	$0.00	($24,368,044.50)	($19,095,972.46)	$0.00	$0.00
58658	UnitedHealthcare Insurance Company of the River Valley	NC	$0.00	$0.00	$0.00	$0.00	$450,190.13	$633,744.08	$0.00	$0.00
61644	Aetna Life Insurance Company	NC	$0.00	$0.00	$0.00	$0.00	$18,023.75	$25,372.46	$0.00	$0.00
61671	Aetna Health Inc. (a PA corp.)	NC	$0.00	$0.00	$0.00	$0.00	$562.22	$791.45	$0.00	$0.00
69347	UnitedHealthcare Insurance Company	NC	$0.00	$0.00	$0.00	$0.00	$832,786.62	$1,172,335.01	$0.00	$0.00
72487	All Savers Insurance Company	NC	$0.00	$0.00	$0.00	$0.00	$256.47	$361.05	$0.00	$0.00
73943	Cigna HealthCare of North Carolina, Inc.	NC	($1,340,950.79)	($919,213.12)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
77264	Ambetter of North Carolina Inc.	NC	($2,916,613.91)	($1,999,320.06)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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37160	Blue Cross Blue Shield of North Dakota	ND	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
39364	Medica Insurance Company	ND	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
73751	Medica Health Plans	ND	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
76311	UnitedHealthcare Insurance Company	ND	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
89364	Sanford Health Plan	ND	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
20305	Medica Insurance Company	NE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
29678	Blue Cross and Blue Shield of Nebraska	NE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
44751	UnitedHealthcare of the Midlands, Inc.	NE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
59699	Aetna Life Insurance Company	NE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
73102	UnitedHealthcare Insurance Company	NE	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
51889	UnitedHealthcare Insurance Company	NH	$0.00	$0.00	$0.00	$0.00	$5,630.06	$4,687.06	$0.00	$0.00
57601	Anthem Health Plans of NH(Anthem BCBS)	NH	$0.00	$0.00	$0.00	$0.00	($648,531.32)	($539,905.67)	$0.00	$0.00
59025	Harvard Pilgrim Health Care of NE	NH	$0.00	$0.00	$0.00	$0.00	$251,657.95	$209,506.53	$0.00	$0.00
71616	HPHC Insurance Company, Inc	NH	$0.00	$0.00	$0.00	$0.00	$44,778.55	$37,278.36	$0.00	$0.00
75841	Celtic Insurance Company	NH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
86365	Tufts Health Freedom Insurance Company	NH	$0.00	$0.00	$0.00	$0.00	$158,871.11	$132,260.98	$0.00	$0.00

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96751	Matthew Thornton Hlth Plan(Anthem BCBS)	NH	$0.00	$0.00	$0.00	$0.00	$187,593.66	$156,172.69	$0.00	$0.00
13953	Horizon Healthcare of New Jersey, Inc.	NJ	$0.79	$0.51	$0.00	$0.00	$93,585.54	$60,291.24	$0.00	$0.00
23458	Cigna Health and Life Insurance Company	NJ	$0.00	$0.00	$0.00	$0.00	$1,851.65	$1,192.90	$0.00	$0.00
23818	Oscar Garden State Insurance Corporation	NJ	$28,793.50	$18,641.96	$0.00	$0.00	$104,542.20	$67,349.94	$0.00	$0.00
41014	Cigna HealthCare of New Jersey, Inc.	NJ	$0.00	$0.00	$0.00	$0.00	$92.74	$59.75	$0.00	$0.00
48834	Oxford Health Plans (NJ), Inc.	NJ	$0.00	$0.00	$0.00	$0.00	$38,897.35	$25,059.11	$0.00	$0.00
77263	Oxford Health Insurance, Inc.	NJ	($1,021,874.83)	($661,598.77)	$0.00	$0.00	($20,145,136.74)	($12,978,236.87)	$0.00	$0.00
77606	AmeriHealth HMO	NJ	$50,887.46	$32,946.39	$0.00	$0.00	$481,929.73	$310,476.82	$0.00	$0.00
91661	Horizon Healthcare Services, Inc.	NJ	$645,503.62	$417,922.41	$0.00	$0.00	$16,969,380.68	$10,932,298.09	$0.00	$0.00
91762	AmeriHealth Ins Company of New Jersey	NJ	$296,689.45	$192,087.49	$0.00	$0.00	$2,454,856.97	$1,581,509.09	$0.00	$0.00
19722	Molina Healthcare of New Mexico, Inc.	NM	($378,537.10)	($212,421.45)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
42776	True Health New Mexico, Inc.	NM	$0.00	$0.00	$0.00	$0.00	($735,323.49)	($414,694.97)	$0.00	$0.00
52744	Presbyterian Insurance Company	NM	$0.00	$0.00	$0.00	$0.00	($535,319.83)	($301,900.43)	$0.00	$0.00
57173	Presbyterian Health Plan	NM	($138,704.25)	($77,835.88)	($1,350.95)	($757.88)	($708,741.08)	($399,703.50)	$0.00	$0.00
72034	CHRISTUS Health Plan	NM	($20,425.00)	($11,461.77)	($12.75)	($7.17)	$0.00	$0.00	$0.00	$0.00
75605	Blue Cross Blue Shield of New Mexico	NM	$888,847.60	$498,789.42	$1,363.69	$765.02	$2,579,543.17	$1,454,766.03	$0.00	$0.00

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90762	UnitedHealthcare Insurance Company	NM	$0.00	$0.00	$0.00	$0.00	($600,159.04)	($338,467.21)	$0.00	$0.00
93091	New Mexico Health Connections	NM	($351,181.32)	($197,070.35)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
16698	Prominence HealthFirst	NV	$0.00	$0.00	$0.00	$0.00	$697,132.70	$523,153.05	$0.00	$0.00
19298	Aetna Health Inc. (a PA corp.)	NV	$0.00	$0.00	$0.00	$0.00	$68,921.50	$51,721.14	$0.00	$0.00
27990	Aetna Life Insurance Company	NV	$0.00	$0.00	$0.00	$0.00	$585,913.57	$439,690.27	$0.00	$0.00
33670	Rocky Mountain Hos&Med Svc(Anthem BCBS)	NV	$0.00	$0.00	$12,030.78	$9,301.56	$3,183,480.43	$2,388,996.38	$0.00	$0.00
41094	Hometown Health Plan Inc	NV	$322,346.90	$248,214.08	$1,459.60	$1,128.49	$257,907.13	$193,542.65	$0.00	$0.00
42313	WMI Mutual Insurance Company	NV	$0.00	$0.00	$0.00	$0.00	$648.39	$486.58	$0.00	$0.00
45142	SilverSummit Healthplan, Inc.	NV	$7,329,103.28	$5,643,567.82	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
60156	HMO Colorado Inc(Anthem BCBS)	NV	$0.00	$0.00	$3,012.25	$2,328.91	$146,573.04	$109,993.61	$0.00	$0.00
68524	Prominence Preferred Health Insurance Company, Inc.	NV	$0.00	$0.00	$0.00	$0.00	$33,715.47	$25,301.29	$0.00	$0.00
74222	UnitedHealthcare Insurance Company	NV	$0.00	$0.00	$0.00	$0.00	$3,470,080.36	$2,604,071.29	$0.00	$0.00
83198	Sierra Health and Life Insurance Company, Inc.	NV	($6,720,556.47)	($4,943,935.28)	($15,300.14)	($11,394.93)	($9,831,087.12)	($7,268,199.48)	$0.00	$0.00
85266	Hometown Health Providers Insurance Company, Inc	NV	$1,311,072.05	$1,009,553.79	$8,955.08	$6,923.61	$1,508,436.08	$1,131,983.84	$0.00	$0.00
95865	Health Plan of Nevada, Inc.	NV	($2,241,965.78)	($1,957,400.47)	($10,157.59)	($8,287.68)	($121,721.48)	($200,740.50)	$0.00	$0.00

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11177	Metro Plus Health Plan	NY	$166,653.93	$144,966.72	$0.83	$0.73	$147,163.40	$124,919.51	$0.00	$0.00
17210	Aetna Life Insurance Company	NY	$296.21	$257.66	$0.00	$0.00	$4,406,423.13	$3,740,388.07	$0.00	$0.00
18029	Independent Health Benefits Corporation	NY	$62,380.73	$54,262.90	$8.71	$7.58	$4,082,734.96	$3,465,625.56	$0.00	$0.00
25303	New York State Catholic Health Plan, Inc.	NY	$1,058,392.61	$920,660.56	$448.27	$390.02	$0.00	$0.00	$0.00	$0.00
36346	BlueShield of Northeastern New York	NY	$39,092.38	$34,005.17	$0.00	$0.00	$3,927,948.88	$3,334,235.63	$0.00	$0.00
43477	Crystal Run Health Insurance Company, Inc.	NY	$0.00	$0.00	$0.00	$0.00	$429,400.32	$364,496.05	$0.00	$0.00
44113	Empire HealthChoice Assurance, Inc.	NY	$390,662.19	$339,824.08	$158.57	$137.95	$5,620,541.22	$4,770,991.03	$0.00	$0.00
49526	BlueCross BlueShield of Western New York	NY	$76,078.26	$66,177.94	$0.00	$0.00	$11,233,770.44	$9,535,775.18	$0.00	$0.00
54235	UnitedHealthcare of New York, Inc	NY	($3,543,104.65)	($3,082,029.08)	($3,030.21)	($2,636.53)	$0.00	$0.00	$0.00	$0.00
54297	UnitedHealthcare Insurance Company of New York	NY	$1,707.65	$1,485.42	$0.00	$0.00	$114,092.46	$96,847.31	$0.00	$0.00
56184	MVP Health Care Inc.	NY	$354,091.45	$308,012.40	$47.05	$40.94	$747,258.23	$634,309.37	$0.00	$0.00
61405	Healthfirst Insurance Company, Inc.	NY	$2,573.46	$2,238.52	$0.00	$0.00	$1,618,029.86	$1,373,463.08	$0.00	$0.00
73886	Crystal Run Health Plan, LLC	NY	$1,058.68	$920.89	$0.27	$0.23	$189,359.42	$160,737.57	$0.00	$0.00
74289	Oscar Insurance Corporation	NY	$284,684.74	$247,637.82	$2,122.52	$1,846.77	$2,091,752.52	$1,775,582.17	$0.00	$0.00
78124	Excellus Health Plan, Inc.	NY	$336,987.38	$293,134.11	$107.16	$93.23	$30,166,766.51	$25,607,030.55	$0.00	$0.00

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80519	Empire HealthChoice HMO, Inc.	NY	$0.00	$0.00	$0.00	$0.00	$262,575.72	$222,887.15	$0.00	$0.00
85629	Oxford Health Insurance, Inc.	NY	$0.00	$0.00	$0.00	$0.00	($87,662,058.33)	($74,411,853.56)	$0.00	$0.00
88582	Health Insurance Plan of Greater New York	NY	$265,667.02	$231,094.93	$59.64	$51.90	$5,076,723.85	$4,309,372.14	$0.00	$0.00
89846	MVP Health Care Inc.	NY	$0.00	$0.00	$0.00	$0.00	$11,403,178.53	$9,679,577.02	$0.00	$0.00
91237	Healthfirst PHSP Inc.	NY	$429,754.52	$373,829.18	$74.59	$64.90	$0.00	$0.00	$0.00	$0.00
92551	CDPHP, Universal Benefits Inc.	NY	$0.00	$0.00	$0.00	$0.00	$5,037,542.88	$4,276,113.38	$0.00	$0.00
94788	Capital District Physicians' Health Plan, Inc.	NY	$73,023.53	$63,520.70	$2.58	$2.24	$1,106,795.95	$939,502.67	$0.00	$0.00
28162	AultCare Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$25,974.36	$22,981.77	$0.00	$0.00
29276	Community Insurance Company(Anthem BCBS)	OH	$0.00	$0.00	$0.00	$0.00	$839,925.60	$743,154.54	$0.00	$0.00
29341	Oscar Buckeye State Insurance Corp.	OH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
33232	UnitedHealthcare Insurance Company of the River Valley	OH	$0.00	$0.00	$0.00	$0.00	$25,919.47	$22,933.19	$0.00	$0.00
33931	UnitedHealthcare of Ohio, Inc.	OH	$0.00	$0.00	$0.00	$0.00	$44,563.76	$39,429.40	$0.00	$0.00
41047	Buckeye Community Health Plan	OH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
45845	Oscar Insurance Corporation of Ohio	OH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
52664	Summa Insurance Company Inc.	OH	$0.00	$0.00	$0.00	$0.00	$41,761.68	$36,950.15	$0.00	$0.00

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56726	UnitedHealthcare Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$64,598.67	$57,156.03	$0.00	$0.00
61724	UnitedHealthcare Life Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$775,812.07	$686,427.83	$0.00	$0.00
64353	Molina Healthcare of Ohio, Inc.	OH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
66083	Humana Health Plan of Ohio, Inc.	OH	$0.00	$0.00	$0.00	$0.00	($2,246,128.60)	($1,987,343.95)	$0.00	$0.00
67129	Aetna Life Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$12,409.49	$10,979.76	$0.00	$0.00
74313	Paramount Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$36,416.53	$32,220.88	$0.00	$0.00
77552	CareSource	OH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
80627	Medical Mutual of Ohio	OH	$0.00	$0.00	$0.00	$0.00	$358,569.20	$317,257.01	$0.00	$0.00
83396	The Health Plan of the Upper Ohio Valley	OH	$0.00	$0.00	$0.00	$0.00	$5,500.13	$4,866.45	$0.00	$0.00
84867	Aetna Health Inc. (a PA corp.)	OH	$0.00	$0.00	$0.00	$0.00	$6,161.10	$5,451.28	$0.00	$0.00
97596	Humana Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$6,662.84	$5,895.23	$0.00	$0.00
98810	THP Insurance Company	OH	$0.00	$0.00	$0.00	$0.00	$1,853.72	$1,640.15	$0.00	$0.00
99969	Medical Mutual of Ohio	OH	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
21333	Medica Insurance Company	OK	($1,372,352.80)	($917,334.45)	($17,347.02)	($11,475.75)	$0.00	$0.00	$0.00	$0.00
45480	UnitedHealthcare of Oklahoma, Inc.	OK	$0.00	$0.00	$0.00	$0.00	($680,318.14)	($452,529.59)	$0.00	$0.00
66946	Aetna Life Insurance Company	OK	$0.00	$0.00	$0.00	$0.00	($31,052.95)	($20,655.59)	$0.00	$0.00
76275	Aetna Health Inc. (a PA corp.)	OK	$0.00	$0.00	$0.00	$0.00	($871.12)	($579.45)	$0.00	$0.00
85757	UnitedHealthcare Insurance Company	OK	$0.00	$0.00	$0.00	$0.00	($3,767,849.87)	($2,506,273.89)	$0.00	$0.00

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87571	Blue Cross Blue Shield of Oklahoma	OK	$1,893,193.30	$1,265,484.68	$25,493.93	$16,865.25	$8,927,113.22	$5,938,079.33	$0.00	$0.00
87698	CommunityCare Life & Health Insurance Co	OK	$0.00	$0.00	$0.00	$0.00	($505,613.32)	($336,320.55)	$0.00	$0.00
98905	CommunityCare HMO Inc.	OK	($520,840.52)	($348,150.23)	($8,146.92)	($5,389.51)	($3,941,408.00)	($2,621,720.20)	$0.00	$0.00
10091	PacificSource Health Plans	OR	($4,360,460.63)	($3,605,178.02)	($5,960.60)	($5,267.13)	($1,200,277.42)	($965,000.15)	$0.00	$0.00
10940	Health Net Plan of Oregon, Inc.	OR	($98,322.58)	($81,291.98)	$0.00	$0.00	($345,281.93)	($277,600.08)	$0.00	$0.00
33375	Samaritan Health Plans	OR	$0.00	$0.00	$0.00	$0.00	($36,142.02)	($29,057.45)	$0.00	$0.00
39424	Moda Health Plan Inc	OR	$14,321,953.67	$11,346,881.46	$0.00	$0.00	$2,133,666.24	$1,713,304.57	$0.00	$0.00
56707	Providence Health Plan	OR	($12,344,173.35)	($10,206,018.62)	$0.00	$0.00	($5,778,763.27)	($4,646,015.68)	$0.00	$0.00
63474	BridgeSpan Health Company (OR)	OR	($305,353.74)	($252,462.91)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
71287	Kaiser Foundation Health Plan of the Northwest	OR	$2,748,439.63	$2,807,361.28	$5,960.59	$5,267.13	$3,326,889.03	$3,182,331.57	$0.00	$0.00
77969	Regence BlueCross BlueShield of Oregon	OR	$37,916.96	($9,291.18)	$0.00	$0.00	$3,591,202.28	$2,381,804.55	$0.00	$0.00
90175	UnitedHealthcare Insurance Company	OR	$0.00	$0.00	$0.00	$0.00	($1,691,293.15)	($1,359,767.50)	$0.00	$0.00
16322	UPMC Health Options	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18939	Aetna HealthAssurance Pennsylvania, Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
22444	Geisinger Health Plan	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23489	UnitedHealthcare Insurance Company	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
24872	UnitedHealthcare of PA, Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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31609	Independence Blue Cross (QCC Ins Co.)	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
33709	Highmark Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
33871	Keystone Health Plan East	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
33906	Aetna Life Insurance Company	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
36247	Highmark Select Resources Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
38949	Keystone Health Plan West	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
45127	Capital Advantage Assurance Company	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
53789	Keystone Health Plan Central	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
55957	First Priority Life Insurance Company	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
62560	UPMC Health Coverage	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
64844	Aetna Health Inc. (a PA corp.)	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
67430	UPMC Health Benefits, Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
70194	Highmark Health Insurance Company	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
75729	Geisinger Quality Options	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
79279	Highmark Coverage Advantage Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
79962	Highmark Benefits Group Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
82795	Capital Advantage Insurance Company CAIC	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
83731	First Priority Health	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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86199	Pennsylvania Health & Wellness, Inc.	PA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
15287	Blue Cross & Blue Shield of Rhode Island	RI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
26322	Tufts Associated Health Maintenance Organization Inc.	RI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
79881	UnitedHealthcare of New England, Inc.	RI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90010	Tufts Associated Health Maintenance Organization Inc.	RI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90117	UnitedHealthcare Insurance Company	RI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
22369	Aetna Life Insurance Company	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
26065	Blue Cross and Blue Shield of South Carolina	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
38408	Aetna Health Inc. (a PA corp.)	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
57860	UnitedHealthcare Insurance Company	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
64146	UnitedHealthcare Insurance Company of the River Valley	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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79222	Absolute Total Care, Inc	SC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
31195	Sanford Health Plan	SD	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
50305	Wellmark of South Dakota, Inc	SD	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
60536	Avera Health Plans, Inc.	SD	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
62210	South Dakota State Medical Holding Company, Inc.	SD	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
76458	UnitedHealthcare Insurance Company	SD	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
96594	Medica Insurance Company	SD	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
10958	UnitedHealthcare Insurance Company of the River Valley	TN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
14002	BlueCross BlueShield of Tennessee	TN	($10,867,993.01)	($8,863,695.35)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23552	Oscar Insurance Company of Texas	TN	($823,757.46)	($671,838.41)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
31552	Aetna Life Insurance Company	TN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
69443	UnitedHealthcare Insurance Company	TN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
70111	Celtic Insurance Company	TN	($592,040.76)	($482,855.38)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
82120	Humana Insurance Company	TN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
97906	Bright Health Insurance Company of Tennessee	TN	($798,253.29)	($651,037.75)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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99248	Cigna Health and Life Insurance Company	TN	$13,082,044.46	$10,669,426.86	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
20069	Oscar Insurance Company of Texas	TX	($4,133,334.33)	($3,574,889.62)	($110,993.71)	($96,180.79)	$0.00	$0.00	$0.00	$0.00
26539	SHA, LLC	TX	($2,127,128.43)	($1,839,737.32)	$0.00	$0.00	($721,047.18)	($625,161.14)	$0.00	$0.00
27248	Community Health Choice, Inc.	TX	($11,740,195.99)	($10,154,006.79)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
29418	Celtic Insurance Company	TX	($30,382,548.51)	($26,277,636.55)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
30609	Memorial Hermann Health Insurance Company	TX	$0.00	$0.00	$0.00	$0.00	($114,240.77)	($99,048.85)	$0.00	$0.00
32673	Humana Health Plan of Texas, Inc.	TX	$0.00	$0.00	$0.00	$0.00	($6,693,301.22)	($5,803,215.08)	$0.00	$0.00
33602	Blue Cross Blue Shield of Texas	TX	$63,909,798.74	$55,275,101.98	$126,428.95	$109,556.07	$24,707,534.60	$21,421,886.18	$0.00	$0.00
37392	Prominence HealthFirst of Texas, Inc.	TX	$0.00	$0.00	$0.00	$0.00	($2,649.93)	($2,297.54)	$0.00	$0.00
37755	Insurance Company of Scott & White	TX	($60,975.30)	($52,737.07)	$0.00	$0.00	($476,116.86)	($412,802.02)	$0.00	$0.00
40220	UnitedHealthcare of Texas, Inc.	TX	$0.00	$0.00	$0.00	$0.00	($622,851.06)	($540,023.31)	$0.00	$0.00
40788	Scott and White Health Plan	TX	($243,026.18)	($210,191.53)	$0.00	$0.00	($1,171,672.32)	($1,015,861.33)	$0.00	$0.00
41549	Southwest Life and Health	TX	$0.00	$0.00	$0.00	$0.00	($26,558.03)	($23,026.31)	$0.00	$0.00
45786	Molina Healthcare of Texas, Inc.	TX	($11,567,215.99)	($10,004,397.71)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
58840	Aetna Health Inc. (a TX corp.)	TX	$0.00	$0.00	$0.00	$0.00	($255.40)	($221.43)	$0.00	$0.00
63141	Humana Insurance Company	TX	$0.00	$0.00	$0.00	$0.00	($1,017,728.65)	($882,389.33)	$0.00	$0.00
66252	CHRISTUS Health Plan	TX	($2,270,849.74)	($1,964,040.78)	($15,435.26)	($13,375.31)	$0.00	$0.00	$0.00	$0.00
71837	Sendero Health Plans, Inc.	TX	($1,384,524.30)	($1,197,464.61)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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75394	Texas Health + Aetna Health Insurance Company	TX	$0.00	$0.00	$0.00	$0.00	($9,495.68)	($8,232.93)	$0.00	$0.00
75655	MemorialHermann Commercial Health Plan	TX	$0.00	$0.00	$0.00	$0.00	($201,059.31)	($174,322.10)	$0.00	$0.00
91716	Aetna Life Insurance Company	TX	$0.00	$0.00	$0.00	$0.00	($135,085.43)	($117,121.56)	$0.00	$0.00
98809	UnitedHealthcare Insurance Company	TX	$0.00	$0.00	$0.00	$0.00	($13,515,472.33)	($11,718,162.71)	$0.00	$0.00
18167	Molina Healthcare of Utah, Inc.	UT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
22013	Regence BlueCross BlueShield of Utah	UT	$0.00	$0.00	$0.00	$0.00	$163,737.30	$131,070.75	$0.00	$0.00
29031	National Health Insurance Company	UT	$0.00	$0.00	$0.00	$0.00	$6,362.50	$5,093.15	$0.00	$0.00
34541	BridgeSpan Health Company	UT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
38927	Altius Health Plans Inc.	UT	$0.00	$0.00	$0.00	$0.00	$597.94	$478.64	$0.00	$0.00
42261	University of Utah Health Insurance Plans	UT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
46958	Humana Insurance Company	UT	$0.00	$0.00	$0.00	$0.00	$2,916.09	$2,334.29	$0.00	$0.00
48588	Aetna Life Insurance Company	UT	$0.00	$0.00	$0.00	$0.00	$289.95	$232.10	$0.00	$0.00
66413	UnitedHealthcare of Utah, Inc.	UT	$0.00	$0.00	$0.00	$0.00	$1,122.15	$898.26	$0.00	$0.00
68781	SelectHealth	UT	$0.00	$0.00	$0.00	$0.00	$551,133.74	$441,179.49	$0.00	$0.00
80043	WMI Mutual Insurance Company	UT	$0.00	$0.00	$0.00	$0.00	$381.27	$305.20	$0.00	$0.00
97462	UnitedHealthcare Insurance Company	UT	$0.00	$0.00	$0.00	$0.00	($726,540.89)	($581,591.97)	$0.00	$0.00

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10207	CareFirst BlueChoice	VA	($968,238.42)	($565,826.61)	$0.00	$0.00	$194,341.29	$124,664.09	$0.00	$0.00
12028	Innovation Health Insurance Company	VA	$0.00	$0.00	$0.00	$0.00	$10,849.03	$6,959.32	$0.00	$0.00
16064	Anthem Health Plans of VA(Anthem BCBS)	VA	$0.00	$0.00	$0.00	$0.00	$494,216.12	$317,024.73	$0.00	$0.00
20507	Optima Health	VA	($3,318,052.39)	($1,939,028.94)	$0.00	$0.00	$228,219.90	$146,396.11	$0.00	$0.00
24251	Optimum Choice, Inc.	VA	$0.00	$0.00	$0.00	$0.00	$36,282.51	$23,274.10	$0.00	$0.00
25978	UnitedHealthcare Insurance Company	VA	$0.00	$0.00	$0.00	$0.00	$362,465.50	$232,510.69	$0.00	$0.00
37204	Piedmont Community HealthCare HMO, Inc.	VA	($813,334.17)	($475,302.46)	$0.00	$0.00	$9,277.74	$5,951.38	$0.00	$0.00
38234	Aetna Life Insurance Company	VA	$0.00	$0.00	$0.00	$0.00	$1,300.15	$834.01	$0.00	$0.00
38599	UnitedHealthcare of the Mid-Atlantic Inc	VA	$0.00	$0.00	$0.00	$0.00	($1,916,609.13)	($1,229,447.00)	$0.00	$0.00
40308	Group Hospitalization and Medical Services	VA	($665,355.57)	($388,825.60)	$0.00	$0.00	$96,735.27	$62,052.75	$0.00	$0.00
41921	Cigna Health and Life Insurance Company	VA	$21,804,969.91	$12,742,555.91	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
80352	Virginia Premier Health Plan, Inc.	VA	($379,728.08)	($221,908.42)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
86443	Innovation Health Plan, Inc.	VA	$0.00	$0.00	$0.00	$0.00	$3,807.65	$2,442.49	$0.00	$0.00
88380	HealthKeepers, Inc(Anthem BCBS)	VA	($12,375,439.13)	($7,232,054.19)	$0.00	$0.00	$385,237.08	$247,117.96	$0.00	$0.00
89242	Optima Health	VA	$0.00	$0.00	$0.00	$0.00	$10,394.64	$6,667.85	$0.00	$0.00

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89498	UnitedHealthcare Plan of the River Valley, Inc.	VA	$0.00	$0.00	$0.00	$0.00	$14,002.46	$8,982.20	$0.00	$0.00
93187	Aetna Health Inc. (a PA corp.)	VA	$0.00	$0.00	$0.00	$0.00	$1,657.35	$1,063.14	$0.00	$0.00
95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	VA	($3,284,822.14)	($1,919,609.57)	$0.00	$0.00	$67,822.56	$43,506.09	$0.00	$0.00
13627	Blue Cross Blue Shield of Vermont	VT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
77566	MVP Health Care Inc.	VT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18699	UnitedHealthcare Insurance Company	WA	$0.00	$0.00	$0.00	$0.00	$479,559.76	$383,270.97	$0.00	$0.00
23371	Kaiser Foundation Health Plan of the Northwest	WA	$3,602,148.12	$3,105,215.55	$19,700.16	$17,140.71	$2,674,953.18	$2,305,245.42	$0.00	$0.00
25768	Kaiser Foundation Health Plan of Washington Options	WA	$0.00	$0.00	$0.00	$0.00	$741,625.16	$592,717.47	$0.00	$0.00
34673	Aetna Life Insurance Company	WA	$0.00	$0.00	$0.00	$0.00	$61,125.86	$48,852.66	$0.00	$0.00
36026	Health Net Plan of Oregon, Inc.	WA	$0.00	$0.00	$0.00	$0.00	$13,898.26	$11,107.67	$0.00	$0.00
38229	Health Alliance Northwest Health Plan Inc.	WA	$240.59	$190.95	$0.00	$0.00	$91.65	$73.25	$0.00	$0.00
38498	Lifewise Health Plan of Washington	WA	$408,474.11	$324,189.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
43861	UnitedHealthcare of Washington, Inc.	WA	$0.00	$0.00	$0.00	$0.00	$2,124.88	$1,698.24	$0.00	$0.00
49831	Premera Blue Cross	WA	($8,502,021.90)	($6,994,049.26)	$0.00	$0.00	($7,317,308.41)	($6,015,482.32)	$0.00	$0.00
53732	BridgeSpan Health Company (WA)	WA	$20,644.27	$16,384.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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61836	Coordinated Care Corporation	WA	$1,455,041.89	$1,154,808.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
69364	Asuris Northwest Health	WA	$39,451.94	$31,311.42	$0.00	$0.00	$195,333.51	$156,113.36	$0.00	$0.00
71281	Regence BlueCross BlueShield Of Oregon (Clark County)	WA	$82,848.18	$65,753.29	$0.00	$0.00	$110,789.89	$88,544.87	$0.00	$0.00
80473	Kaiser Foundation Health Plan of Washington	WA	$2,044,319.69	$1,622,494.77	($19,700.18)	($17,140.72)	$539,089.16	$430,847.71	$0.00	$0.00
84481	Molina Healthcare of Washington, Inc.	WA	$819,968.94	$650,776.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
87718	Regence BlueShield	WA	$28,884.14	$22,924.21	$0.00	$0.00	$2,498,717.32	$1,997,010.63	$0.00	$0.00
14630	Children's Community Health Plan	WI	$7,000,624.59	$3,987,203.08	$41,382.78	$23,431.27	$0.00	$0.00	$0.00	$0.00
16245	Group Health Cooperative of Eau Claire	WI	$0.00	$0.00	$0.00	$0.00	($90,304.83)	($75,454.84)	$0.00	$0.00
20173	HealthPartners Insurance Company	WI	$258,725.27	$323,589.01	$168.99	$502.90	$148,421.77	$148,262.55	$0.00	$0.00
35334	MercyCare Insurance Co	WI	$0.00	$0.00	$0.00	$0.00	($4,560.60)	($3,810.66)	$0.00	$0.00
37833	Unity Health Plans Insurance Corporation	WI	$17,241,228.36	$14,723,470.49	$40,703.99	$35,802.92	$10,125,167.07	$8,475,348.58	$0.00	$0.00
38166	Security Health Plan of Wisconsin, Inc.	WI	$4,496,175.19	$3,844,753.15	$6,056.66	$6,568.15	$933,037.64	$740,163.93	$0.00	$0.00
38345	Dean Health Plan	WI	($5,242,356.17)	($4,136,323.42)	($26,694.22)	($20,042.11)	($1,099,642.01)	($918,813.54)	$0.00	$0.00
38752	Aetna Life Insurance Company	WI	$0.00	$0.00	$0.00	$0.00	($2,106.13)	($1,759.80)	$0.00	$0.00
39924	All Savers Insurance Company	WI	$0.00	$0.00	$0.00	$0.00	($1,323.71)	($1,106.03)	$0.00	$0.00
47342	Health Tradition Health Plan	WI	$0.00	$0.00	$0.00	$0.00	($83,931.97)	($70,129.90)	$0.00	$0.00

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52697	Molina Healthcare of Wisconsin, Inc.	WI	($1,935,835.91)	($1,527,413.08)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
55103	Humana Wisconsin Health Org. Ins. Copr	WI	$0.00	$0.00	$0.00	$0.00	($315,720.25)	($263,802.21)	$0.00	$0.00
57637	Medica Insurance Company	WI	$0.00	$0.00	$0.00	$0.00	($450,710.60)	($376,594.38)	$0.00	$0.00
57845	Medica Health Plans of Wisconsin	WI	($1,896,757.00)	($1,496,579.00)	($5,372.40)	($4,033.62)	$0.00	$0.00	$0.00	$0.00
58326	MercyCare HMO, Inc.	WI	($910,649.76)	($718,520.76)	$0.00	$0.00	($236,149.51)	($197,316.39)	$0.00	$0.00
58564	Physicians Plus	WI	$0.00	$0.00	$0.00	$0.00	($866.88)	($724.32)	$0.00	$0.00
59158	UnitedHealthcare Insurance Company	WI	$0.00	$0.00	$0.00	$0.00	($4,849,521.03)	($4,052,051.16)	$0.00	$0.00
64772	Medical Associates Health Plans	WI	$0.00	$0.00	$0.00	$0.00	($34,598.92)	($28,909.37)	$0.00	$0.00
79475	Compcare Health Serv Ins Co(Anthem BCBS)	WI	$0.00	$0.00	$0.00	$0.00	($2,152,923.40)	($1,798,890.19)	$0.00	$0.00
80180	UnitedHealthcare of Wisconsin, Inc.	WI	$0.00	$0.00	$0.00	$0.00	($350,060.73)	($292,495.64)	$0.00	$0.00
81413	Network Health Plan	WI	($1,874,881.63)	($1,479,318.92)	$0.00	$0.00	($2,970.64)	($2,482.14)	$0.00	$0.00
81974	Wisconsin Physicians Svc Insurance Corp - WI	WI	($94,695.92)	($74,716.96)	($35.06)	($26.33)	($254,377.42)	($212,546.84)	$0.00	$0.00
84670	WPS Health Plan, Inc. - WI	WI	($328,896.97)	($259,506.26)	($635.75)	($477.33)	($205,828.11)	($171,981.09)	$0.00	$0.00
86584	Aspirus Arise Health Plan of Wisconsin, Inc.	WI	($2,229,677.89)	($1,759,260.20)	($1,148.61)	($862.38)	($142,816.22)	($119,331.07)	$0.00	$0.00
87416	Common Ground Healthcare Cooperative	WI	($13,898,681.59)	($10,966,336.48)	($53,077.08)	($39,850.44)	($42,415.06)	($35,440.21)	$0.00	$0.00
90028	BCBS of Wisconsin(Anthem BCBS)	WI	$0.00	$0.00	$0.00	$0.00	($65,325.40)	($54,583.13)	$0.00	$0.00

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91604	Humana Insurance Company	WI	$0.00	$0.00	$0.00	$0.00	($715,140.11)	($597,540.27)	$0.00	$0.00
94529	Group Health Cooperative of South Central Wisconsin	WI	($584,320.60)	($461,040.65)	($1,349.26)	($1,013.02)	($105,333.24)	($88,011.94)	$0.00	$0.00
31274	Highmark Blue Cross Blue Shield West Virginia	WV	$0.00	$0.00	$0.00	$0.00	$745,823.17	$563,161.71	$0.00	$0.00
50318	Aetna Life Insurance Company	WV	$0.00	$0.00	$0.00	$0.00	$4,895.17	$3,696.30	$0.00	$0.00
50328	CareSource West Virginia Co.	WV	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
59772	THP Insurance Company	WV	$0.00	$0.00	$0.00	$0.00	$33,191.21	$25,062.26	$0.00	$0.00
72982	The Health Plan of the Upper Ohio Valley	WV	$0.00	$0.00	$0.00	$0.00	$40,209.95	$30,362.04	$0.00	$0.00
77060	UnitedHealthcare Insurance Company	WV	$0.00	$0.00	$0.00	$0.00	($827,113.84)	($624,543.33)	$0.00	$0.00
95628	Optimum Choice, Inc.	WV	$0.00	$0.00	$0.00	$0.00	$2,994.37	$2,261.01	$0.00	$0.00
11269	Blue Cross Blue Shield of Wyoming	WY	$0.00	$0.00	$0.00	$0.00	($999,297.59)	($910,222.54)	$0.00	$0.00
49714	UnitedHealthcare Insurance Company	WY	$0.00	$0.00	$0.00	$0.00	$999,297.61	$910,222.49	$0.00	$0.00

NATIONAL CENTER FOR HEALTH STATISTICS
National Health Interview Survey Early Release Program

Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021

by Robin A. Cohen, Ph.D. and Amy E. Cha, M.P.H., Ph.D.
Division of Health Interview Statistics, National Center for Health Statistics

Since 2001, the National Center for Health Statistics (NCHS) National Health Interview Survey (NHIS) Early Release Program has released selected estimates of health and health care for the civilian noninstitutionalized U.S. population. This table presents quarterly estimates of health insurance coverage disaggregated by age group and family income as a percentage of the federal poverty level (FPL) for the civilian noninstitutionalized U.S. population based on data from the July–September 2021 NHIS. Quarterly estimates for July–September 2020 through April–June 2021 are also presented for comparison. These estimates are being published prior to final data editing and final weighting to provide access to the most recent information from the NHIS.

Table. Percentage (and 95% confidence interval) of people who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, family income as a percentage of the federal poverty level and quarter: United States, July 2020–September 2021

Health insurance coverage status, age group (years) and family income as a percentage of the FPL[1]	Quarter 3, 2020 (Jul–Sep)	Quarter 4, 2020 (Oct–Dec)	Quarter 1, 2021 (Jan–Mar)	Quarter 2, 2021 (Apr–Jun)	Quarter 3, 2021 (Jul–Sep)
Uninsured[2]					
All ages	9.7 (8.8–10.7)	10.3 (9.3–11.5)	9.5 (8.6–10.4)	9.7 (8.6–10.8)	8.9 (8.2–9.6)
Less than 100% FPL	18.8 (14.3–24.0)	18.4 (14.4–22.8)	18.4 (14.6–22.7)	16.7 (13.3–20.6)	14.4 (11.3–18.0)
100% to less than 200% FPL	15.2 (12.7–18.0)	17.4 (14.0–21.2)	13.7 (11.2–16.4)	15.8 (13.2–18.8)	14.0 (11.6–16.7)
200% and greater FPL	6.2 (5.3–7.1)	6.3 (5.4–7.3)	6.1 (5.5–6.9)	5.9 (5.2–6.8)	6.1 (5.4–6.9)
Under 65	11.5 (10.4–12.7)	12.3 (11.1–13.7)	11.3 (10.3–12.4)	11.5 (10.3–12.8)	10.7 (9.8–11.5)
Less than 100% FPL	20.5 (15.6–26.1)	20.2 (15.7–25.2)	20.0 (15.9–24.7)	19.0 (15.2–23.4)	16.2 (12.7–20.3)
100% to less than 200% FPL	18.0 (15.0–21.3)	21.3 (17.2–25.8)	16.6 (13.6–19.9)	19.0 (15.8–22.4)	17.1 (14.1–20.4)
200% and greater FPL	7.3 (6.2–8.4)	7.6 (6.4–8.8)	7.4 (6.6–8.2)	7.1 (6.2–8.1)	7.3 (6.4–8.2)
0–17	4.5 (2.9–6.6)	6.4 (4.6–8.7)	4.6 (3.6–5.8)	4.2 (3.1–5.6)	4.2 (3.3–5.3)
Less than 100% FPL	*	*	6.8 (3.5–11.8)	7.0 (3.6–12.0)	6.1 (3.3–10.1)
100% to less than 200% FPL	*	10.9 (5.6–18.8)	6.9 (4.4–10.3)	5.4 (3.1–8.6)	7.0 (4.1–11.0)
200% and greater FPL	3.5 (2.0–5.7)	3.7 (2.1–5.9)	3.0 (2.2–4.1)	2.7 (1.8–3.9)	2.3 (1.5–3.4)
18–64	14.1 (12.8–15.5)	14.5 (13.1–15.9)	13.8 (12.6–15.1)	14.2 (12.7–15.8)	13.0 (12.0–14.1)
Less than 100% FPL	28.6 (23.0–34.8)	26.9 (21.5–32.8)	27.4 (21.8–33.5)	26.5 (21.0–32.6)	21.7 (16.8–27.4)
100% to less than 200% FPL	24.8 (20.9–29.1)	26.5 (22.0–31.4)	21.9 (18.1–26.1)	25.5 (21.5–29.9)	22.3 (18.6–26.4)
200% and greater FPL	8.4 (7.3–9.7)	8.8 (7.5–10.2)	8.8 (7.8–9.8)	8.5 (7.3–9.8)	8.9 (7.9–10.0)
Public health plan coverage[3]					
All ages	38.5 (36.9–40.1)	38.0 (36.4–39.7)	40.0 (38.5–41.5)	39.0 (37.4–40.7)	38.8 (37.4–40.2)
Less than 100% FPL	68.9 (63.4–74.1)	68.5 (63.5–73.2)	67.5 (62.6–72.1)	71.7 (67.1–75.9)	67.9 (61.7–73.8)
100% to less than 200% FPL	59.8 (56.0–63.5)	57.2 (53.1–61.3)	62.3 (58.8–65.6)	58.6 (54.9–62.1)	60.5 (57.1–63.7)
200% and greater FPL	26.0 (24.6–27.4)	25.9 (24.4–27.5)	26.9 (25.5–28.4)	26.3 (24.6–27.9)	26.5 (25.1–27.9)

See footnotes at the end of table.

Table. Percentage (and 95% confidence interval) of people who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, family income as a percentage of the federal poverty level and quarter: United States, July 2020–September 2021—cont.

Health insurance coverage status, age group (years) and family income as a percentage of the FPL[1]	Quarter 3, 2020 (Jul–Sep)	Quarter 4, 2020 (Oct–Dec)	Quarter 1, 2021 (Jan–Mar)	Quarter 2, 2021 (Apr–Jun)	Quarter 3, 2021 (Jul–Sep)
Under 65	26.8 (24.9–28.8)	26.3 (24.4–28.2)	28.3 (26.6–30.0)	27.3 (25.7–29.0)	26.9 (25.3–28.5)
Less than 100% FPL	66.1 (60.0–71.8)	65.2 (59.6–70.6)	64.3 (59.1–69.2)	67.7 (62.5–72.6)	63.9 (56.9–70.5)
100% to less than 200% FPL	51.9 (47.4–56.4)	47.8 (42.9–52.7)	54.4 (50.5–58.3)	50.4 (46.5–54.2)	51.3 (47.5–55.1)
200% and greater FPL	12.5 (11.0–14.0)	11.8 (10.4–13.4)	12.8 (11.6–14.1)	12.6 (11.2–14.1)	13.2 (11.8–14.6)
0–17	44.4 (40.0–48.9)	41.7 (37.1–46.3)	45.6 (42.6–48.6)	43.8 (41.2–46.4)	42.5 (39.9–45.3)
Less than 100% FPL	**88.1 (76.4–95.3)	85.9 (77.2–92.2)	87.5 (81.7–92.1)	87.0 (81.2–91.6)	85.2 (79.9–89.6)
100% to less than 200% FPL	74.6 (66.2–81.9)	69.2 (60.2–77.3)	76.4 (71.5–80.8)	78.0 (73.2–82.2)	74.9 (69.0–80.2)
200% and greater FPL	18.4 (14.6–22.8)	16.7 (13.1–20.9)	19.1 (16.8–21.5)	16.7 (14.5–19.2)	19.4 (16.9–22.1)
18–64	20.3 (18.8–21.9)	20.6 (19.2–22.1)	22.0 (20.5–23.5)	21.3 (19.5–23.3)	21.1 (19.6–22.7)
Less than 100% FPL	51.3 (44.7–57.8)	52.7 (46.6–58.8)	51.3 (45.4–57.1)	55.8 (48.5–62.9)	52.3 (44.2–60.4)
100% to less than 200% FPL	40.2 (35.6–44.9)	37.1 (32.4–42.1)	42.3 (38.1–46.7)	37.0 (32.4–41.7)	39.1 (35.0–43.3)
200% and greater FPL	10.6 (9.4–11.8)	10.3 (9.0–11.6)	10.8 (9.6–12.1)	11.3 (9.7–13.0)	11.1 (9.9–12.5)
Private health insurance coverage[4]					
All ages	61.4 (59.6–63.1)	61.2 (59.4–63.0)	59.7 (58.0–61.4)	60.6 (59.1–62.0)	61.4 (59.9–62.9)
Less than 100% FPL	16.8 (13.1–21.0)	18.1 (14.2–22.5)	17.0 (13.2–21.5)	15.7 (12.5–19.4)	20.8 (15.4–27.1)
100% to less than 200% FPL	33.4 (29.7–37.3)	34.9 (31.2–38.7)	32.2 (29.1–35.4)	34.2 (31.2–37.4)	34.9 (31.5–38.5)
200% and greater FPL	77.9 (76.4–79.3)	78.2 (76.6–79.7)	77.1 (75.9–78.2)	77.9 (76.7–79.2)	77.0 (75.4–78.6)
Under 65	63.7 (61.6–65.7)	63.2 (61.1–65.4)	62.3 (60.4–64.2)	63.2 (61.6–64.8)	64.2 (62.4–65.9)
Less than 100% FPL	15.8 (12.1–20.1)	17.2 (13.1–21.9)	17.3 (13.2–22.0)	14.8 (11.3–19.0)	21.2 (15.1–28.4)
100% to less than 200% FPL	32.6 (28.4–37.1)	34.1 (29.8–38.6)	31.8 (28.0–35.8)	34.6 (31.2–38.2)	34.4 (30.3–38.6)
200% and greater FPL	81.9 (80.2–83.5)	82.0 (80.1–83.7)	81.6 (80.2–82.9)	82.0 (80.5–83.3)	81.1 (79.4–82.7)
0–17	53.6 (49.2–58.0)	54.3 (49.6–58.9)	52.0 (48.9–55.0)	54.3 (51.6–57.1)	55.5 (52.4–58.5)
Less than 100% FPL	*	*	6.7 (4.0–10.5)	8.0 (4.5–13.0)	10.1 (6.4–15.0)
100% to less than 200% FPL	23.4 (16.5–31.6)	24.8 (17.2–33.7)	20.2 (15.7–25.3)	20.3 (16.1–25.1)	22.6 (17.8–27.9)
200% and greater FPL	79.9 (75.5–83.9)	80.8 (76.4–84.8)	80.0 (77.5–82.4)	82.3 (79.8–84.7)	80.2 (77.2–82.9)
18–64	67.4 (65.6–69.1)	66.5 (64.7–68.3)	66.1 (64.2–68.1)	66.4 (64.7–68.2)	67.3 (65.5–69.1)
Less than 100% FPL	22.3 (17.4–27.9)	22.1 (17.2–27.7)	23.2 (17.4–29.9)	19.0 (14.3–24.5)	27.2 (18.7–37.0)
100% to less than 200% FPL	37.4 (32.9–42.0)	38.8 (34.3–43.3)	38.2 (33.5–43.1)	41.5 (37.4–45.8)	40.5 (35.8–45.2)
200% and greater FPL	82.5 (80.9–84.1)	82.3 (80.6–84.0)	82.1 (80.8–83.4)	81.8 (80.1–83.5)	81.3 (79.7–82.9)

*Estimate is not shown, as it does not meet NCHS standards of reliability.

**While the estimate meets NCHS standards of reliability, its complement does not.

[1]FPL is federal poverty level. The percentage of respondents in the unknown FPL category in the third quarter of 2020 was 10.4%, in the fourth quarter of 2020 was 10.4%, in the first quarter of 2021 was 10.5%, in the second quarter of 2021 was 9.7% and in the third quarter of 2021 was 9.5%. Estimates may differ from estimates that are based on both reported and imputed income.

[2]People were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. People were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Public health plan coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of people were covered by both public and private plans and were included in both categories.

[4]Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of people were covered by both public and private plans and were included in both categories.

NOTES: These health insurance estimates are being released prior to final data editing and final weighting to provide access to the most recent information from the National Health Interview Survey (NHIS). Occasionally, due to decisions made for the final data editing and weighting, estimates based on preliminary editing procedures may differ from estimates based on final files. The estimates are based on a sample of the population and therefore are subject to sampling error. Quarterly estimates have wider confidence intervals than annual estimates due to smaller sample sizes, and this should be taken into account when evaluating the statistical significance of differences between groups and changes over time. Due to the COVID-19 pandemic, NHIS data collection switched to a telephone-only mode beginning March 19, 2020. Personal visits (with telephone attempts first) resumed in all areas in September 2020. In addition, from August–December 2020., a subsample of adult respondents who completed the NHIS in 2019 were recontacted by telephone and asked to participate again. Response rates were lower and respondent characteristics were different in July–December 2020. Differences observed in estimates between July–December 2020 and other time periods may have been impacted by these differences in respondent characteristics. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020–2021.

Suggested citation:
Cohen RA and Cha AE. Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, July 2020–September 2021. National Center for Health Statistics. January 2022. Available from: https://www.cdc.gov/nchs/nhis/releases.htm.

social service agencies, they may be less effective or less efficient in addressing social determinants of health than those agencies, which may have more knowledge and practical expertise in upstream drivers of health.[5] Understanding how these trade-offs inform optimal allocation of scarce societal resources will be critical to improving population health, particularly in marginalized populations. Discussions of trade-offs must recognize the fact that policymakers may assign widely varying weights to specific benefits and harms in their decision making (e.g., ongoing debates over school closures during the pandemic). Many economists would argue that the people who stand to be most affected by a given policy or health condition should be the ones to determine how to weigh various benefits and harms.

An audio interview with Dr. Green is available at NEJM.org

Public health practitioners come from a wide range of disciplines that reflects the multifaceted range of problems they must tackle. Economics meaningfully adds to these perspectives by clarifying key trade-offs and illuminating new policy options — including those that go beyond the delivery of public health services. A key contribution of economics to public health is the elucidation of complex trade-offs that may affect health-related behaviors, which include nonmonetary costs and benefits that are often ignored by policymakers. Economic models can help public health policymakers craft more equitable policies that more fully account for the lived experiences and realities of various populations.

Disclosure forms provided by the authors are available at NEJM.org.

From the Departments of Population Health Sciences and Obstetrics and Gynecology, University of Wisconsin–Madison, Madison (T.G.); and the Department of Medical Ethics and Health Policy, Perelman School of Medicine, and the Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia (A.S.V.).

This article was published on January 29, 2022, at NEJM.org.

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DOI: 10.1056/NEJMp2104360

Automatic Insurance Policies — Important Tools for Preventing Coverage Loss

Adrianna McIntyre, Ph.D., M.P.H., M.P.P., and Mark Shepard, Ph.D.

The Affordable Care Act (ACA) is more than a decade old, but universal health care coverage in the United States remains elusive. An underappreciated fact about the roughly 28 million uninsured Americans is how many of them already qualify for subsidized coverage. It has been estimated that 57% of uninsured people in 2019 qualified for Medicaid or subsidized marketplace coverage, and 40% qualified for insurance plans with no premiums — either Medicaid or state health insurance marketplace plans (typically plans in the least-generous "bronze" tier).[1] To reduce the proportion of uninsured Americans, policymakers have focused on increasing marketplace subsidies and persuading holdout states to expand Medicaid. But policies that broaden eligibility for affordable coverage, though necessary, are unlikely to completely close the coverage gap.

Affordability-based policies do little to address the administrative burdens involved in securing and maintaining health coverage. People must navigate complicated and onerous systems to apply for, enroll in, and retain insurance. There is growing evidence that even minor hassles substantially reduce take-up. Conversely, policies that remove barriers and make it easier to stay insured can help shrink the ranks of the uninsured.

The American Rescue Plan Act (ARPA), enacted in March 2021, improved insurance affordability, at least temporarily. ARPA allowed

families with incomes below 150% of the federal poverty level (FPL) and those collecting unemployment benefits in 2021 to enroll in "benchmark" silver plans in the marketplace and pay no monthly premium (enrollees may still be charged deductibles and copayments). ARPA also increased subsidies for enrollees with higher incomes, which has made zero-premium bronze plans more widely available. As a result, nearly half the uninsured population in 2021 probably qualified for free coverage.[1]

Absent congressional action, however, these subsidy enhancements will expire at the end of 2022. States have also stopped removing people from Medicaid programs during the Covid-19 public health emergency, but eventually this "maintenance of eligibility" will end, and affected beneficiaries will need to seek other insurance. Together, these changes could instigate widespread coverage loss.

To mitigate potentially massive disenrollment, state and federal policymakers will need to take coordinated action. During key periods when people are at elevated risk for becoming uninsured — because, for example, they must switch sources of coverage — systems could employ "automatic" policies that make it easy to stay insured. The availability of zero-premium plans facilitates implementation of these policies, since it provides a free option to which people can be assigned rather than lose coverage. Recent research from Massachusetts shows sizable effects of two such policies: automatic enrollment and automatic retention.

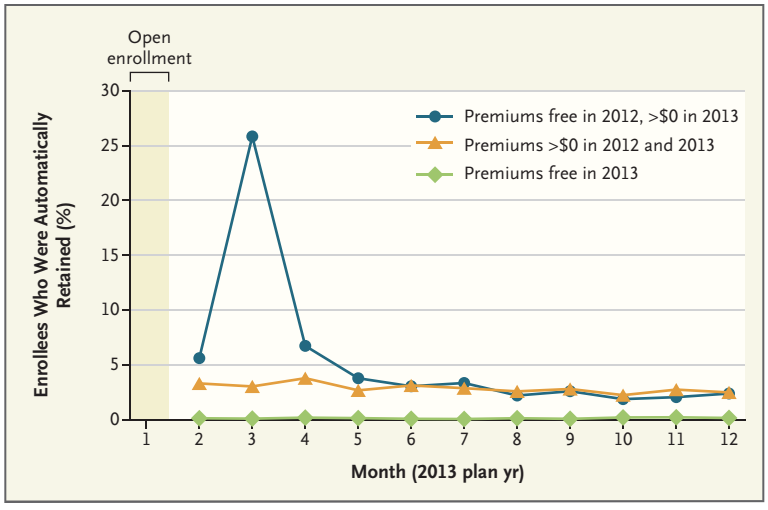
Automatic enrollment promotes take-up when people gain or lose eligibility for various types of coverage, a phenomenon known as churn. For instance, people can simultaneously lose Medicaid eligibility and qualify for marketplace subsidies because of minor changes in income or personal circumstances. Unless they successfully navigate the marketplace-enrollment process, many of them could become uninsured — and locked out of coverage until the next open-enrollment period. Evidence suggests that take-up challenges are common. One experiment found that less than 5% of people referred to California's insurance marketplace from county Medicaid programs enrolled in coverage, even after personalized reminder letters were sent to the whole group.[2]

Although universal autoenrollment is probably infeasible today, a targeted autoenrollment approach could be implemented for people who have already qualified for subsidized marketplace coverage — on the basis of either an online application or information from the Medicaid eligibility-redetermination process — but who haven't completed the enrollment process. Before the ACA was implemented, Massachusetts' insurance exchange used a similar approach for applicants qualifying for zero-premium coverage. Quasi-experimental research showed that this policy increased total enrollment by 30 to 50%. People who were automatically enrolled were younger and healthier than other enrollees, with medical costs 44% below average.[3] By reducing average costs, autoenrollment policies could result in lower premiums. California intends to start automatically enrolling people churning from Medicaid to marketplace coverage in 2022.

Policies that automate enrollment can also improve retention of marketplace coverage. Many enrollees stop (or never start) paying their premiums for marketplace plans, despite maintaining eligibility for subsidies. Changes in after-subsidy premiums when rates are reset in a new plan year appear to be important — particularly when plans that have been free begin requiring a small premium. Enrollees who don't notice this change and so don't actively set up a bill-payment mechanism can easily fall behind; if they miss premiums for 3 consecutive months, their coverage can be terminated.

Enrollment figures suggest that maintenance of eligibility has kept millions of people on Medicaid — many of whom could lose coverage when the Covid-19 emergency ends.

Automatic retention, another policy enacted in Massachusetts before implementation of the ACA, sought to address this issue. Exchange enrollees who fell behind on premium payments were automatically transitioned to a zero-premium plan if one was available, rather than losing coverage. Our research found that this



Estimated Share of Enrollees Who Were Automatically Retained in Massachusetts Health Insurance Exchange Plans in 2013.

Rates could not be estimated for the open-enrollment month. Enrollees who fell behind on premium payments were switched to an available zero-premium plan after a 2-month grace period, rather than being disenrolled (as occurs in the Affordable Care Act marketplaces). Automatic retention had an especially large effect 3 months after a plan began charging premiums between years. As expected, the policy wasn't relevant for plans that were free in 2013, since enrollees cannot lapse on a $0 premium. Data are from McIntyre et al.[4] Adapted with permission.

policy prevented coverage loss for 14% of enrollees who were eligible for zero-premium plans.[4] The graph shows the estimated share of enrollees who maintained insurance coverage because of automatic retention in each month of 2013. The largest effects occurred just after plans shifted from having a zero after-subsidy premium in 2012 to a small positive premium in the new year, with automatic retention rates exceeding 25%. The policy also kept enrolled a sizable group of people (2 to 3% per month) who missed premium payments at other times. As with autoenrollment, people who were automatically retained in plans were younger and cheaper to insure than other enrollees.

Current circumstances create new urgency surrounding these policies. Enrollment figures suggest that maintenance of eligibility has kept millions of people on Medicaid — many of whom could lose coverage when the Covid-19 emergency ends. In addition, for many enrollees, the cheapest silver-tier offerings (the ones fully subsidized under ARPA) will have changed for the new plan year; this means that enrollees who elected zero-dollar silver coverage in 2021 could face new premiums for the same plans in 2022. Absent automatic retention, these dynamics could lead to disenrollment.

Automatic insurance policies pose several challenges. Some require federal action — at a minimum, guidance is needed on what states can do under existing rules or with a Section 1332 innovation waiver.

Currently, subsidies for marketplace plans are calculated using estimated annual household income; discrepancies between estimated and actual income are later "reconciled" through taxes. Automatic insurance policies could therefore create unexpected tax liabilities for some enrollees. Federal policymakers could establish safe harbors for people who are autoenrolled or autoretained in marketplace plans so that any unexpected tax liabilities are forgiven. Alternatively, they could harmonize the marketplace's income rules with Medicaid's system of using real-time monthly income to determine eligibility.

Another concern is automatic enrollment of people who are ineligible for subsidized insurance (e.g., because they have employer-sponsored insurance). Evidence from Massachusetts, however, suggests that duplicative-enrollment rates were generally less than 5%.[3,4] State regulators could work with carriers to minimize this issue.

To address potential enrollee dissatisfaction, policymakers could add automated coverage assignments to the list of qualifying life events that trigger special-enrollment periods — windows in which plan changes are permitted. Under a new regulation finalized in September 2021, states may also permit enrollees with incomes below 150% of the FPL who qualify for zero-premium silver-tier coverage to change marketplace plans throughout the year.[5]

Challenges could be further mitigated with improved eligibility and enrollment systems. States' health information–technology infrastructure varies widely: some states, such as Massachusetts, have integrated Medicaid and marketplace eligibility systems, but most have not. When people churn off Medicaid, the timing and content of data sent

to state marketplaces varies. Inconsistent administrative capabilities create uneven opportunities, which suggests that sustained federal investments in states' data infrastructure could be valuable.

Achieving universal health care coverage in the United States will require more than making insurance affordable; policymakers also need to make it easier to stay insured than to fall through the cracks of the country's complicated insurance system. In combination with expanded eligibility and outreach, we believe automatic enrollment policies should be central to strategies for reducing the proportion of uninsured people in the United States.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Health Policy and Management, Harvard T.H. Chan School of Public Health, Boston (A.M.), and the Harvard Kennedy School and the National Bureau of Economic Research, Cambridge (M.S.) — all in Massachusetts.

This article was published on January 29, 2022, at NEJM.org.

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DOI: 10.1056/NEJMp2114189

The Care I Needed

Jessica Gregg, M.D., Ph.D.

One afternoon last winter, I caught myself massaging aches in my wrists and hands, aches that hadn't been there the day before. A few hours later, I was rolling away pain in my shoulders, then in my neck. The next morning, my knees hurt too, and my stiff paws fumbled as I tried to turn the doorknob.

I was worried, but not terrified; I've been healthy my whole life, and I have excellent insurance through a large HMO. Also, I'm a doctor; I would get the care I needed. I scheduled an urgent telehealth visit for the following day through my HMO's elegant app. So easy! Then I took extra-strength Tylenol, chased it with ibuprofen, and went to work.

I had a new patient to see, an older guy, with stubble and jowls. Though I'm trained in internal medicine, I mostly treat addiction now, mostly among people without housing, steady incomes, or loved ones to catch them when they fall. My new patient told me about his slide into addiction, his terrible luck and lousy choices. He told me opioids numbed his pains, and cannabis and methamphetamines helped him forget — but now he worried that the forgetting was becoming permanent: he was having trouble remembering basic things, like a friend's address or which bus lines went where. Maybe, he said, it came from too many drugs and too much hard living. Or maybe, he shrugged and smiled, he was just getting old.

"Aren't we all?" I replied, rolling and popping my creaky neck.

He laughed. "You got that right."

He spoke to me as if I were a friend, and I forgot my own hurts and remembered to slow my speech and check for understanding. I prescribed medication to reduce opioid cravings and said I wanted to see him again in a week. He thanked me, blessed me, and said he'd try to remember.

The following morning, I shuffled and groaned myself to the coffee maker and a cup whose handle I couldn't quite grip, before settling in front of my computer as if it were Christmas morning and Santa was bringing me telehealth. I imagined unburdening myself to a white-coated colleague, someone about my age, maybe a little older. She would lean forward, asking concerned questions. Did I have any rashes? What about fevers? Did it feel safe to drive? Then she would think aloud about possible causes of my symptoms while reassuring me that we'd get to the root of it all. My imaginary doctor was unrushed, had no other thoughts but of my problems, and sort of loved me.

Health Insurance Loss during COVID-19 May Increase Support for Universal Health Coverage

Ashley Fox
Yongjin Choi
State University of New York at Albany

Heather Lanthorn
IDinsight

Kevin Croke
Harvard University

Abstract

Context: The United States is the only high-income country that relies on employer-sponsored health coverage to insure a majority of its population. Millions of Americans lost employer-sponsored health insurance during the COVID-19–induced economic downturn. We examine public opinion toward universal health coverage policies in this context.

Methods: Through a survey of 1,211 Americans in June 2020, we examine the influence of health insurance loss on support for Medicare for All (M4A) and the Affordable Care Act (ACA) in two ways. First, we examine associations between pandemic-related health insurance loss and M4A support. Second, we experimentally prime some respondents with a vignette of a sympathetic person who lost employer-sponsored coverage during COVID-19.

Findings: We find that directly experiencing recent health insurance loss is strongly associated (10 pp, $p < 0.01$) with greater M4A support and with more favorable views of extending the ACA (19.3 pp, $p < 0.01$). Experimental exposure to the vignette increases M4A support by 6 pp ($p = 0.05$).

Conclusions: In the context of the COVID-19 pandemic, situational framings can induce modest change in support for M4A. However, real-world health insurance losses are associated with larger differences in support for M4A and with greater support for existing safety net policies such as the ACA.

Keywords Medicare for All, framing, COVID-19, survey experiment, unemployment

Sixty percent of working-age Americans received health insurance through an employer-sponsored plan in 2019 (KFF 2019). Consequently, the massive job losses associated with the COVID-19–induced economic downturn led to an estimated 3–27 million Americans losing their employer-sponsored health insurance in the first months of the pandemic in 2020 (Banthin and

Journal of Health Politics, Policy and Law, Vol. 47, No. 1, February 2022
DOI 10.1215/03616878-9417428

Holohan 2020; Fronstin and Woodbury 2021; Garfield et al. 2020). Given that alternative insurance options are often unaffordable, many of these working-age Americans remained uninsured in the midst of a pandemic (Garfield and Tolbert 2020).

The pandemic highlights the risks of relying on employer-sponsored health coverage in two ways: (1) millions of Americans have lost their jobs and often their health coverage (for any illness), and (2) the pandemic itself brings increased risk of illness and associated costs, as a potential COVID-19–related hospital stay could cost tens of thousands of dollars (FAIR Health 2020; Rae et al. 2020). The increased salience of these risks may affect Americans' views about health insurance in general and about the risks of linking insurance to employment in particular. If so, it offers an opportunity for advocates of expanded health insurance coverage to highlight the limitations of employer-sponsored coverage and make the case for delinking insurance from employment. Moreover, it could enable new political coalitions in favor of universal health coverage, if the millions of Americans who unexpectedly lost employer-sponsored coverage could be persuaded to support this alternative.

Prior to the emergence of COVID-19, policies to achieve universal health coverage (UHC), including through Medicare for All or expansions of the Affordable Care Act, were already on the policy agenda in the United States, most notably during the 2019–20 Democratic presidential primary campaign. Various Democratic candidates proposed plans to increase coverage, ranging from wrap-around policies to fill gaps in the existing system ("Medicare for All who want it" or "Medicare buy-ins") to more expansive visions of "Medicare for All" (hereafter, M4A), which has become shorthand for single-payer insurance with universal coverage in the United States. Popularized by Senator Bernie Sanders, M4A would fully delink health coverage from employment and provide universal, tax-financed health insurance coverage (Uhrmacher et al. 2020). Yet the candidates most associated with M4A, Senator Bernie Sanders and Senator Elizabeth Warren, lost the primary to Joe Biden; Biden supported a plan to expand health insurance coverage, including with a public insurance option, but did not support M4A. Just as this intra-Democratic primary election was concluding in spring 2020, the COVID-19 pandemic, and the sudden job and health insurance loss that it entailed, became a feature of American life.

Amid this context of increasing health risks, large-scale job loss, and health insurance disruption, we explore public opinion about policies to expand health insurance coverage among an online sample of 1,211 Americans. We examine whether elements of this pandemic, notably the

widespread experience of health insurance and job loss, increase support for government's role in the health system; we focus particularly on plans, such as M4A, that delink health insurance from employment. We also include questions about support for the Affordable Care Act as well as more general support for universal health coverage as a goal.

We present five main findings. First, we find that respondents who experienced recent health insurance loss have 10–15 percentage points (pp) higher support for M4A ($p < 0.01$) than those who have not, including when controlling for a wide range of demographic and socioeconomic factors. Following Lawrence R. Jacobs and Suzanne Mettler (2011), we consider this experience a "structural" factor. Second, we find that this effect is moderated by political party affiliation; most movement toward M4A associated with insurance loss is among self-identified Republicans, who have much lower levels of support for M4A overall. Third, we show that priming respondents about the relationship between involuntary job loss and insurance loss shifts their views about M4A. Experimentally priming respondents with emotive vignettes about no-fault job and insurance loss during COVID-19 results in a 5.5 pp increase in support for M4A ($p < 0.050$). Following Jacobs and Mettler, we consider this vicarious (via vignette) experience of insurance loss a "situational frame." However, the results of the survey experiment are relatively modest in magnitude compared to the real world, "structural" determinants of opinion, such as the impact of losing one's insurance. Fourth, political party affiliation does not moderate the effect of this situational frame. Fifth, in a secondary battery of questions in which multiple policies for coverage expansions were presented as options, we find that the survey vignette treatment increases support for M4A, but that personal health insurance loss is associated with increased support for the Affordable Care Act and strong opposition to ACA repeal, and less support for M4A.

Background

Changing Support for Medicare for All

Many health policy experts view the barriers to a "Medicare for All" system in the United States as primarily political, rather than technical (Berwick, Nolan, and Whittington 2008). While there are many barriers to comprehensive reform, including the multiple veto points that characterize American political institutions (Steinmo and Watts 1995) and widespread opposition from industry stakeholders, an important element of the political

feasibility of M4A is public opinion. In public opinion polls, majorities of the American public have consistently, over the past two decades, favored a greater role for government in health care; 50%–60% have been found to be supportive of greater government involvement in health care in general or universal coverage policies in particular (Gallup 2021a; KFF 2020; Steinmo and Watts 1995). Likewise, a majority of US physicians, a group once overwhelmingly opposed to a national health plan, now support a single-payer system (Bluth 2017). Moreover, M4A plans, in name if not in substance, are generally popular with the public, with majorities expressing support (Karra and Sandoe 2020; KFF 2020).

However, general popularity does not translate into unconditional support for M4A. Previous studies have found support to be sensitive to question wording and framing of the issue, with specific framings either increasing or reducing support (Karra and Sandoe 2020; KFF 2020; Oberlander 2019). In addition, while "Medicare for All" has a clear meaning in the health policy world, it is less clear how it is understood by voters. Many may consider it shorthand for a general expansion of health coverage or may believe it also refers to more incremental Medicare buy-in plans (Oberlander 2019). Furthermore, when given more head-to-head comparisons of different potential health reform options, including keeping and expanding the Affordable Care Act or giving states more flexibility to design public health insurance options for their residents, recent polling has found that the public splits nearly evenly among the three options (30% favoring each option) (McIntyre et al. 2020), including with Democrats somewhat more favorable toward building on the ACA (KFF 2020).

In this study, we focus on M4A approval as our main outcome, as it is the health plan that most directly captures the delinking of employment and insurance. We do, however, recognize that M4A opinions may be a proxy in many voters' minds for general government support for health insurance coverage. There is ambiguity about whether support for M4A has increased since the onset of COVID-19 in the United States in March 2020: for example, polling by Morning Consult showed a nine percentage point increase in support for M4A between February and March 2020 (Murad 2020), while other polls indicate that support for M4A has remained constant (*Hill* 2020). It therefore remains unclear if COVID-19 is sufficiently disruptive to cause a long-lasting ("structural") change in public opinion toward M4A as well as whether ongoing experience with the ACA increases public approval of the law. These ambiguities motivate the remainder of this article.

Theoretical Frames

Our theoretical motivation on opinion toward health insurance coverage builds on Jacobs and Mettler's (2011) framework of "situational" versus "structural" framing of public opinion about health care. Jacobs and Mettler (2011) argue that public opinion about the US health system is primarily rooted in structural factors, which reflect citizens' long-standing, institutionalized interactions with health insurance and the health care system in the course of their lives. This suggests that the salience of one's own lived experience or other relatively fixed characteristics of individuals largely shape views toward health care and health insurance policy questions.

However, in the short run, opinions can also vary depending on situational framing, that is, the way the message is conveyed and the moment or context in which it is conveyed. Such frames may temporarily boost the salience of issues outside one's lived experience. Frames are used by individuals and groups to highlight specific aspects of the problem and to emphasize certain causal links (accurate or not) that temporarily increase or dampen support (Entman 1993). Health issues frequently typify a competitive framing environment, in which two sides or opposing arguments compete with each other in the public sphere (Chong and Druckman 2007).

There is evidence that situational frames affect support for health policies such as M4A and the ACA. For example, M4A in particular is susceptible to a number of common forms of attack; polling often shows high initial support followed by a decline in enthusiasm as policy details are framed in unflattering ways (KFF 2020). Certain counterarguments tend to depress support for M4A—for instance, the idea that a single-payer system could increase wait times for appointments, lead to large tax increases and a doubling of the government budget, and constitute a "government take-over" of health care (KFF 2020).

Conversely, support for health reforms such as M4A or the ACA can be strengthened through positive situational frames. Jason Barabas, Benjamin Carter, and Kevin Shan (2020) find that providing survey respondents with policy "analogies" for various health programs increased support (such as using car insurance analogies to describe the individual mandate of the Affordable Care Act). Other recent survey experiments find that simpler framing elements can also increase support for the policy—for example, by including the policy name "Medicare for All" with a description of the policy (Karra and Sandoe 2020).

More fundamentally than situational or framing effects, crises (such as the COVID-19 pandemic that struck the United States starting in early

2020) can act as shocks that could theoretically disrupt equilibria and lead to more structural changes in public opinion as well as changes in political alignments that may facilitate policy change (Baumgartner and Jones 1993). However, situational frames may still be invoked by policy elites to counteract these shifts in public opinion at critical junctures.

Research Questions and Hypotheses

Our study design allows for examination of both situational and structural elements of opinion formation and change around M4A. First, given the broader context of the pandemic, we examine the association between recent insurance loss and attitudes toward M4A. Second, we examine the situational framing of attitudes toward M4A with a survey experiment, by measuring how priming respondents about the effects of job loss on insurance coverage affects their attitudes toward M4A. Through this experiment, we randomly expose readers to either no vignette (control) or one of two emotive vignettes of job and insurance loss; we present identical, sympathetic victims who experience no-fault job loss—because of either COVID-19 or technological and market changes.

We hypothesized that both personal experience with insurance loss and exposure to vicarious insurance loss, via vignette, would increase support for M4A. We further hypothesized that framing effects would vary based on political partisanship. This moderating effect was prespecified in an Evidence in Governance and Politics (EGAP)–registered analysis plan. Strong partisans may have more rigid attitudes and therefore be less susceptible to priming. This view aligns with theories of motivated reasoning, which suggest that strong political partisans will be unlikely to change their core positions and may even dig in their heels more firmly in the face of counterevidence (Strickland, Taber, and Lodge 2011). We therefore hypothesized that among strong partisans of either political party, the priming treatment would have limited impact. By contrast, we hypothesized that self-described Independent voters would be more likely to shift opinions in response to priming.

Methods

Sampling and Data Collection

We conducted an online opinion survey with a national sample of 1,211 Americans between June 3 and June 8, 2020, during the height of the

COVID-19 lockdowns in the United States. Respondents had to be at least 18 years of age and consent to completing the survey. The project underwent ethical review and received approval from the University at Albany Institutional Review Board. Respondents provided informed consent before participating.

We used the third-party firm Qualtrics to administer the survey. Qualtrics is an internet survey provider that recruits respondents who have signed up to take online surveys in exchange for incentives such as cash, airline miles, and gift cards. Qualtrics aggregates respondents initially recruited by other firms. Recruitment and compensation are handled by the third-party firm, but researchers may define the audience and specify certain quotas.

While Qualtrics does not provide a probability sample of the US population, a recent study found that among internet survey providers, a Qualtrics-recruited sample came closest to a national probability sample on most variables relative to samples recruited through Amazon MTurk or Facebook (Boas, Christenson, and Glick 2018). We report on key characteristics of our sample in table 2. Notably, when compared to the US population, our sample has higher proportions of Republicans and Democrats and is more likely to be younger (table A5).

On average, the survey took 15 minutes for respondents to complete. Qualtrics provides quality-control measures to weed out those who do not complete the survey and who do not appear to be taking the survey seriously (such as "speeders") as well as those who appear to be bots based on input provided in open-ended questions. Twenty percent of the starting sample was dropped through the quality checks, leaving us with an analytic sample of 1,211 high-quality responders.

Outcome Variables

Our main outcome of interest is support for M4A. Our primary outcome variable is the response to the following question, which is the same question wording used by the Kaiser Family Foundation's recurring survey "Public Opinion on Single Payer, National Health Plans, and Expanding Access to Medicare Coverage" (KFF 2020): "As of today, do you favor or oppose a national health plan or 'Medicare for All' plan, in which all Americans would get their health insurance from a single government plan?" Respondents could select: strongly favor, somewhat favor, somewhat oppose, or strongly oppose this statement, or report that they do not know. We show the breakdown of responses in table 1. For analysis, we

Table 1 Main Outcome Variable—Support for Medicare for All

	N	%
Strongly favor	442	36.50
Somewhat favor	372	30.72
Somewhat oppose	164	13.54
Strongly oppose	135	11.15
Do not know	98	8.09
Total	1,211	100

recoded this 4-point Likert scale into a binary variable capturing support for M4A for those who reported "strongly" or "somewhat" favoring M4A.

We also ask about support for other health care reform options using alternative survey items that gave respondents the choice of other health policies, such as expansion or repeal of the Affordable Care Act. We explore the robustness of our findings by using these additional questions to gauge opinion about health insurance expansion via differing question wording, response options, and issue framing.

Actual Insurance Loss

We also leverage variation in pandemic-associated insurance loss to examine the association between having lost one's own health insurance and support for M4A. Our survey collected information about health insurance loss by asking whether the respondent had lost their health insurance in the last 6 months for any reason. We examine the effect of insurance loss on support for M4A through regressions controlling for age, race/ethnicity, gender, previous year income, and political partisanship.

Vicarious Insurance and Job Loss: Experimental Conditions and Randomization Procedure

Our experimental condition is a vignette about job and insurance loss, intended to prime the reader to think about job loss and consequent loss of employer-sponsored health coverage. Respondents were randomly assigned to one of three groups with equal probability: the control group (no vignette), a COVID-19 vignette, or an Airbnb vignette, described below.

In each of the experimental conditions, we present the job-loss vignettes as brief newspaper articles at the beginning of the survey, narrating

the story of a white, male former football player ("Sean McGuire") who gets laid off from his job as hotel concierge in Philadelphia and loses his employer-sponsored health coverage. In one vignette (hereafter "the COVID-19 vignette"), Sean is laid off as a result of COVID-19–induced economic downturns; a plausible scenario, as COVID-19 caused major job losses in the hospitality industry. In the second experimental condition, the layoff is the result of competition from Airbnb ("the Airbnb vignette"). We take this second condition as a "normal" unemployment condition related to market changes. Please see the online appendix for the full vignettes.

We chose to use a newspaper article to present the vignette in order to simulate how people might receive information in the real world. The article was adapted from an actual news story. We chose for the protagonist in the vignette to be a white male to avoid known racial biases/empathy gaps in redistributive politics (e.g., Alesina, Glaeser, and Sacerdote 2001). In both conditions, we take Sean to be a generally sympathetic victim and his job loss to be not his fault. At the end of our survey, respondents were informed that the newspaper article they had read was fictitious but that the information provided in it was accurate. We included two comprehension questions to ensure respondents actually read and understood the vignettes, which respondents had to pass to proceed in the survey.

Data Analysis

Prior to data collection, the survey experiment was preregistered with EGAP, and experimental results are reported according to the original study design. Observational analyses of the association between insurance loss and M4A support were not preregistered. All analyses were completed in Stata 15. In all of our main analyses, we control for sex, age, previous year's income, political party identification, and race/ethnicity. To explore the moderating effects of political party identification, we interacted Democratic, Republican, or Independent party identification variables with the pooled treatment (exposure to either job loss vignette) to estimate the impact on support for M4A, in unadjusted models as well as models that controlled for gender, age, income, and race/ethnicity. Party identification was measured by asking respondents, "In politics today, do you consider yourself a Republican, Democrat, or Independent?" We repeat these models with different question wordings and with the "do not know" responses dropped (results available in the online appendix).

Results

Sample and Descriptive Findings

In the 6 months prior to our survey, 22% of respondents lost health insurance. More than half (13% of total) of these respondents lost health insurance because of losing their job, while the remaining 9% lost health insurance for other reasons. Another 23% report that someone close to them lost health insurance.

Our sample is comparable to the US population on gender balance (52% female) and the percentage of respondents who lack health insurance (9%); however, our sample is younger, more likely to be white (72%), and less likely to be Hispanic (6%). Our sample contains more self-described Democrats and Independents, as well as fewer Republicans, than Gallup's data on party affiliation from the same week that our survey was fielded (Gallup 2021b). Compared to the national unemployment rate in June 2020 (11.2%), 24.74% of our under-65 sample reported being currently unemployed (*Economic Daily* 2020). While the sample has representation from all 50 states as well as Washington, DC, roughly proportional to the population in each state, New York is overrepresented in our sample.

The sample was mostly balanced across experimental conditions on key covariates with the exception of age (see table 2). The control condition was significantly younger, with 20% of respondents in that condition younger than 25, compared to between 10% and 12% in other study arms. Party identification, ethnicity, income, and gender were balanced across treatment arms. We present both unadjusted models as well as those that adjust for age and other covariates (gender, race/ethnicity, previous calendar year income, and political party identification). As is standard practice, we account for sample imbalance by controlling for these characteristics in the regression. We also reweight our sample to account for age-related imbalance using inverse probability weighting (IPW) methods. This is discussed further in the robustness checks section; the results of this reweighting are presented in the online appendix.

Situational Framing: Vicarious Insurance Loss through Experimentally Assigned Vignettes

In bivariate analysis, the COVID-19 vignette increased M4A support by 6.2 pp ($p = 0.06$), while the Airbnb arm increased support for M4A by 4.8 pp ($p = 0.14$). A combined treatment indicator pooling both vignettes increased support by 5.5 pp ($p = 0.05$) (fig. 1).

Table 2 Balance across Study Arms

	No treatment N (%)	Airbnb arm N (%)	COVID-19 arm N (%)	Total N (%)	*p*
Age, years					
<25	90 (20.55)	47 (12.02)	41 (10.73)	178 (14.70)	
25–44	228 (52.05)	217 (55.50)	203 (53.14)	648 (53.51)	
45–64	73 (16.67)	73 (18.67)	95 (24.87)	241 (19.90)	
65+	47 (10.73)	54 (13.81)	43 (11.26)	144 (11.89)	Pr = 0.00
Gender					
Male	199 (45.43)	198 (50.64)	184 (48.17)	581 (47.98)	
Female	239 (54.57)	193 (49.36)	198 (51.83)	630 (52.02)	Pr = 0.32
Race/ethnicity					
White	306 (69.86)	282 (72.12)	291 (76.18)	879 (72.58)	
Black	64 (14.61)	52 (13.3)	42 (10.99)	158 (13.05)	
Hispanic	30 (6.85)	25 (6.39)	20 (5.24)	75 (6.19)	
Other	38 (8.68)	32 (8.18)	29 (7.59)	99 (8.18)	Pr = 0.623
Income					
<$20,000	109 (24.89)	82 (20.97)	67 (17.54)	258 (21.3)	
$20,000–$74,999	160 (36.53)	148 (37.85)	147 (38.48)	455 (37.57)	
$75,000–$149,000	82 (18.72)	75 (19.18)	73 (19.11)	230 (18.99)	
$150,000+	87 (19.86)	86 (21.99)	95 (24.87)	268 (22.13)	Pr = 0.256
Party identification					
Democrat	185 (42.24)	165 (42.2)	157 (41.1)	507 (41.87)	
Republican	148 (33.79)	142 (36.32)	143 (37.43)	433 (35.76)	
Independent	105 (23.97)	84 (21.48)	82 (21.47)	271 (22.38)	Pr = 0.797
Total	438 (100.00)	391 (100.00)	382 (100.00)	1,211 (100.00)	

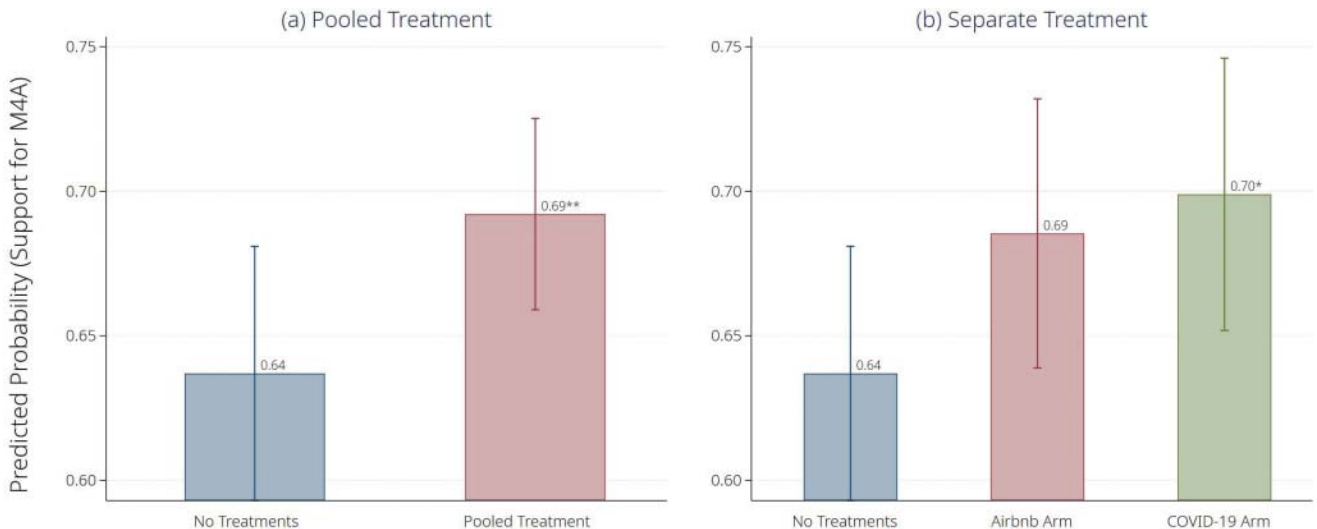

Figure 1 Support for Medicare for All by treatment arm.

Note: Capped spikes indicate 95% prediction intervals. Controls included but not shown: age, gender, race/ethnicity, income, party identification. Stars indicate the significance level of the difference between the treatment and no-treatment groups. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 3 Experimental Priming Results

	Separate treatment		Pooled treatment	
	No controls	With controls	No controls	With controls
COVID-19 arm	0.062*	0.057*		
	(0.033)	(0.031)		
Airbnb arm	0.0484	0.046		
	(0.033)	(0.031)		
Pooled treatment			0.055**	0.051*
			(0.028)	(0.027)
Controls	No	Yes	No	Yes
Observations	1,211	1,211	1,211	1,211

Note: Standard errors in parentheses. Controls included but not shown: age, gender, race/ethnicity, income, party identification. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

In multivariate analysis, we again examined the impact of each treatment (vignette) study arm separately relative to control, then pooled both vignettes into a single treatment. Priming respondents with the COVID-19 vignette increased stated support for M4A by 5.7 pp ($p = 0.07$). Priming with the Airbnb vignette increased support for M4A by 4.6 pp ($p = 0.14$) (table 3). We cannot reject the null hypothesis that the two treatment arms are equivalent ($p = 0.68$), thus we reported pooled treatment effects going forward. The pooled effect of any prime on M4A support is 5.1 pp ($p = 0.057$). Treatment effects drop to 2.6–3.1 pp when "do not know" responses are excluded (table A2). This implies that the priming treatment affects both "oppose" and "do not know" groups.

Structural Framing: Personal Insurance Loss

Next, we estimate the association between recent health insurance loss on support for M4A (table 4). In columns 1 and 2, the independent variable is any health insurance loss within the previous 6 months, with controls for age, gender, race/ethnicity, political party identification, and previous-year income. Recent health insurance loss is associated with a 10 pp increase in M4A support. In columns 3 and 4 we restrict this to respondents who lost health insurance specifically as a result of losing their job; in these specifications, insurance and job loss is associated with a 15 pp increase in support for M4A. In columns 2 and 4 we restrict the sample to respondents not currently on Medicare, since job loss should not be strongly related to

Table 4 Health Insurance Loss and Medicare for All Favorability

	All respondents	Without Medicare enrollees	All respondents	Without Medicare enrollees
Lost health insurance in last 6 months	0.099*** (0.032)	0.104*** (0.033)		
Lost insurance because of job loss in last 6 months			0.151*** (0.039)	0.150*** (0.039)
Controls	Yes	Yes	Yes	Yes
Observations	1211	1011	1211	1011

Note: Standard errors in parentheses. Controls included but not shown: pooled treatment, age, gender, race/ethnicity, income, party identification. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

insurance status for respondents older than 65. We find similar results with respondents on Medicare removed.

Moderating Effects of Reported Political Party Identification

Next, we examine the moderating variables of political party identification on both the experimental treatment and on real-life job and insurance loss (see table 5). In the experimental component, we find no significant differences in the impact of priming by party identification. Independents were not more likely to switch their positions, counter to our prespecified hypothesis. By contrast, in the observational analysis of the association between insurance loss and M4A support, political party identification is an important effect moderator. Virtually all of the increased support for M4A among those who have lost health insurance comes from Republican respondents. The additional effect of the interaction of insurance loss with GOP identification is 20 pp ($p < 0.05$); for insurance loss specifically because of job loss it is slightly smaller, and we cannot reject the null hypothesis of zero differential effect (17–18 pp, $p = 0.12$). In all analysis of partisanship, results are unchanged whether we include strong partisans only or whether we include those who consider themselves Independent but acknowledge "leaning" Republican and Democratic when pushed.

Robustness Checks

As robustness checks, we examine alternative closely related outcome variables for both the structural insurance loss and situational frame outcome

Table 5 Experimental and Personal Insurance Loss by Political Party Identification

Panel A: Experimental priming interacted with party identification

	Separate treatment		Pooled treatment	
	No controls	With controls	No controls	With controls
Democrat X COVID-19 arm	0.068 (0.085)	0.071 (0.082)		
Republican X COVID-19 arm	0.035 (0.087)	0.005 (0.084)		
Independent X COVID-19 arm	0.021 (0.068)	0.025 (0.066)		
Democrat X Airbnb arm	0.007 (0.084)	0.014 (0.081)		
Republican X Airbnb arm	–0.029 (0.087)	–0.040 (0.084)		
Independent X Airbnb arm	0.055 (0.068)	0.055 (0.065)		
Democrat X pooled treatment			0.037 (0.072)	0.042 (0.069)
Republican X pooled treatment			0.003 (0.074)	–0.018 (0.072)
Independent X pooled treatment			0.038 (0.058)	0.040 (0.056)
Democrat	0.1611*** (0.057)	0.132** (0.055)	0.161*** (0.057)	0.132** (0.055)
Republication	0.0490 (0.059)	0.012 (0.057)	0.049 (0.059)	0.012 (0.057)

(*continued*)

Table 5 Experimental and Personal Insurance Loss by Political Party Identification (*continued*)

Panel B: Effect of health insurance loss interacted with party identification

	Lost insurance		Lost insurance because of job loss	
	No controls	With controls	No controls	With controls
Democrat X all insurance loss	0.024 (0.094)	0.031 (0.092)		
Republican X all insurance loss	0.210** (0.095)	0.203** (0.092)		
Independent X all insurance loss	0.053 (0.081)	0.000 (0.079)		
Democrat X job-related insurance loss			0.051 (0.126)	0.064 (0.122)
Republican X job-related insurance loss			0.177 (0.128)	0.170 (0.123)
Independent X job-related insurance loss			0.097 (0.112)	0.044 (0.108)
Democrat	0.175*** (0.038)	0.152*** (0.037)	0.171*** (0.036)	0.148*** (0.036)
Republican	–0.009 (0.039)	–0.052 (0.039)	0.018 (0.037)	–0.027 (0.037)
Controls	No	Yes	No	Yes
Observations	1,211	1,211	1,211	1,211

Note: Standard errors in parentheses. Controls included but not shown: age, gender, race/ethnicity, income, party identification. Reference category: independents. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table 6 Alternative Measures of Opinion about Health Programs

Panel A: Effect of experimental priming on alternative outcomes					
Mostly positive view:	M4A	Medicare buy-in	UHC	NHI	Obamacare
Pooled treatment	0.071**	0.045	0.034	0.023	0.019
	(0.028)	(0.028)	(0.027)	(0.028)	(0.028)
Panel B: Effect of insurance loss on alternative outcomes					
Mostly positive view:	M4A	M4A for some	UHC	NHI	Obamacare
Lost health insurance in last 6 months	–0.083**	–0.031	0.007	0.007	0.072**
	(0.034)	(0.034)	(0.033)	(0.034)	(0.034)
Controls	Yes	Yes	Yes	Yes	Yes
Observations	1,211	1,211	1,211	1,211	1,211

Note: Standard errors in parentheses. Controls included but not shown: age, gender, race/ethnicity, income, party identification. * $p<0.1$, ** $p<0.05$, *** $p<0.01$

variables. We compare the results of the main outcome measure with two other measures of support for M4A (tables 6 and 7). The first alternative is a series of questions that ask respondents whether they have a mostly positive, or mostly negative, impression of a series of labels: Medicare for All, Medicare for those who want it, universal health coverage (UHC), national health insurance (NHI), and Obamacare. Notably, the experiment only increases the percentage reporting "mostly positive" opinions significantly about M4A (7.1 pp, $p<0.05$) and to a lesser extent "Medicare for those who want it" (4.5 pp, $p=0.11$) (see table 6, panel A). By contrast, losing one's health insurance is associated with a mostly positive view of Obamacare (7–8 pp, $p<0.05$) and, in covariate-adjusted models, is associated with a more negative view of M4A (–8.4 pp, $p<0.05$) (see table 6, panel B).

In the second alternative set of questions, respondents were asked to choose among three mutually exclusive options that best described their opinion about which direction the United States should go in health policy reform: "incrementally building on the Affordable Care Act," "reversing the Affordable Care Act and moving towards more private health insurance coverage," or "creating a universal M4A system that would replace employer-sponsored health insurance coverage." The experimental treatment did not shift views on any of these significantly; however, personal experience of insurance loss is associated with more favorable views of extending the ACA (19.3 pp, $p<0.01$), more opposition to repealing the

Table 7 Alternative Measures of Public Opinion about Health Policy Reform

Panel A: Effect of experimental priming on alternative outcomes

	M4A	Expanding the ACA	Reversing the ACA	Other option
Pooled treatment	0.019	–0.011	–0.012	0.004
	(0.030)	(0.029)	(0.022)	(0.010)

Panel B: Effect of insurance loss on alternative outcomes

	M4A	Expanding the ACA	Reversing the ACA	Other option
Lost health insurance in last 6 months	–0.098***	0.193***	–0.076***	–0.019
	(0.036)	(0.035)	(0.026)	(0.012)
Controls	Yes	Yes	Yes	Yes
Observations	1,211	1,211	1,211	1,211

Note: Standard errors in parentheses. Controls included but not shown: age, gender, race/ethnicity, income, party identification. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

ACA (–7.6 pp, $p < 0.01$), and less favorable views of M4A (–9.8 pp, $p < 0.01$) (table 7). Full question wording and descriptive statistics from these questions are in the online appendix.

A final robustness check involves addressing the imbalance by age in the experimental sample. In addition to controlling for age in main regressions, we also implement an inverse probability weight (IPW) correction to account for age-related sample imbalance (online appendix table A3). Results are qualitatively similar after this reweighting.

Discussion

We have examined opinion toward a proposed major reform of the US health system, including expansion of health coverage (M4A) in the context of large-scale job and health insurance loss during the COVID-19 pandemic. The experience of health insurance loss—a "structural" factor—is associated with 10–15 pp higher support for M4A. This association is moderated by political party identification, as the effect is driven by respondents who identify as Republicans. We also find a modest impact of an emotive vignette of no-fault job loss on support for M4A: experimental priming increased support for M4A by 5.5 pp. The effect appeared to primarily work through moving people who would otherwise have had ill-formed

preferences on M4A into the more supportive category. Political party identification did not moderate the effect of the situational frame. Alternative question wordings revealed that the situational experimental frame was strongest in moving people to have a more favorable view of M4A, whereas personal ("structural") insurance loss was associated with a more positive view of ACA/"Obamacare," support for expansion of the ACA, and corresponding reductions in support for M4A. However, we note that the associations between job loss and opinion are observational estimates and despite extensive controls may be biased by unmeasured confounding variables.

Taken together, these key results suggest that both situational framing and structural effects can increase support for universal health coverage policies, but that structural effects, although nonexperimentally identified, appear larger and stronger. While it remains too early to tell, those who have lost valuable employer-sponsored insurance may serve as a future constituency in support of programs to expand access to health insurance. Within the sample, there was quite broad support for M4A when asked as a stand-alone question—nearly 70% of the sample reported strong or moderate support. Likewise, nearly 54% of the sample reported that their support for M4A had increased following COVID-19 (see table A4 in the online appendix). This level of support is higher than national polls in which, in October 2020 (pre-COVID), 53% favored a national Medicare-for-All plan (KFF 2020), and where, in 2021, 56% of people thought that it is the government's responsibility to make sure all Americans have health care coverage (Gallup 2021a). However, the lived experience of insurance loss was associated with more support for the ACA in alternative question framings in which the ACA was offered as an alternative to M4A. Among respondents who lost health insurance, a plurality remained on employer-sponsored insurance (either from new employment, their spouse, or their parents), but more than one in four reported purchasing private insurance plans using government subsidies (i.e., benefiting from the ACA). While the sample sizes are too small for reliable inference about these subgroups, we hypothesize that this direct experience with the benefits of the ACA may have led these respondents to favor it instead of the less familiar option of M4A. Thus it is also possible that pandemic-driven insurance loss will build a larger structural coalition in support of the ACA.

Given the role of partisanship as a driver of Americans' policy views, we find it notable that the association of personal health insurance loss and M4A support was stronger among Republicans, suggesting that insurance loss may be powerful enough—at least in the short run—to change the opinion of those with more entrenched oppositional beliefs toward

government involvement in health care. Whether these changes can be sustained and ultimately converted into support for candidates who propose expanded government programs remains a challenge in a deeply polarized electorate.

We also find that situational frames, which can provide additional information linking the impact of job loss to insurance loss, may help solidify people's views on Medicare for All. Practically speaking, this demonstrates that advocacy efforts may be effective at moving opinion on M4A, at least temporarily. However, since counterframes were not directly tested, we cannot assess how similar subjects respond to competing frames.

Directions for Future Research

Our research suggests that expressed preferences for health reform can be moved by both structural factors and situational framing. Given the cross-sectional nature of our data, we cannot assess the stability of these opinions. Longitudinal research designs will be needed to demonstrate how preferences evolve over time, including as COVID-19 vaccines are rolled out and the US economy continues to recover. The US unemployment rate, which peaked at 14.8% in April 2020, had recovered to 6.7% by December 2020, suggesting that any increases in support for M4A among those who lost insurance temporarily could gradually fade. The inauguration of President Joe Biden together with unified Democratic control of Congress may also trigger "thermostatic" dynamics in public opinion, pushing some Republicans and Independent voters to rediscover opposition to universal health programs. Thus, while the mass layoffs stemming from the COVID-19–induced recession may have presented an opportunity for proponents of M4A plans to make the case for the need to decouple insurance from employment, it remains unclear whether this message—and the life experiences that can generate receptivity to the message—can enduringly move the needle on public support for M4A or other UHC programs.

The widespread use of situational frames by political elites in a fragmented media market has given rise to concern about how "frame contests" may be contributing to growing political polarization in the United States (e.g., Baum 2011). An additional line of recommended research is to investigate the stability of health reform preferences not just over time but when exposed to counterarguments. That is, are situational frames pointing to problems with tying insurance to employment sufficiently convincing to inoculate against counterframes that paint M4A in a negative light? Future studies will have to gauge how resilient this new framing is to counterarguments (for instance, frames suggesting that countries with

universal health coverage have had high mortality from COVID, or have had to ration care during the crisis).

Our findings also highlight that the broad term *Medicare for All* may mean different things to different people, and it does not necessarily equate with the idea that insurance coverage should be decoupled from employment. The findings of our secondary outcome analysis suggest uniquely positive features of the "Medicare" label, as these were only abstract concepts that gained support in response to experimental priming (compared to "universal health coverage" or "national health programs"). At the same time, however, we observe that actual loss of insurance was associated with increased approval of the Affordable Care Act/Obamacare rather than M4A, again suggesting that respondent experience with actual programs plays a large role in their opinions.

We also find major differences in magnitudes when comparing experimental versus personal experience of insurance loss. This highlights important methodological trade-offs in research design. While survey experiments generate strong internal validity, the larger effects, and differential patterns of heterogeneity, of our nonexperimental estimates are a reminder that real-life exposures are likely more powerful—and of much greater interest—than differences in issue framing generated by researchers. However, residual confounding of these estimates remains a possibility. Longitudinal study designs could shed further light on these questions.

Limitations

A limitation of the study is that while the "structural" factor—job loss—was unexpected for many, given the unexpected nature of the pandemic, it may be subject to residual confounding; despite extensive covariate adjustment, the associations between health insurance loss and M4A approval cannot be interpreted as causal. In the experimental component, treatment was randomly assigned, although differential attrition with respect to respondent age may also bias point estimates. We mitigate the impact of this imbalance by controlling for age. We also note that, since attrition of younger respondents was higher in the treatment groups, and since younger respondents are on average more favorable to M4A, this imbalance may work against the likelihood of finding treatment effects. This survey experiment is also limited by the controlled environment in which it was implemented: respondents were not exposed to counterframes; as a result, we cannot assess how similar subjects would respond to the COVID-19 priming in the presence of competing frames. A further limitation relates to generalizability: perhaps reflecting the online recruiting

modality, the sample in this article is younger, more likely to be unemployed, and more likely to have lost health insurance recently than the US population as a whole. The relationships identified in this sample may be weaker in older and more stably employed populations. A final limitation is that, while all experimental analysis, including subgroup analyses, were preregistered, observational analyses of the association between insurance loss and M4A support were not preregistered and should be interpreted as exploratory in nature.

Conclusions

We find that sympathetic framing of job loss and its association with insurance loss can bolster support for M4A, but that actual experience of insurance loss increases support for universal health coverage options more. Whether COVID-19 might tip the balance toward broader support for Medicare for All, the Affordable Care Act, or similar proposals will likely hinge on whether affected groups begin to perceive a stake in the programs, particularly the millions of people who lost employer-sponsored coverage in 2020 (Jacobs and Mettler 2011). With a new presidential administration, health care policy will continue to evolve. Our research suggests that while appealing framing can help, concrete benefits delivered by programs, rather than more effective messaging, are the most promising path toward generating a broader consensus around universal health coverage programs in the United States.

■ ■ ■

Ashley Fox is an associate professor of public policy at the Rockefeller College of Public Affairs and Policy, University at Albany, State University of New York. Her research examines the politics of health policy and comparative disease responses. afox3@albany.edu

Yongjin Choi is a PhD candidate with the Department of Public Administration and Policy at the University at Albany, State University of New York. His research interests cover policy side effects, policy design, public health, evidence-based policy, machine learning, and citizen participation in policy making. His recent studies have qualitatively and quantitatively examined how certain consequences of policy become social problems, how knowledge for policy making is socially constructed, and how Medicaid expansions affected birth outcomes.

Heather Lanthorn is an associate director with IDinsight. She studies the implementation and impact of health and education policies and programs.

Kevin Croke is an assistant professor with the Department of Global Health and Population at the Harvard T. H. Chan School of Public Health. He studies the politics of health and health systems.

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UCLA CENTER FOR HEALTH POLICY RESEARCH

The State of Health Insurance in California

Findings From the 2019 and 2020 California Health Interview Surveys

Shana Alex Charles, PhD, MPP

Susan H. Babey, PhD

Joelle Wolstein, PhD, MPP

January 2022

The California Endowment

Funded by a grant from
The California Endowment

The views expressed in this report are those of the authors and do not necessarily represent the UCLA Center for Health Policy Research, the Regents of the University of California, or The California Endowment.

Suggested Citation:
Charles SA, Babey SH, Wolstein J. 2022. *The State of Health Insurance in California: Findings From the 2019 and 2020 California Health Interview Surveys*. Los Angeles, CA: UCLA Center for Health Policy Research.

CHIS california health interview survey

chis.ucla.edu

This study and report were funded by a grant from The California Endowment. The report is based on data from the 2019 and 2020 California Health Interview Surveys, which were supported by funds received from the California Department of Health Care Services; California Department of Public Health; The California Endowment; California Health Benefit Exchange; California Tobacco Control Program; First 5 California; California Department of Mental Health; Kaiser Permanente; San Diego County Health and Human Services Agency; and California Wellness Foundation.

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Foreword

This publication represents the 20th anniversary of the *State of Health Insurance in California (SHIC)* report series. It is the 10th installment of the UCLA Center for Health Policy Research's ongoing, in-depth study of the overall outlook for health insurance coverage in our state, which has the population size of a country but operates within the federalist framework of the U.S. system. Longtime readers of this report series will find similar chapters as in the past—a demographic overview, private coverage, public coverage, and access to care impacts—and will recognize the focus on adults under age 65 and children, since seniors are almost universally covered through Medicare. However, we are now providing the data in a more streamlined and broadly accessible chartpack, allowing readers to draw their own conclusions based on the comprehensive data provided.

Our data are from the 2019 and 2020 California Health Interview Surveys (CHIS), representing the decade following the enactment of the Patient Protection and Affordable Care Act of 2010, also known as the ACA or "Obamacare." Most of the health insurance expansions took full effect in 2014. Since then, ACA expansion has continued in California, including the growth of subsidies and coverage, notwithstanding rollbacks and roadblocks posed by the federal government from 2017 to 2020. Despite these advances, this chartpack shows that significant coverage gaps remain in California. Racial and ethnic disparities persist (Chapter 1); many small businesses struggle to even offer health insurance to employees (Chapter 2); more than half a million low-income people who could be eligible for Medi-Cal remain uninsured (Chapter 3); and being uninsured remains a significant barrier to accessing health care (Chapter 4).

Since the CHIS data are self-reported by respondents, numbers in this chartpack may not match with administrative data totals, particularly for Medi-Cal coverage. Our estimates of Medi-Cal coverage are lower overall than the state administrative enrollment data for 2020, due to known factors: 1) CHIS includes only the noninstitutionalized population and excludes people residing in nursing homes, dormitories, and prisons; 2) there is some respondent confusion between having Medi-Cal and Medicare coverage; and 3) some Medi-Cal beneficiaries who were signed up for the program by other entities (including hospitals, to recoup costs, or through continuing enrollment due to pandemic-era relaxation of cancellation regulations) may be unaware of their current enrollment. In addition, CHIS self-reported data for public coverage in California overall, which combines Medi-Cal and Medicare for all ages (14.7 million), closely matches the self-reported data for public coverage in California reported by the American Community Survey that was administered by the U.S. Census Bureau in 2020 (14.9 million).[1]

Additionally, CHIS instituted a change in its survey administration method beginning in 2019. Prior to 2019, households were mostly required to take CHIS over the phone, with some small component of online surveys.

1 Source: U.S. Census Bureau, 2020 American Community Survey 1-Year Experimental Estimates, Table ID: XK202703; title: Public Health Insurance Status

Starting in 2019, CHIS changed to being a survey that is mainly administered online, with phone surveys given only as a follow-up if a randomly chosen household has failed to complete the online survey.[2] In its evaluation of the methodology change, the CHIS research team cautioned against comparing health insurance data over time. Therefore, we have included only 2019 and 2020 data in this report, and we note that any comparisons with previous *State of Health Insurance in California* reports should be interpreted cautiously, keeping this methodology change in mind.

We hope that providing the 2019–2020 CHIS data will highlight the continued challenges in need of solutions on which policymakers, advocates, government agencies, and other stakeholders can focus their future efforts. There is still much work to be done.

2 For more information on the methodology change and its impact on CHIS estimates, see *CHIS 2019-2020 Redesign: Rationale, Empirical Evaluation, and Trends*, at *https://healthpolicy.ucla.edu/chis/design/Documents/CHIS2019-2020-Redesign-WorkingPaper-09142021.pdf*.

Acknowledgments

The authors would like to thank the programming team at the UCLA Center for Health Policy Research, led by Zebry Jiang, who cleaned the CHIS datasets, created the variables, and performed the data runs without which this chartpack would not have been possible. We also appreciate the work of Ethan Nguyen, who assisted in creating the charts for Chapters 2 and 3 as part of his graduate work at California State University, Fullerton. Thank you to Nadereh Pourat, Anthony Wright, and Lucien Wulsin for their thoughtful and thorough reviews. Finally, thank you to Tiffany Lopes and the entire CHPR Communications team for the final publication work on the chartpack.

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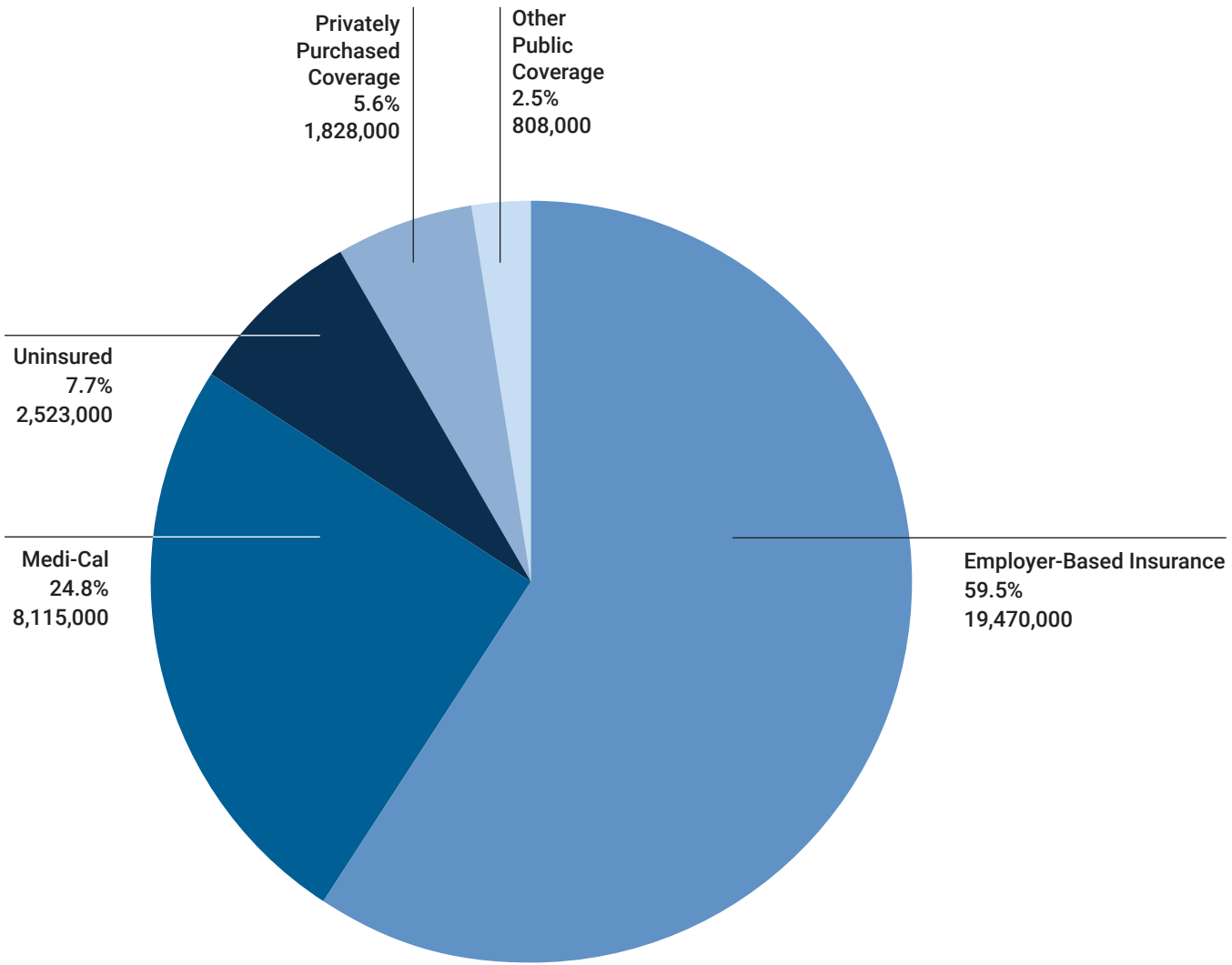
Chapter 1

A Demographic Look at Health Insurance in California

In California, as in the rest of the United States, people obtain health insurance coverage through either privately or publicly funded means. The largest proportions of adults under 65 and children (defined as ages 18 and younger due to the extension of Medi-Cal coverage until age 19) are insured through employer-based insurance. While the privately purchased market remains robust, it has not expanded significantly, even with the subsidies offered through Covered California that make this form of private coverage more affordable. Instead, the expansion of the Medicaid program (known as Medi-Cal in California) under the Patient Protection and Affordable Care Act of 2010 (ACA, also known as "Obamacare") has offered a new publicly funded option for people who were previously uninsured. Medi-Cal acts as an invaluable safety net when combined with the state's Children's Health Insurance Program (CHIP)/Healthy Families, forming a seamless public insurance program. For older Californians, the publicly funded Medicare program serves as the backbone of health insurance coverage. If someone is not able to access any of these pathways to obtain health insurance, then they are uninsured. In this section, health insurance coverage rates among Californians in these categories are examined within subgroups defined by age, gender, racial/ethnic group, education, household income, citizenship status, and region of residence.

Exhibit 1.1 Health Insurance Coverage for Adults and Children Ages 0–64, California, 2019–2020



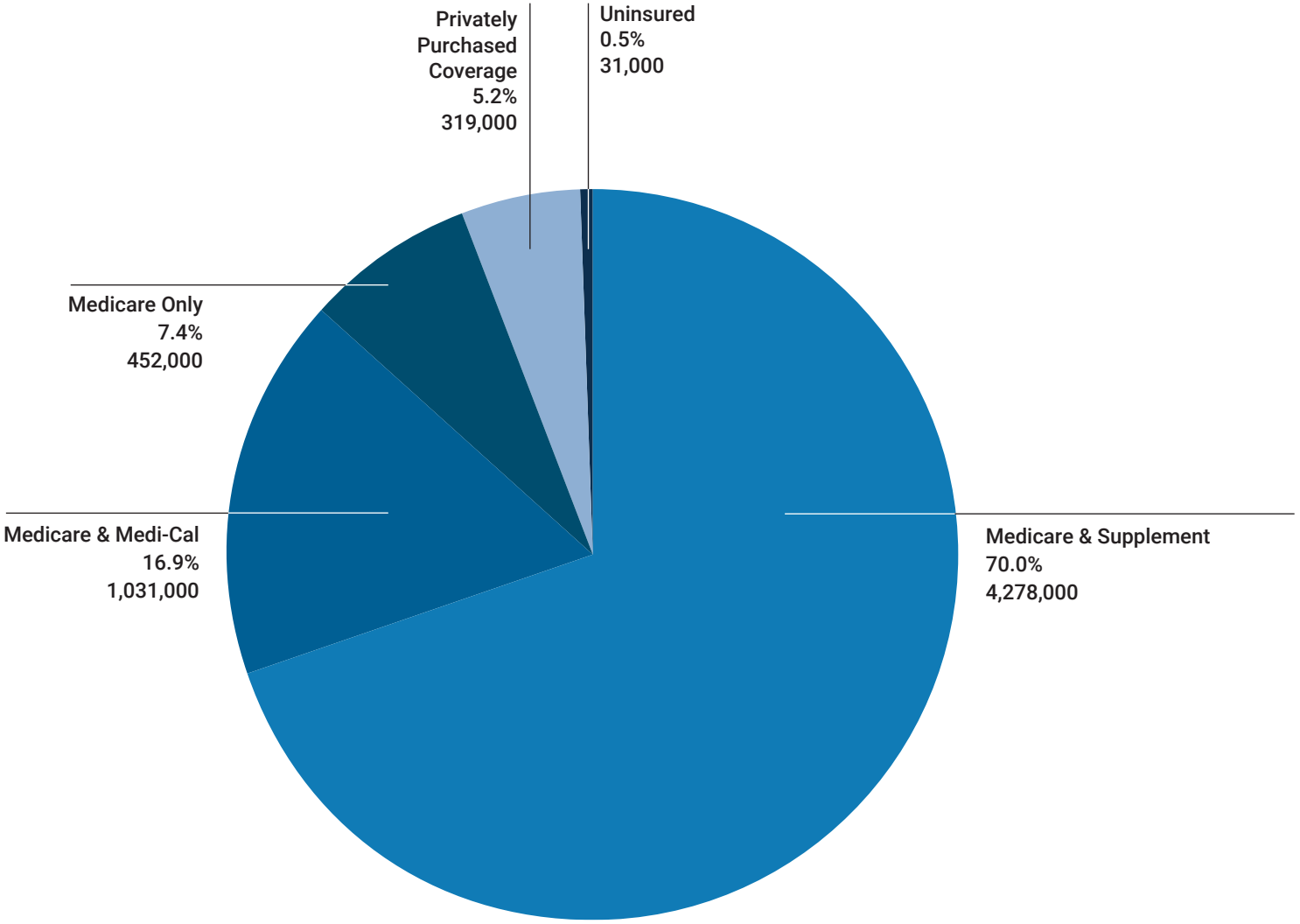
Notes: "Medi-Cal" includes Medi-Cal or CHIP/Healthy Families; "Other public" insurance includes Medicare, military coverage, coverage through Veterans Affairs and other military coverage, and coverage through county programs. Figures may not total 100% because of rounding.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Six in 10 of California's adults under age 65 and children were covered by employer-based insurance (59.5%), while 7.7% (2.5 million) remained uninsured.

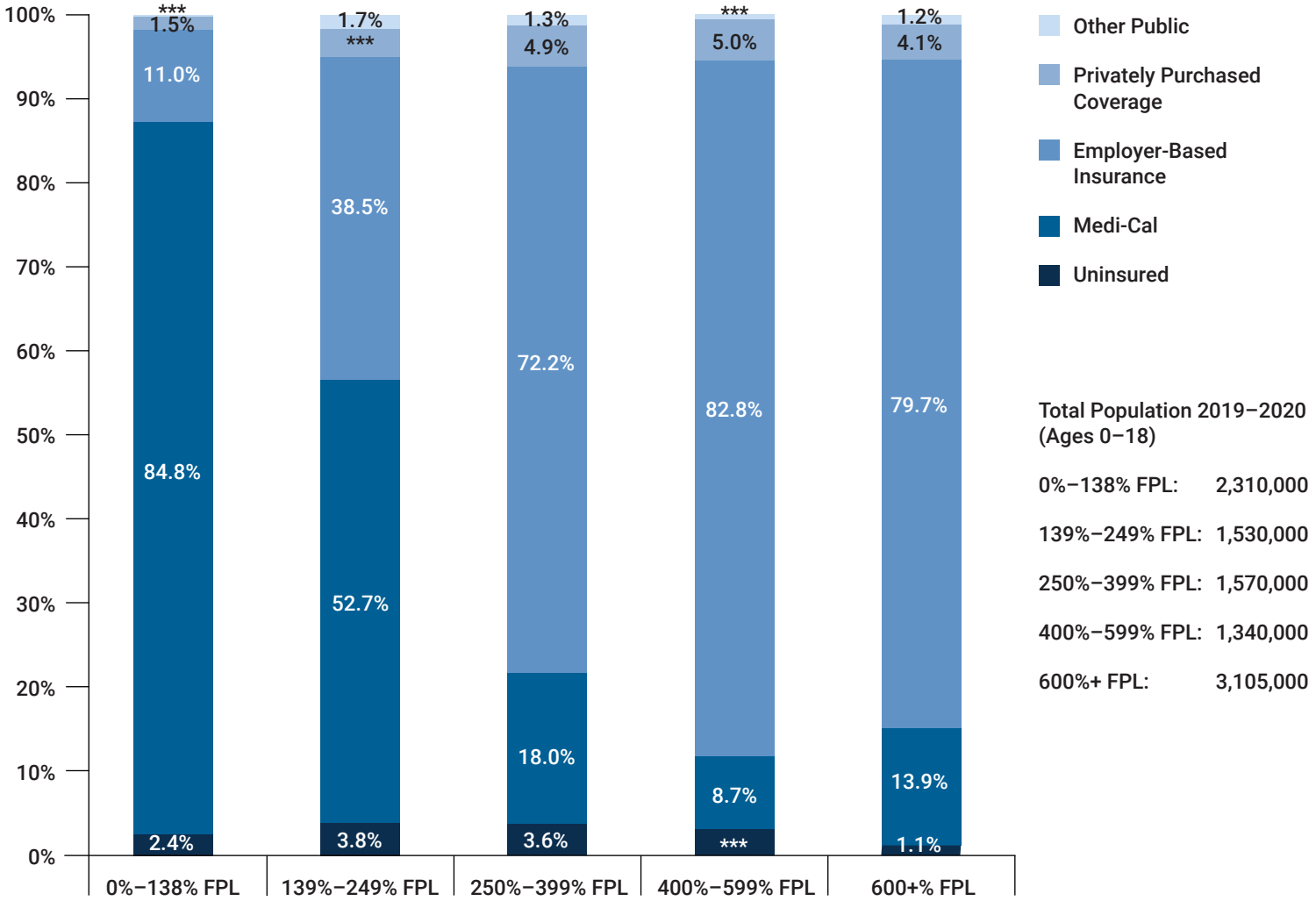
Seven in 10 (70%) Californians ages 65 and older were covered under Medicare and a supplemental plan, as a "wraparound" plan to cover gaps in Medicare; an additional 16.9% had Medi-Cal as their wraparound coverage.

Exhibit 1.2 Health Insurance Coverage for Adults Ages 65 and Older, California, 2019–2020



Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 1.3 **Health Insurance Coverage by Household Income as a Percentage of the Federal Poverty Level (FPL), Ages 0–18, California, 2019–2020**



Total Population 2019–2020 (Ages 0–18)

0%–138% FPL:	2,310,000
139%–249% FPL:	1,530,000
250%–399% FPL:	1,570,000
400%–599% FPL:	1,340,000
600%+ FPL:	3,105,000

***Estimate is unstable because coefficient of variation is above 30%.

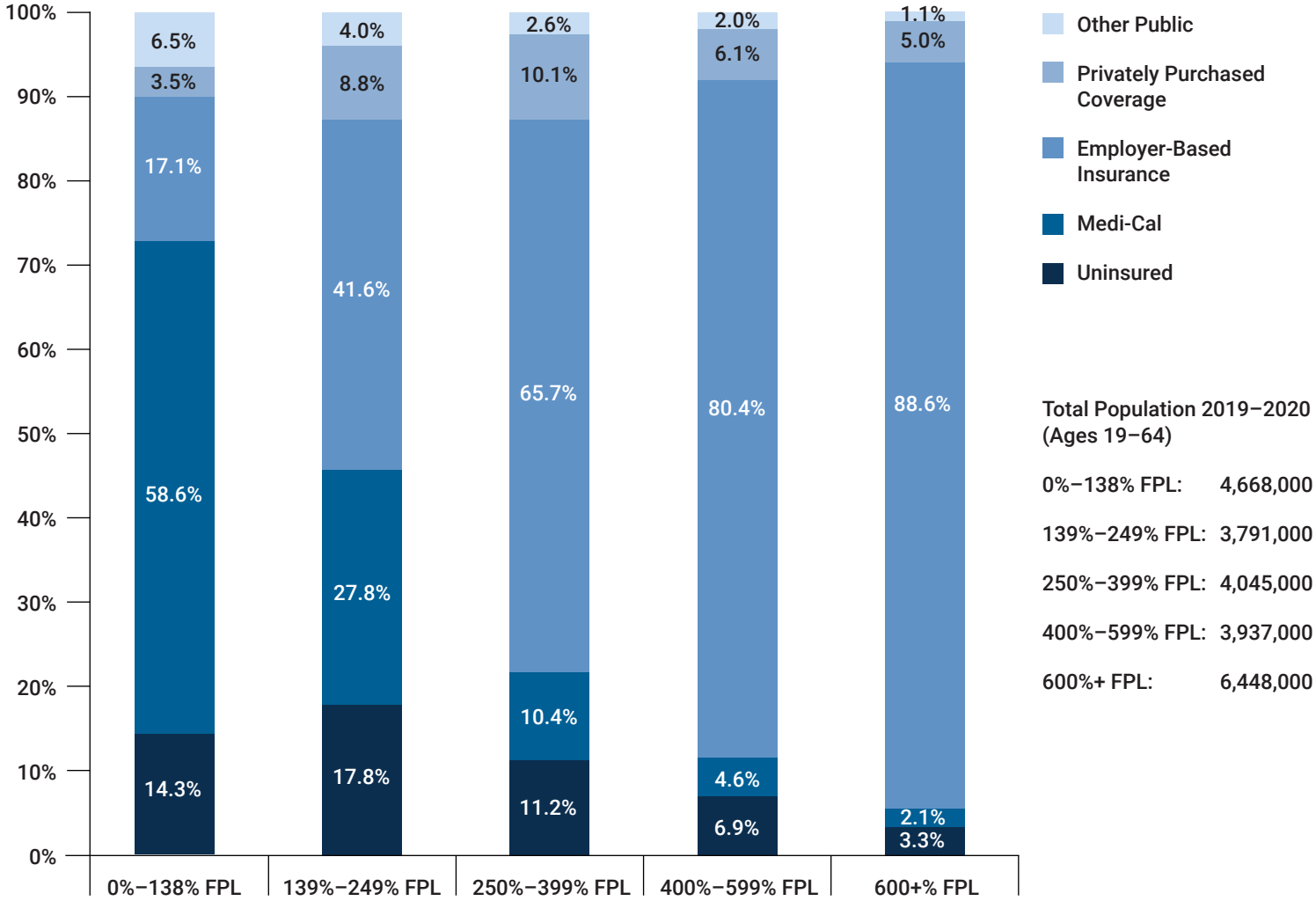
Note: The Federal Poverty Level (FPL), updated annually by the Department of Health and Human Services, is used to calculate eligibility for Medi-Cal and the Children's Health Insurance Program (CHIP), as well as for subsidies to purchase private coverage through Covered California. Households with incomes ≤138% FPL are eligible for no-cost Medi-Cal. In 2020, those in income ranges up to 600% became eligible for progressive subsidies to purchase their own insurance. Households with incomes of 601% FPL and above are not eligible for assistance of any kind.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

There were more health insurance coverage options for low-income children. Medi-Cal covered more than 85% of the lowest-income children and more than half (53%) of children in families with incomes of 139%–249% FPL.

There were fewer health insurance coverage options for low-income adults than for low-income children. Medi-Cal covered fewer than 60% of the lowest-income adults, compared to more than 85% of the lowest-income children (see Exhibit 1.3 for children's data).

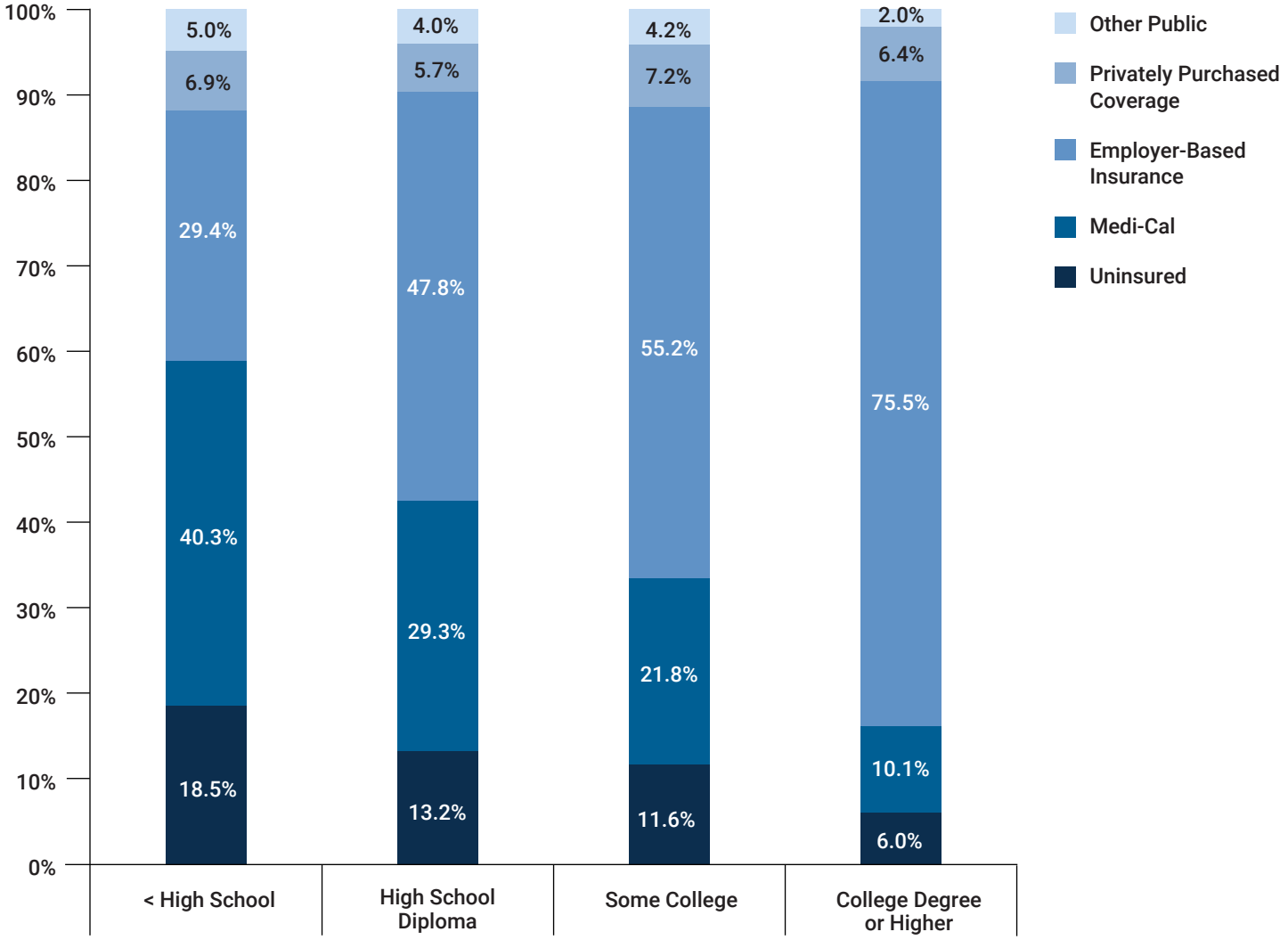
Exhibit 1.4 **Health Insurance Coverage by Household Income as a Percentage of the Federal Poverty Level (FPL), Ages 19–64, California, 2019–2020**



Note: The Federal Poverty Level (FPL), updated annually by the Department of Health and Human Services, is used to calculate eligibility for Medi-Cal and the Children's Health Insurance Program (CHIP), as well as for subsidies to purchase private coverage through Covered California. Households with incomes ≤138% FPL are eligible for no-cost Medi-Cal. In 2020, those in income ranges up to 600% became eligible for progressive subsidies to purchase their own insurance. Households with incomes of 601% FPL and above are not eligible for assistance of any kind.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 1.5 **Health Insurance Coverage by Education, Ages 19–64, California, 2019–2020**

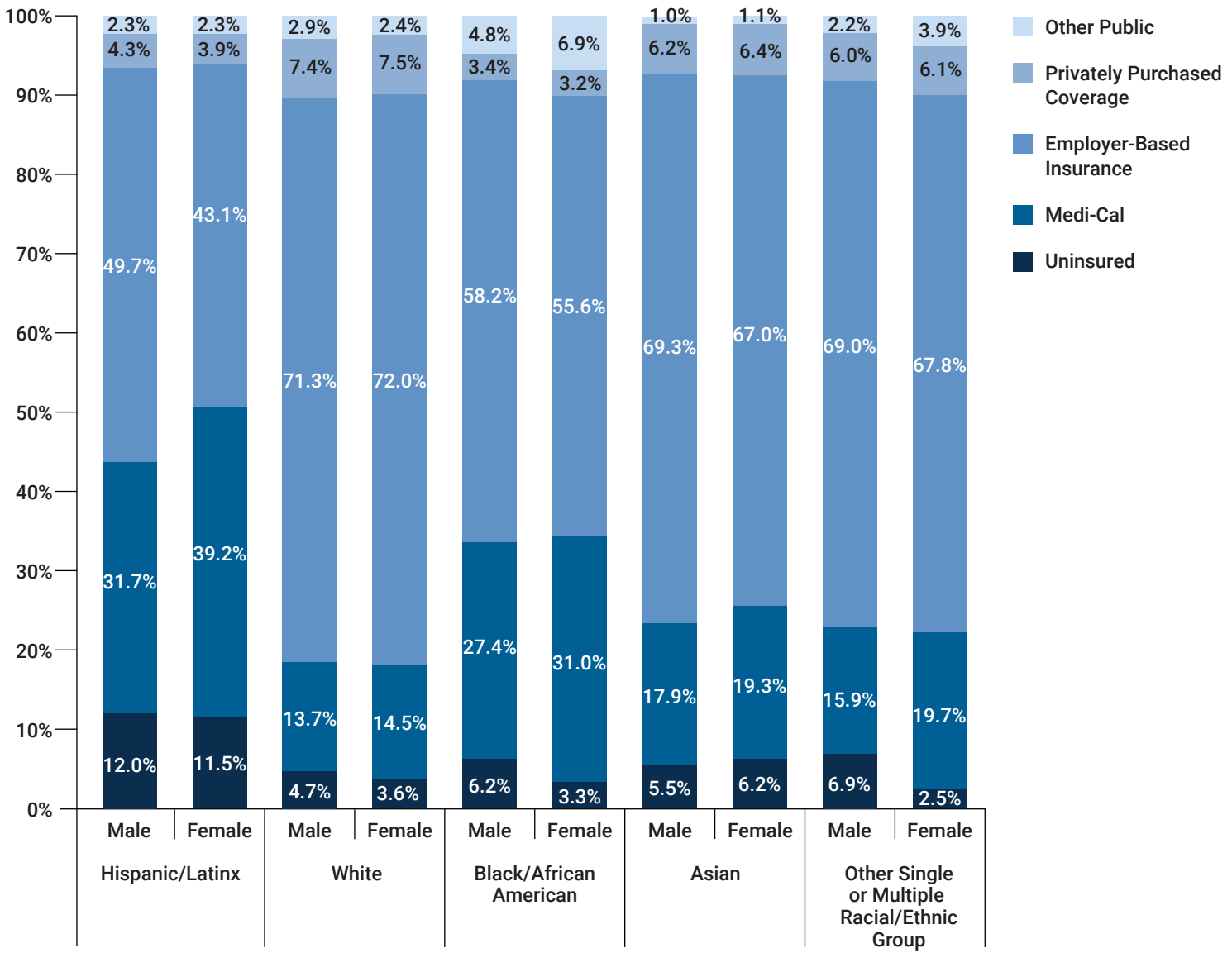


Sources: Pooled 2019 and 2020 California Health Interview Surveys

As education levels increase, the rate of employer-based insurance increases, and the rate of Medi-Cal coverage decreases. Individuals with higher levels of education were more likely to have jobs that offered employer-based health benefits. Of note is the lack of variation in privately purchased insurance coverage across education levels; Covered California is reaching populations regardless of education level.

Among women, those who are Black or African American and Hispanic/Latinx had the lowest rates of employer-based insurance across all groups.

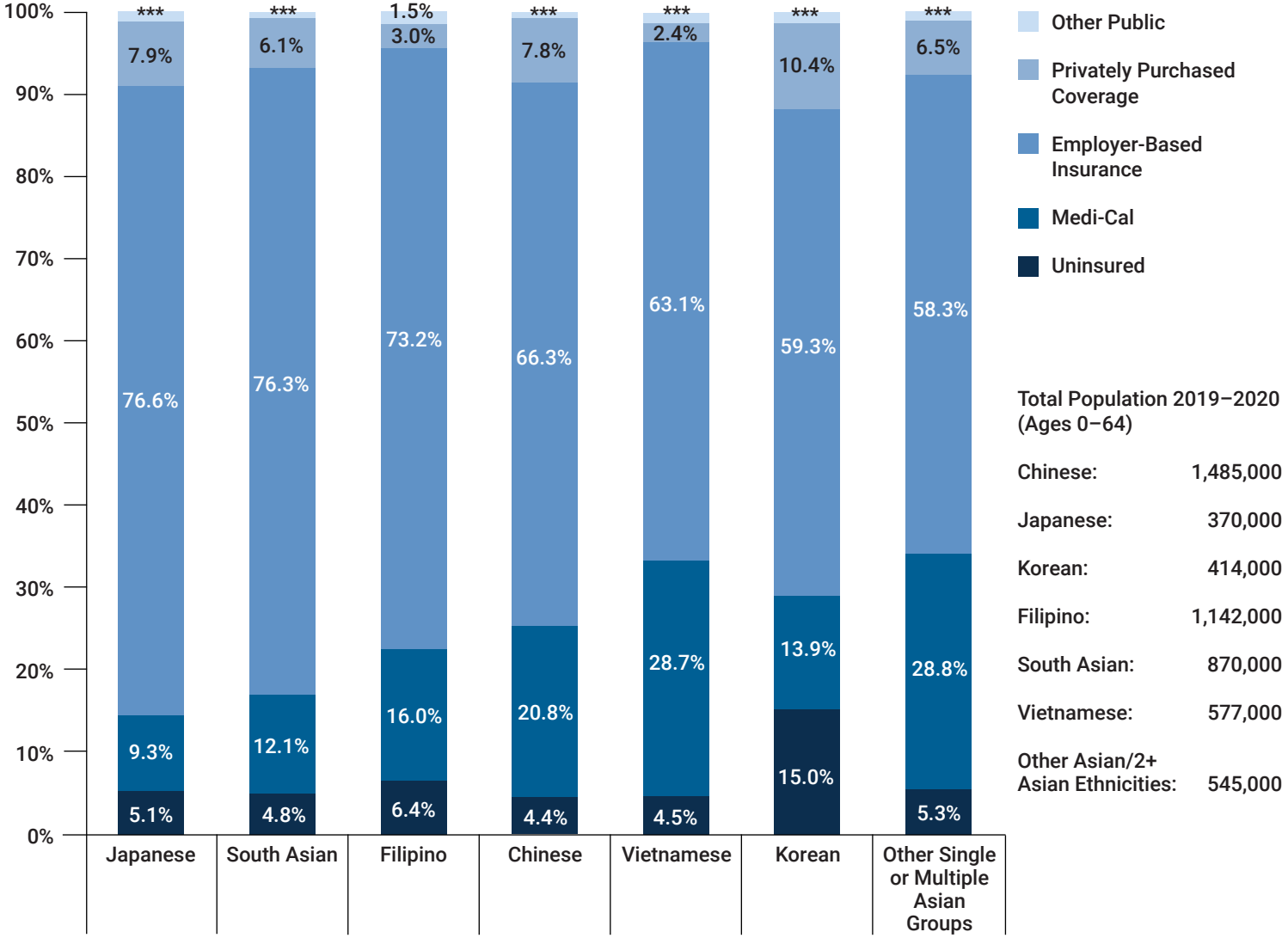
Exhibit 1.6 Health Insurance Coverage by Racial/Ethnic Group and Gender, Ages 0–64, California, 2019–2020



Note: Nonbinary and other genders had sample populations too small to present.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 1.7 Health Insurance Coverage by Asian Ethnicity, Ages 0–64, California, 2019–2020



Total Population 2019–2020 (Ages 0–64)	
Chinese:	1,485,000
Japanese:	370,000
Korean:	414,000
Filipino:	1,142,000
South Asian:	870,000
Vietnamese:	577,000
Other Asian/2+ Asian Ethnicities:	545,000

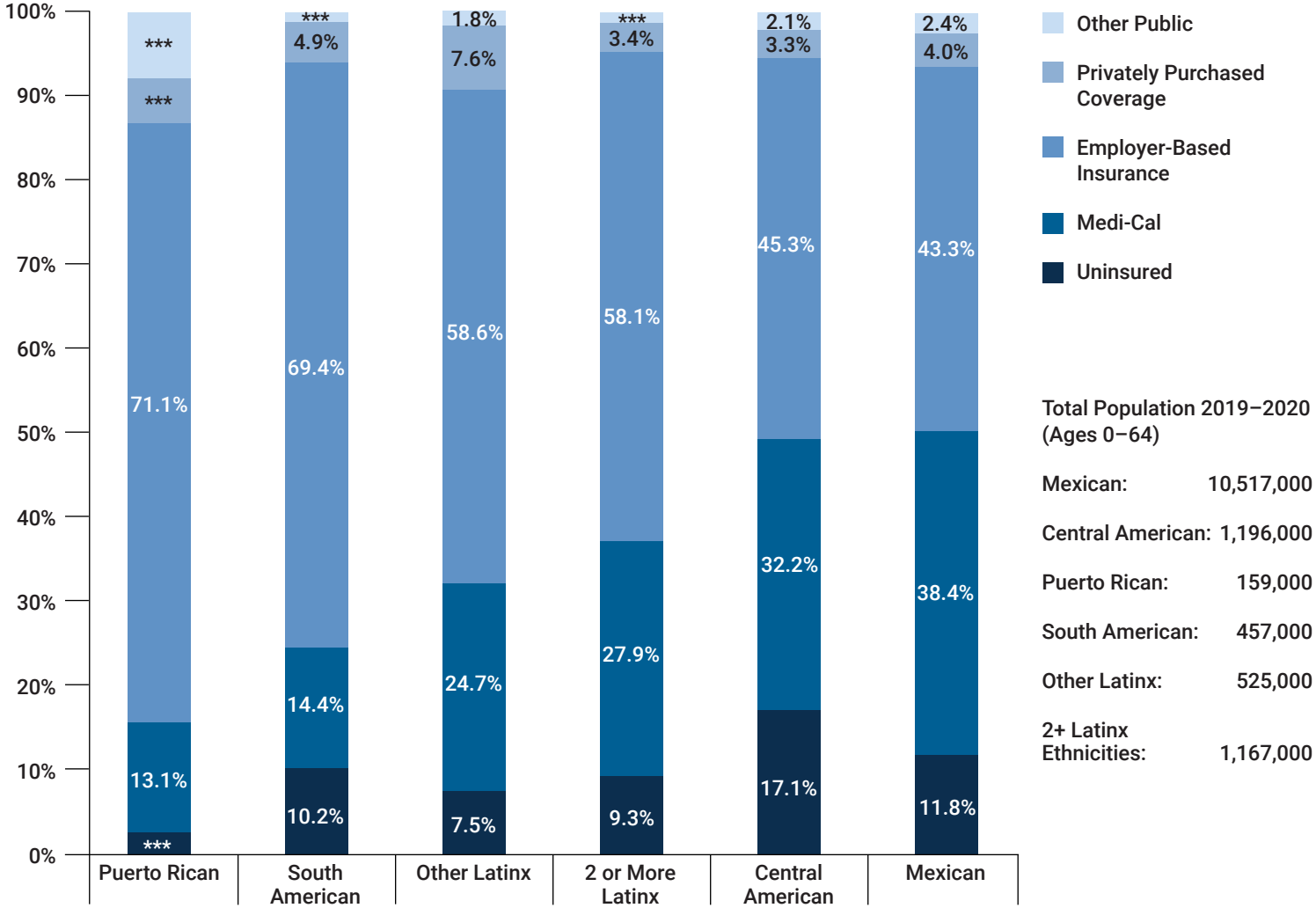
***Estimate is unstable because coefficient of variation is above 30%.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Variation was found in health insurance coverage across Asian ethnic groups. Medi-Cal filled in the gaps where employer-based insurance was lacking for all groups except people of Korean ethnicity, who had the highest rates of uninsurance (15%).

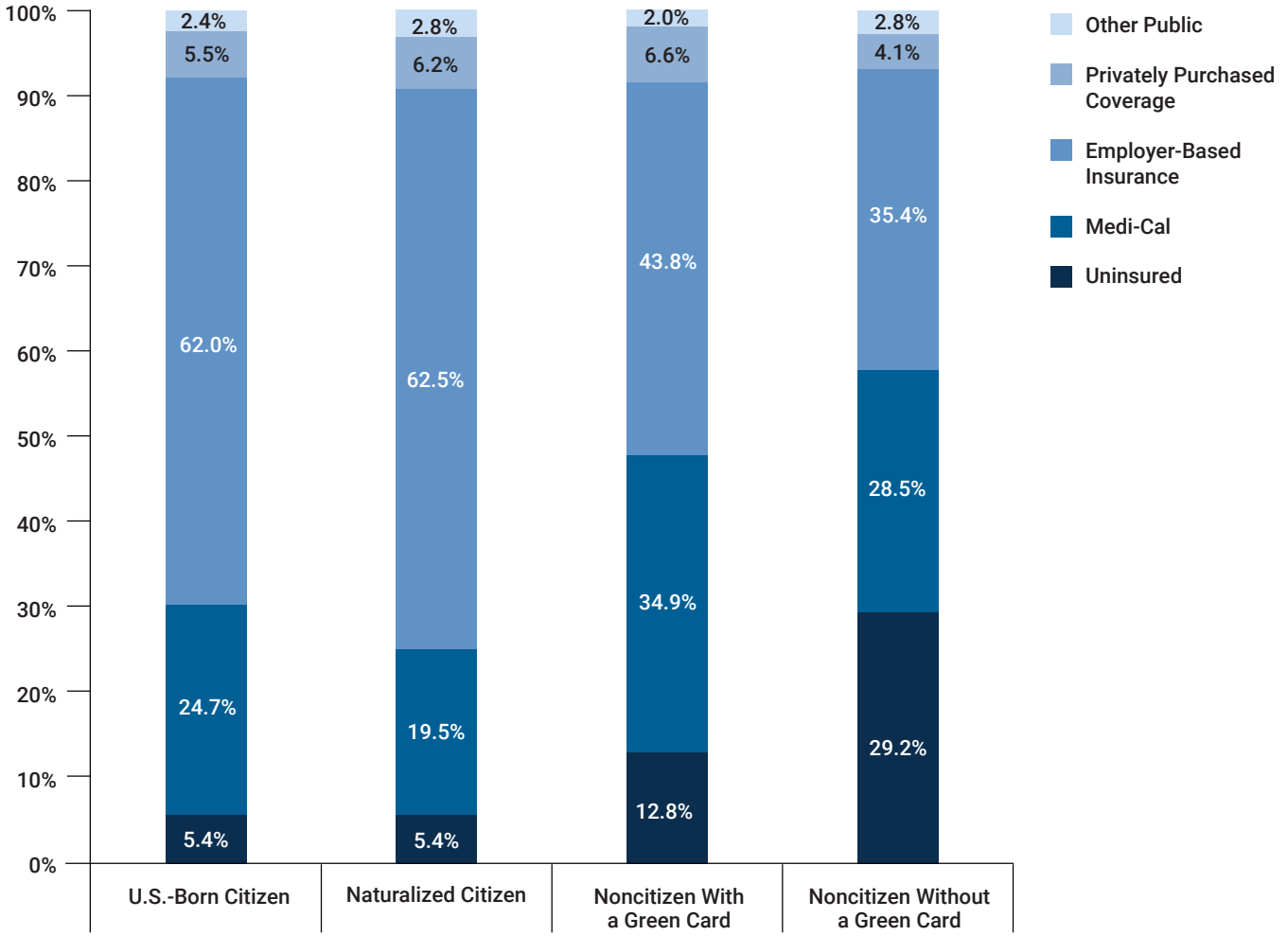
There was variation in health insurance coverage across Hispanic/Latinx ethnic groups. Compared to other Latinx ethnic groups, Mexicans and Central Americans were more likely to be enrolled in Medi-Cal and less likely to have employer-based insurance. Central Americans had the highest rate of uninsurance (17.1%).

Exhibit 1.8 Health Insurance Coverage by Hispanic/Latinx Ethnicity, Ages 0–64, California, 2019–2020



Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 1.9 Health Insurance Coverage by Citizenship Status, Ages 0–64, California, 2019–2020



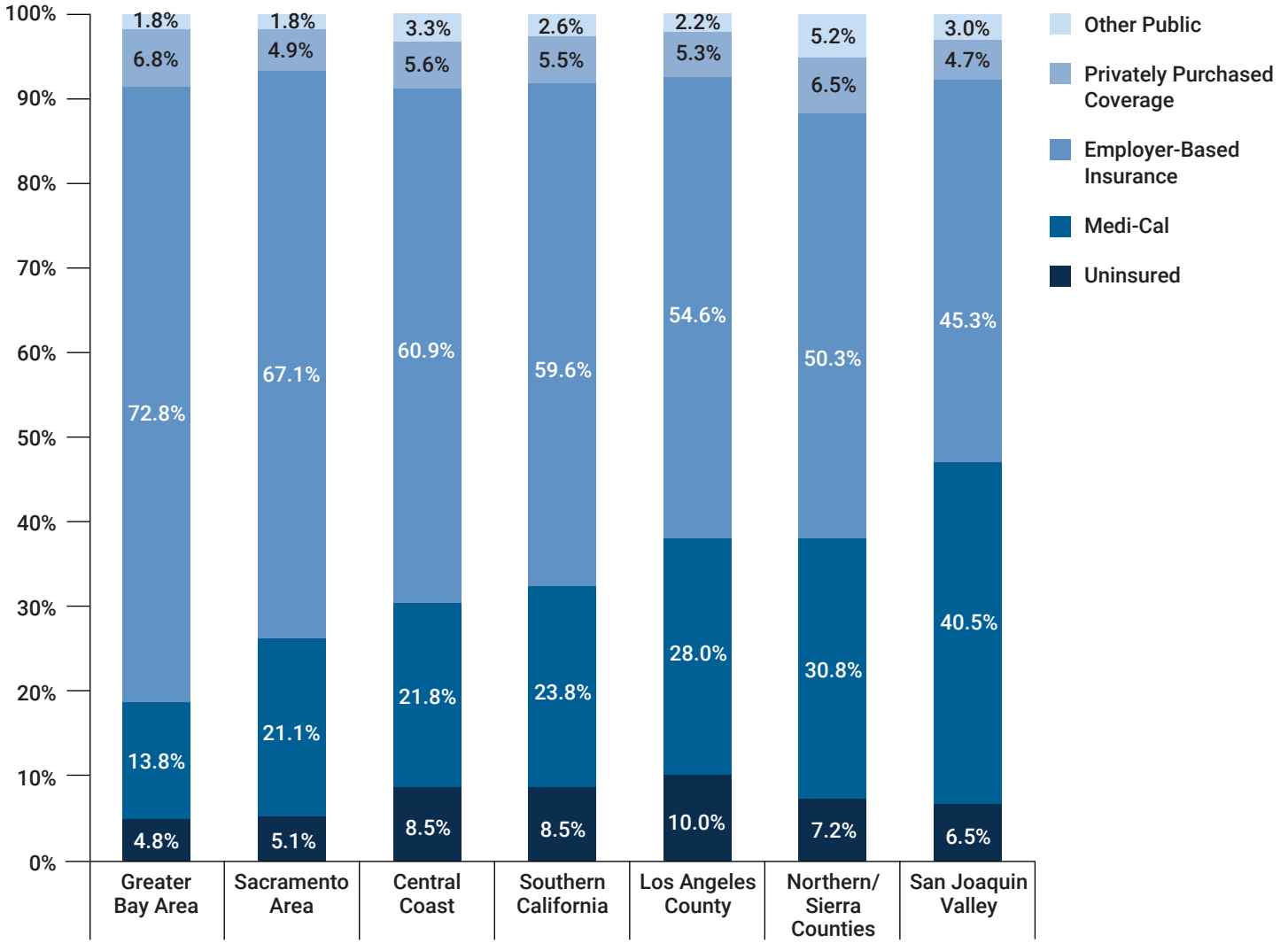
Note: The differences among citizenship groups in Medi-Cal should not be interpreted as being statistically significantly different.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Noncitizens, with or without a green card, had significantly lower rates of employer-based insurance compared to U.S.-born or naturalized citizens.

There was regional variation in health insurance coverage. San Joaquin Valley, Northern/ Sierra counties, and Los Angeles County had the highest rates of Medi-Cal coverage. Los Angeles had the highest rate of people who were uninsured (10%).

Exhibit 1.10 Health Insurance Coverage by Region, Ages 0–64, California, 2019–2020



Sources: Pooled 2019 and 2020 California Health Interview Surveys

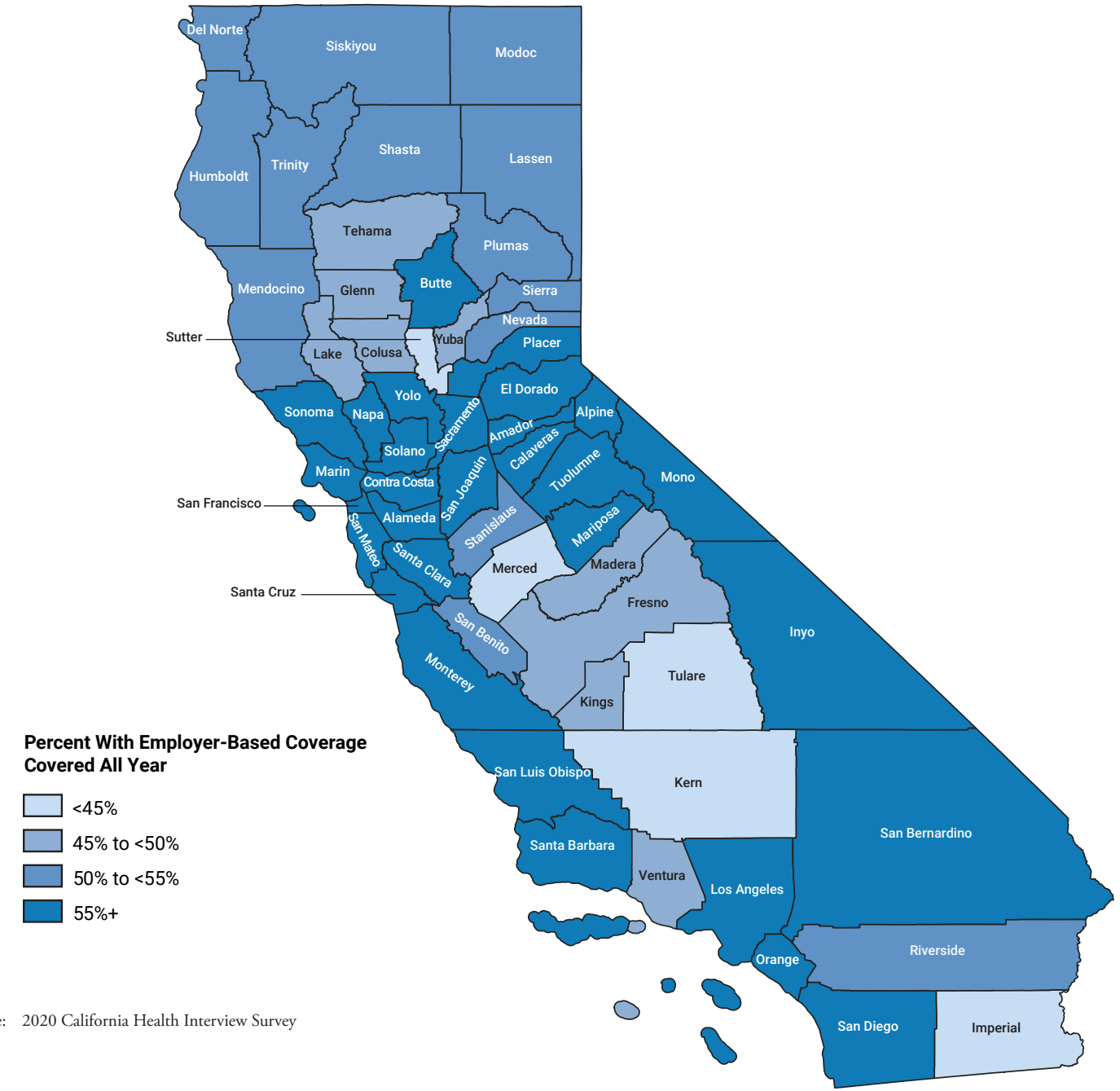
Chapter 2

Private Health Insurance Markets in California

Private health insurance in California is comprised of two broad markets: 1) employer-based insurance from a person's own or a family member's job or union, and 2) privately purchased coverage that is bought either directly from the insurance company or through the Covered California marketplace, for either an individual or a family. Within the category of employer-based insurance, employees can have either "large group" or "small group" insurance, based on the firm size of the employer (the cutoff is most often 50 employees, but it can sometimes be 100 employees for coverage through the Covered California marketplace). For privately purchased health insurance, the Patient Protection and Affordable Care Act of 2010 (ACA) mandated that the plans have to be comparable both in and out of Covered California. However, if a person or family enrolls through Covered California, they are able to access subsidies based on their household income. In January 2020, California expanded the eligibility for those public subsidies to purchase private insurance to up to 600% of the Federal Poverty Level (FPL), to account for high living expenses for state residents. Private insurance covers the majority of Californians prior to enrollment in publicly funded Medicare at age 65. Even after that, the majority obtain a private supplemental Medicare plan in addition to their public coverage. In sum, the private insurance market continues to thrive in California and to provide the foundation of health insurance for a majority of residents.

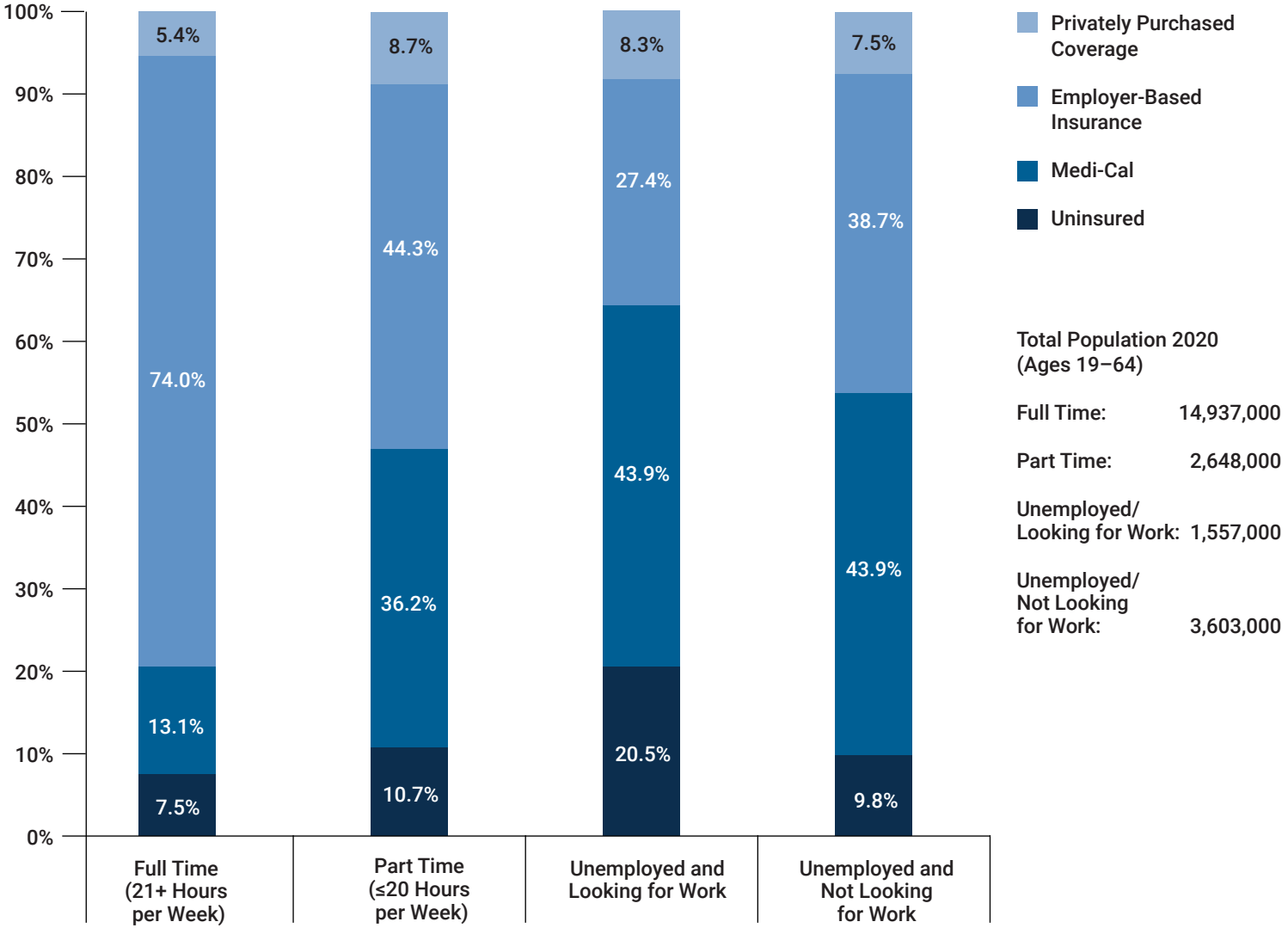
Agricultural centers in California (the Central Valley, Northern California, and Imperial County) had the lowest rates of employer-based insurance among all residents under age 65.

Exhibit 2.1 Employer-Based Insurance by County, Ages 0–64, California, 2020



Source: 2020 California Health Interview Survey

Exhibit 2.2 **Health Insurance Coverage by Work Status, Ages 19–64, California, 2020**



Total Population 2020 (Ages 19–64)

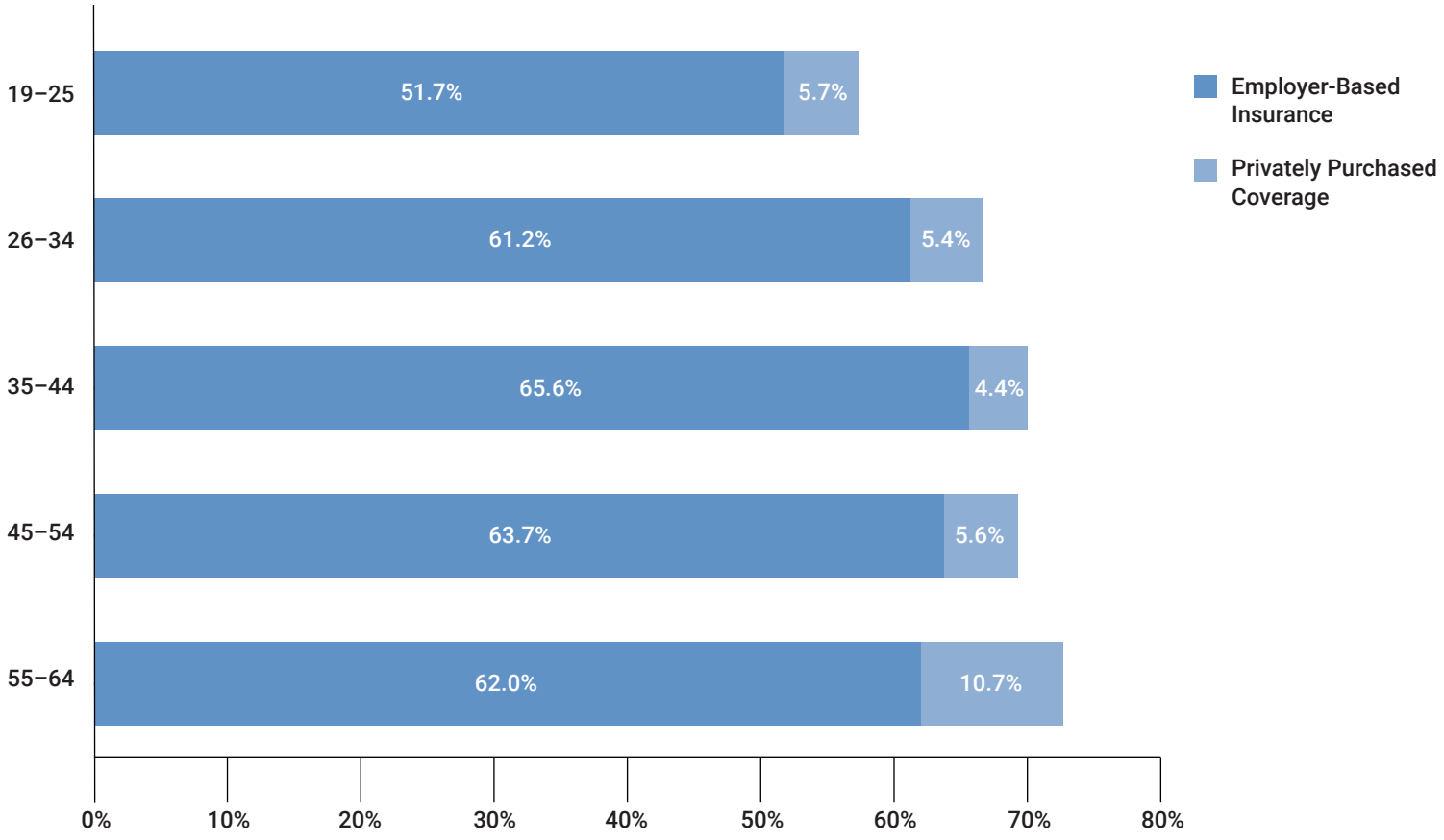
Full Time:	**14,937,000**
Part Time:	**2,648,000**
Unemployed/ Looking for Work:	**1,557,000**
Unemployed/ Not Looking for Work:	**3,603,000**

Source: 2020 California Health Interview Survey

In 2020, nearly three-fourths of full-time employed adults had employer-based insurance (74%); only 7.5% were uninsured, compared to the one out of five adults (20.5%) who were unemployed and looking for work and were uninsured.

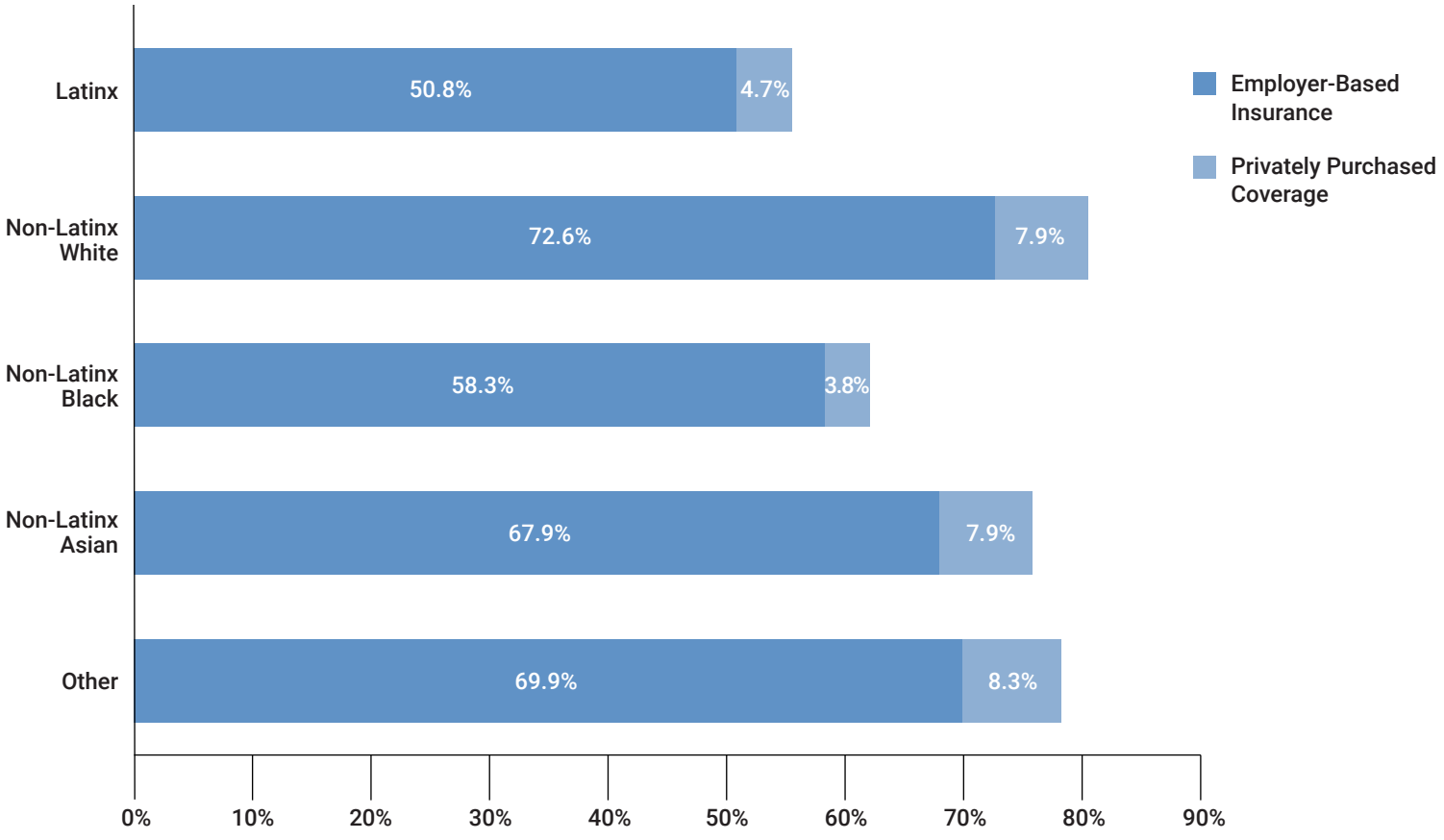
Young adults ages 19–25 still had the lowest rates of employer-based insurance (51.7%, compared to 61%–66% for other age groups), even after the Affordable Care Act of 2010 allowed them to continue on their parents' coverage as dependents.

Exhibit 2.3 Rates of Employer-Based Insurance and Privately Purchased Coverage by Age Group, Adults Ages 19–64, California, 2020



Source: 2020 California Health Interview Survey

Exhibit 2.4 **Rates of Employer-Based Insurance and Privately Purchased Coverage by Racial and Ethnic Group, Adults Ages 19–64, California, 2020**

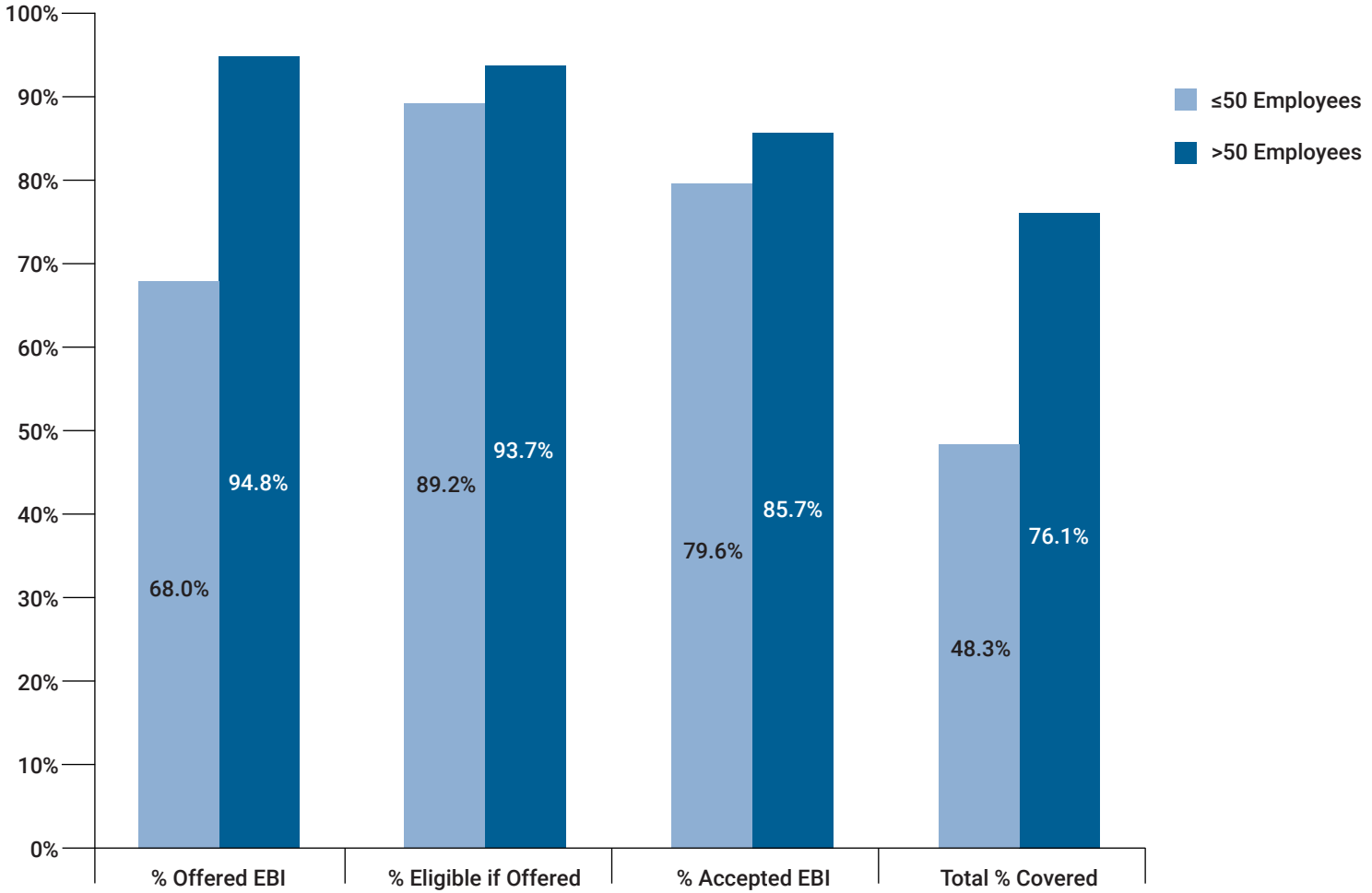


Source: 2020 California Health Interview Survey

In 2020, Latinx adults continued to have the lowest rate of employer-based insurance (50.8%) compared to other racial/ethnic groups.

Only two-thirds of employees at small firms (68%) reported that their employers were able to offer health insurance to any employees, compared to nearly 95% at larger firms (more than 50 employees), resulting in fewer than half of employees at small firms (48.3%) obtaining coverage through their employers.

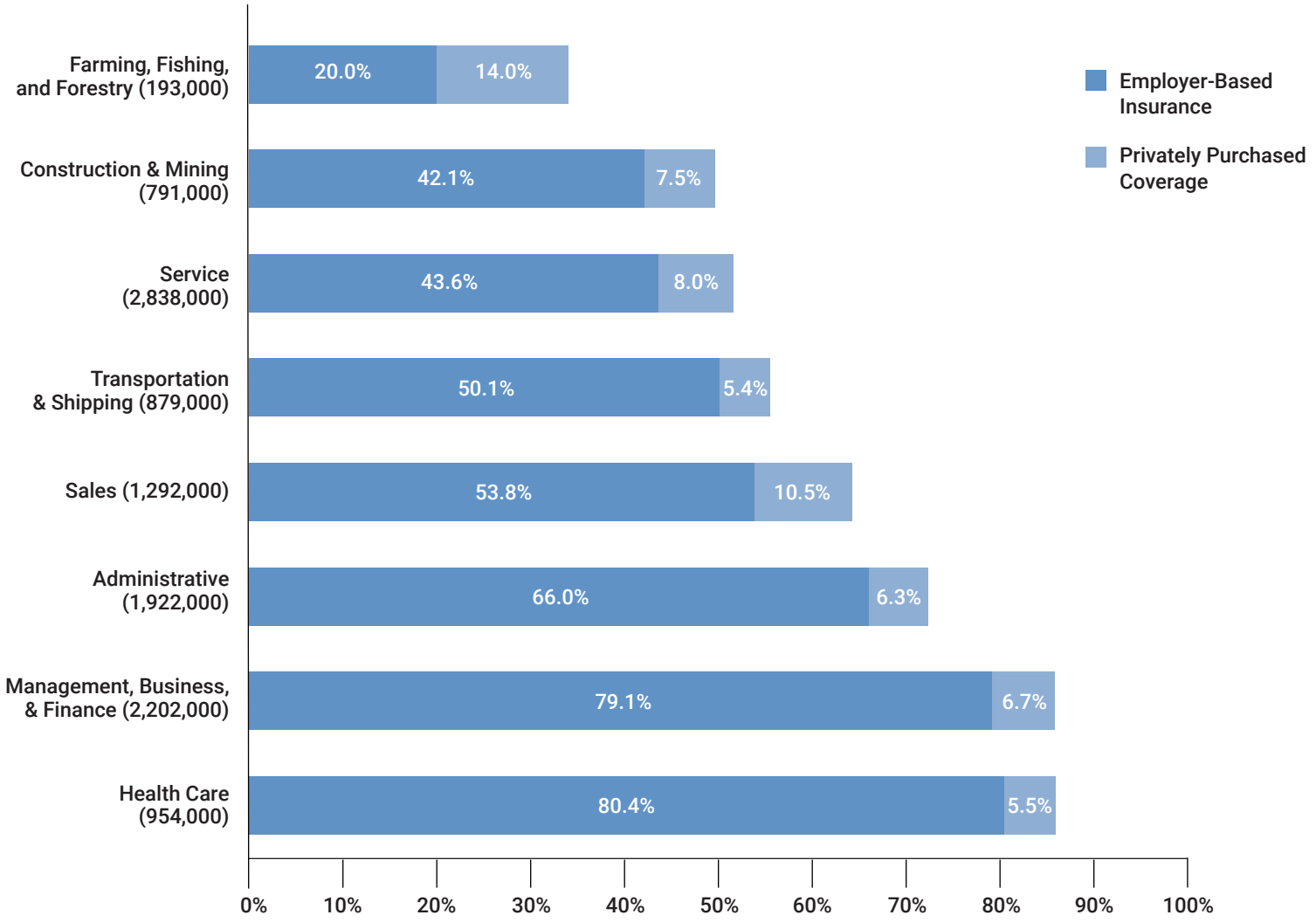
Exhibit 2.5 **Offer, Eligibility, and Take-Up Rates of Employer-Based Insurance by Firm Size, Employed Adults Ages 19–64, California, 2020**



Note: "% Offered EBI" is the percentage of employees who worked for a firm that offered health insurance to any of its employees. "% Eligible if Offered" is the percentage of employees who were eligible for that health insurance if the company offered it to any employee. For example, some companies offer health insurance to management only, or to those in salaried positions but not to hourly workers. "% Accepted EBI" is the percentage of employees who were eligible for the offered health insurance who chose to take up the coverage. Employees may decide to decline coverage if they are covered through a family member's insurance or if they receive a direct payment instead of coverage. "Total % Covered" is the resulting percentage of all employees who were covered through their own employer's health insurance.

Source: 2020 California Health Interview Survey

Exhibit 2.6 **Private Health Insurance Coverage by Main Industry of Employment, Employed Adults Ages 19–64, California, 2019**



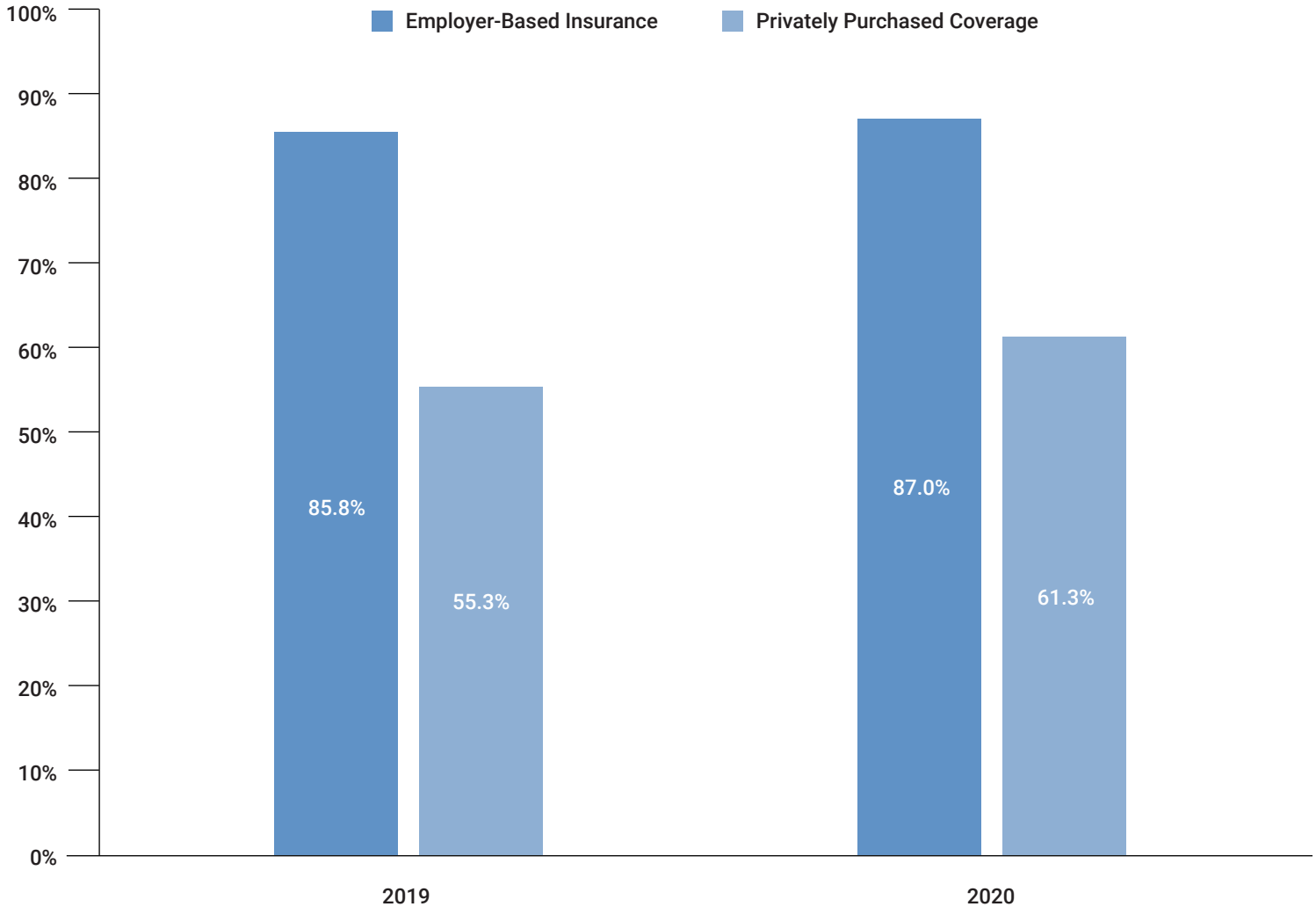
Note: Not all industries are included in this chart; only the largest and most illustrative of comparative industries are presented. CHIS 2020 data for industry are not yet available.

Source: 2019 California Health Interview Survey

Employees in the farming, construction, and service industries had the lowest rates of employer-based insurance, ranging from 20% to 43.6%.

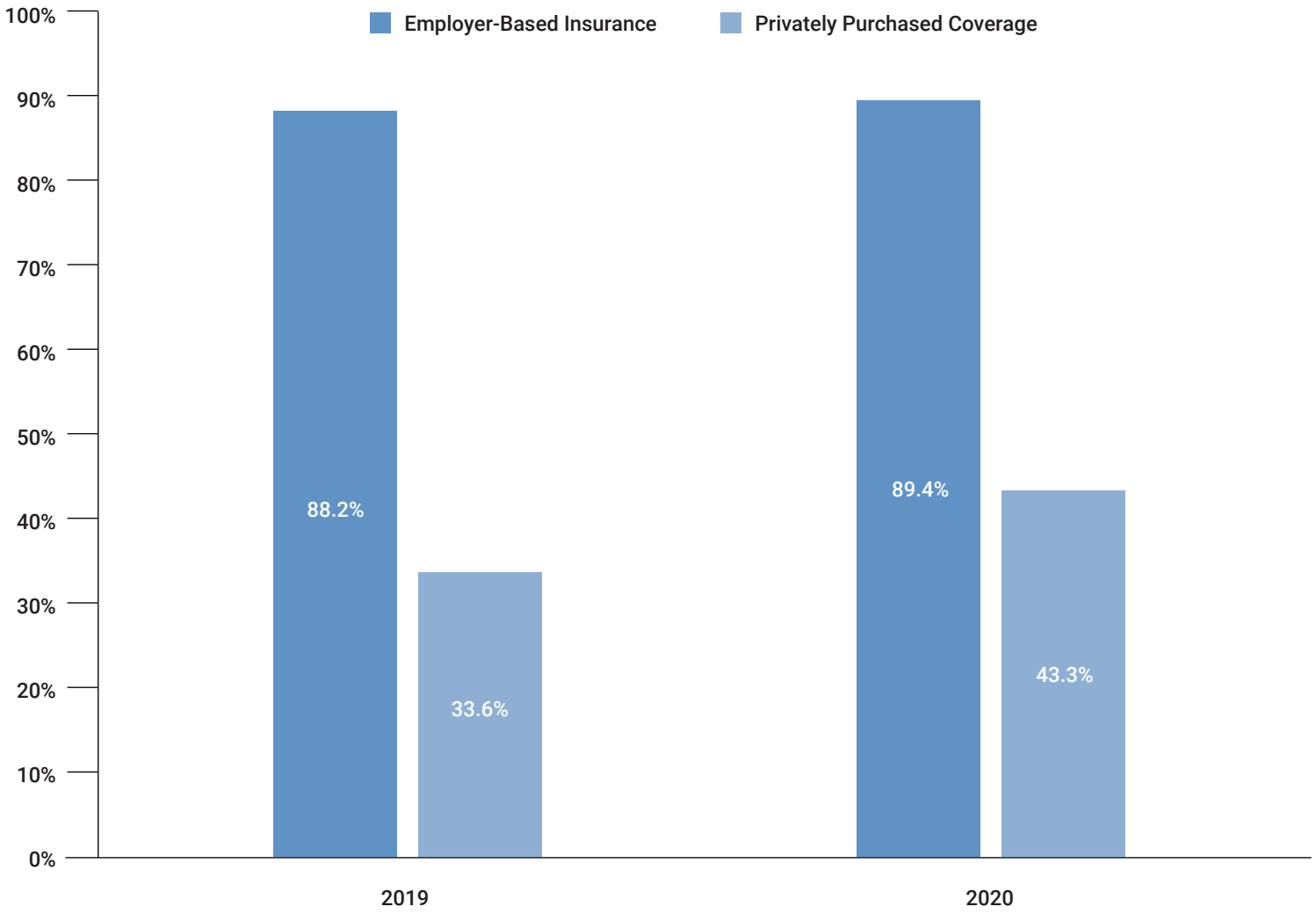
Despite the inclusion of mental health as part of required essential health benefits, more than half of adults under age 65 with privately purchased coverage reported not having mental health insurance in 2019 and 2020 (55.3% and 61.3%), compared to nearly nine in 10 adults with employer-based insurance.

Exhibit 2.7 **Rates of Mental Health Insurance Coverage Among Enrollees in Employer-Based Insurance and Privately Purchased Insurance, Adults Ages 19–64, California, 2019 and 2020**



Sources: 2019 and 2020 California Health Interview Surveys

Exhibit 2.8 **Rates of Dental Health Insurance Coverage Among Enrollees in Employer-Based Insurance and Privately Purchased Insurance, Adults Ages 19–64, California, 2019 and 2020**

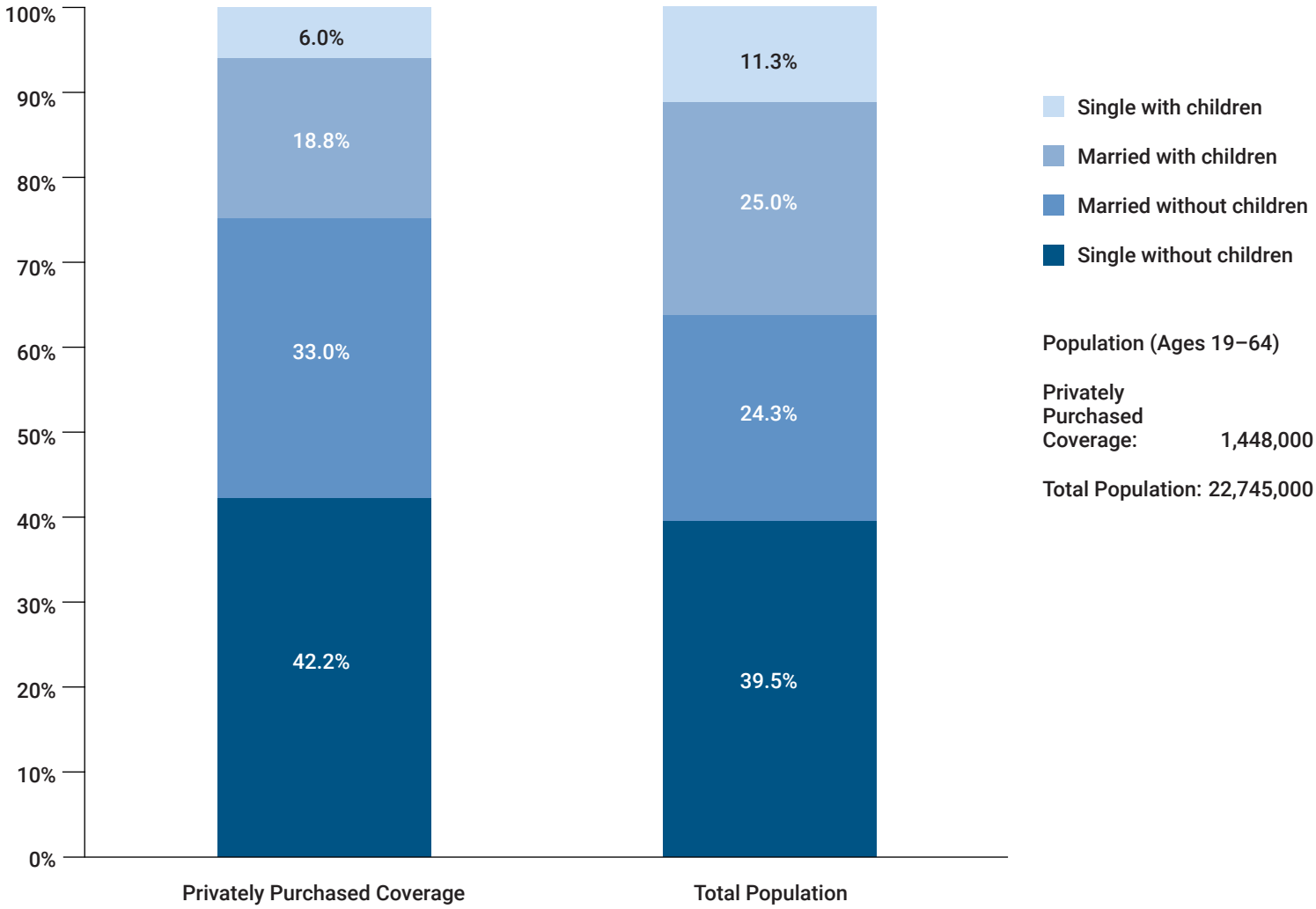


Sources: 2019 and 2020 California Health Interview Surveys

About four in 10 adults under age 65 with privately purchased coverage in 2020 reported also having dental coverage (43.3%), which was less than half the rate among enrollees with employer-based insurance.

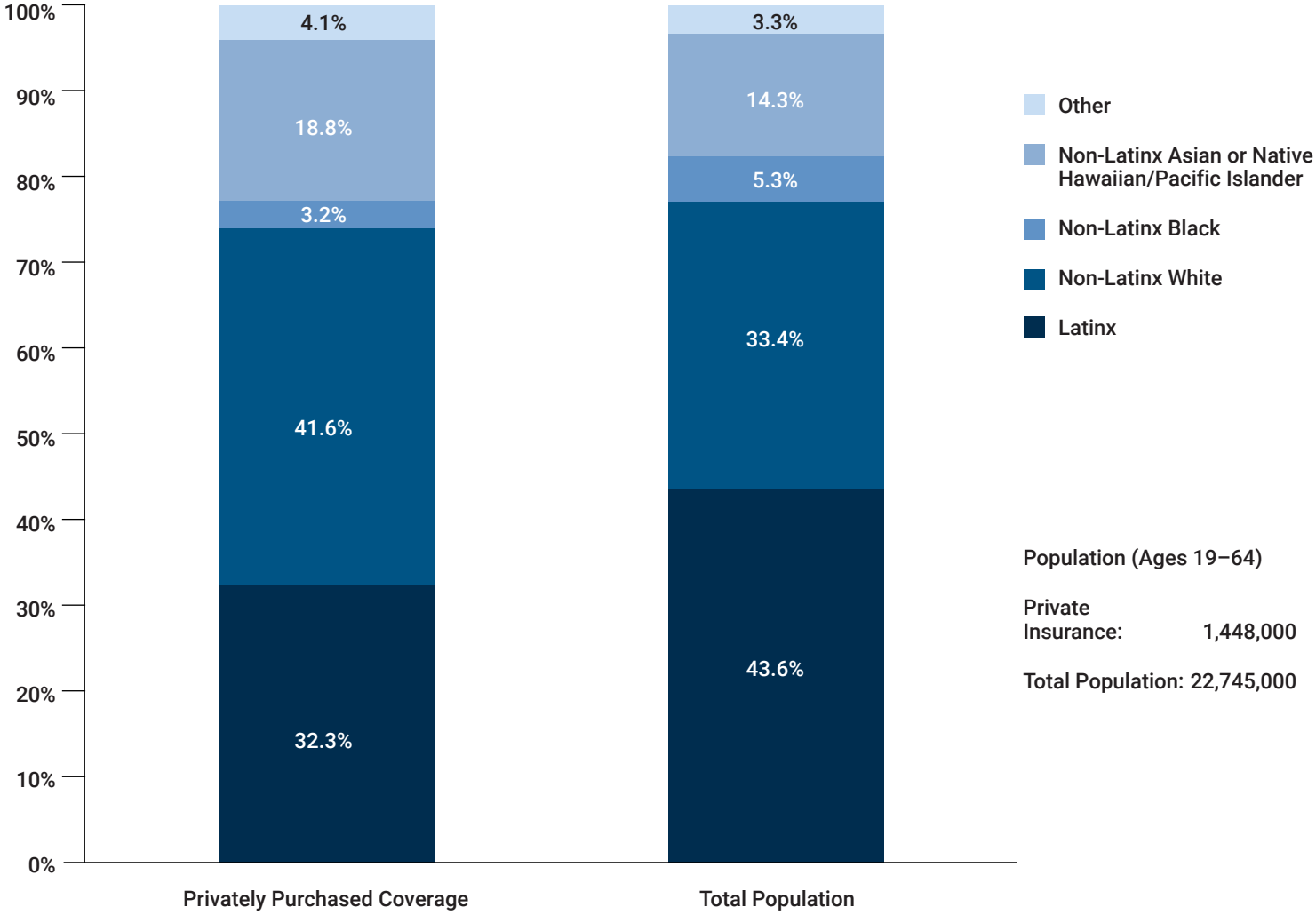
Compared to the general adult population, adults under age 65 who purchased their own health insurance directly were less likely to need insurance for dependents, and a greater proportion had no children (75.2% vs. 63.8%).

Exhibit 2.9 **Distribution of Family Type Among Privately Purchased Coverage Enrollees Compared to Total Population, Ages 19-64, California, 2020**



Sources: 2020 California Health Interview Survey

Exhibit 2.10 **Distribution of Racial/Ethnic Groups Among Privately Purchased Coverage Enrollees Compared to Total Population, Ages 19-64, California, 2020**

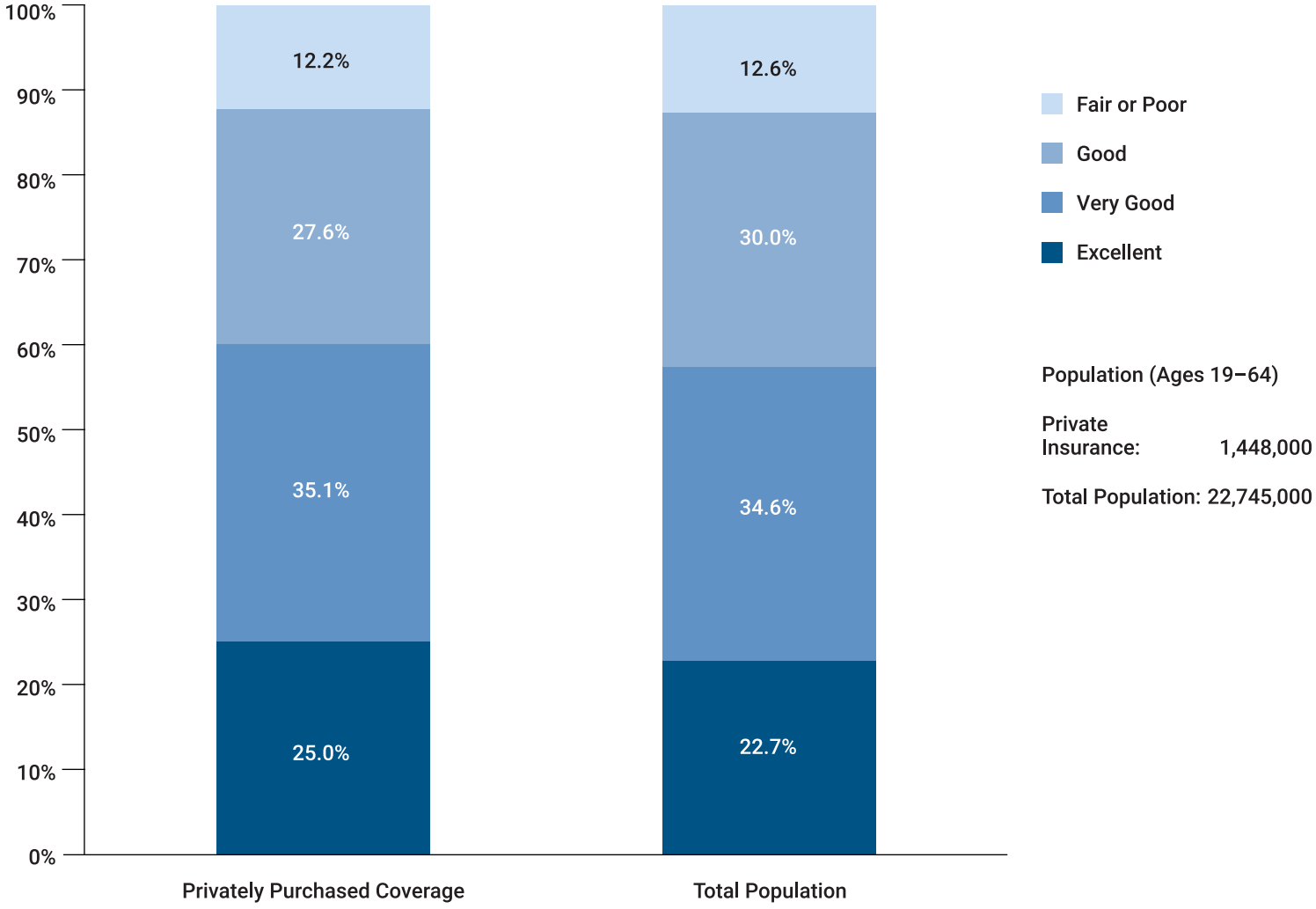


Sources: 2020 California Health Interview Survey

Latinx and non-Latinx Blacks made up smaller proportions of all adults under age 65 who purchased their own health insurance directly compared to the general adult population, showing the potential for more outreach to these groups to promote health equity.

There were no statistically significant differences in health status between adults under age 65 who purchased their own health insurance and the general adult population, showing that the privately purchased market is not experiencing adverse selection in California.

Exhibit 2.11 Distribution of Self-Reported Health Status Among Privately Purchased Coverage Enrollees Compared to Total Population, Ages 19–64, California, 2020



Source: 2020 California Health Interview Survey

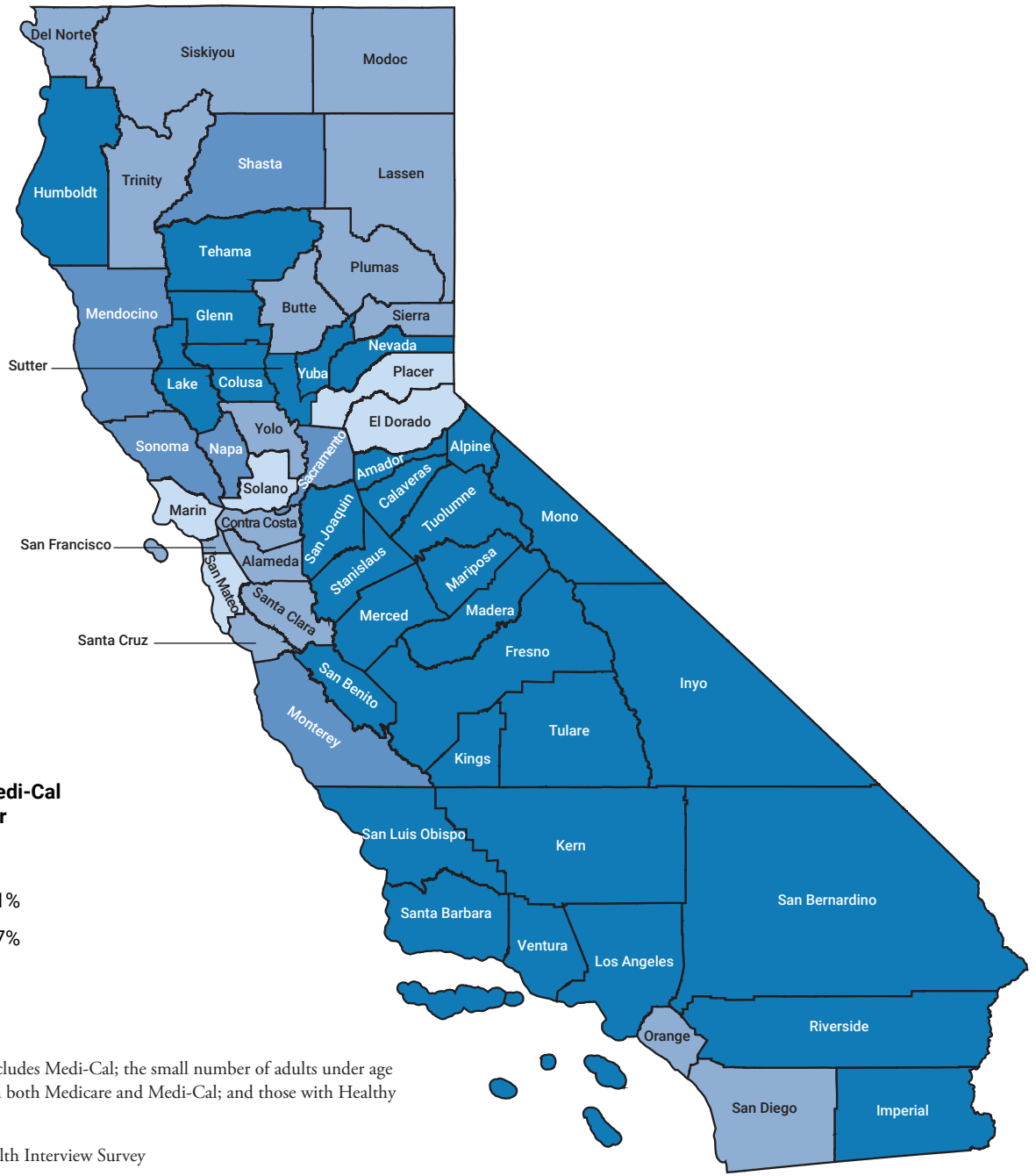
Chapter 3

Medi-Cal Coverage for Children and for Adults Under Age 65 in California

California's public health insurance coverage market is comprised of multiple programs aimed at filling in gaps where private coverage does not reach, but two major programs primarily cover significant portions of the overall population: Medicaid (called Medi-Cal in California) and Medicare. Medi-Cal is a state-federal partnership health insurance program that began as a means to cover low-income parents and children, and that was expanded in 2014 to include low-income childless adults as well. Medicare, in contrast, is a federal universal health insurance program for people ages 65 and older that most workers pay into; there have been some expansions since its inception to include people with permanent disabilities. It is possible to enroll in both programs at the same time, if a person is eligible for both under the different parameters of household income and age. Additionally, the California Healthy Families (CHIP) program, California's version of the federal State Children's Health Insurance Program, still exists as an additional program to cover children of working parents who are not quite eligible for Medi-Cal. This chapter explores the populations who report having public coverage, with a focus on the Medi-Cal population. Because we use self-reported California Health Interview Survey (CHIS) data, the population totals may not match California's administrative data (see Foreword for a full discussion of this issue). While Medi-Cal has proven to be a powerful vehicle for expanding coverage among adults under age 65 since its expansion under the Patient Protection and Affordable Care Act of 2010 (ACA), there remains a segment of Californians who could be eligible for enrollment due to their low household incomes who nonetheless remain uninsured.

In the majority of counties in California, more than one-quarter of the population under age 65 had public health insurance coverage.

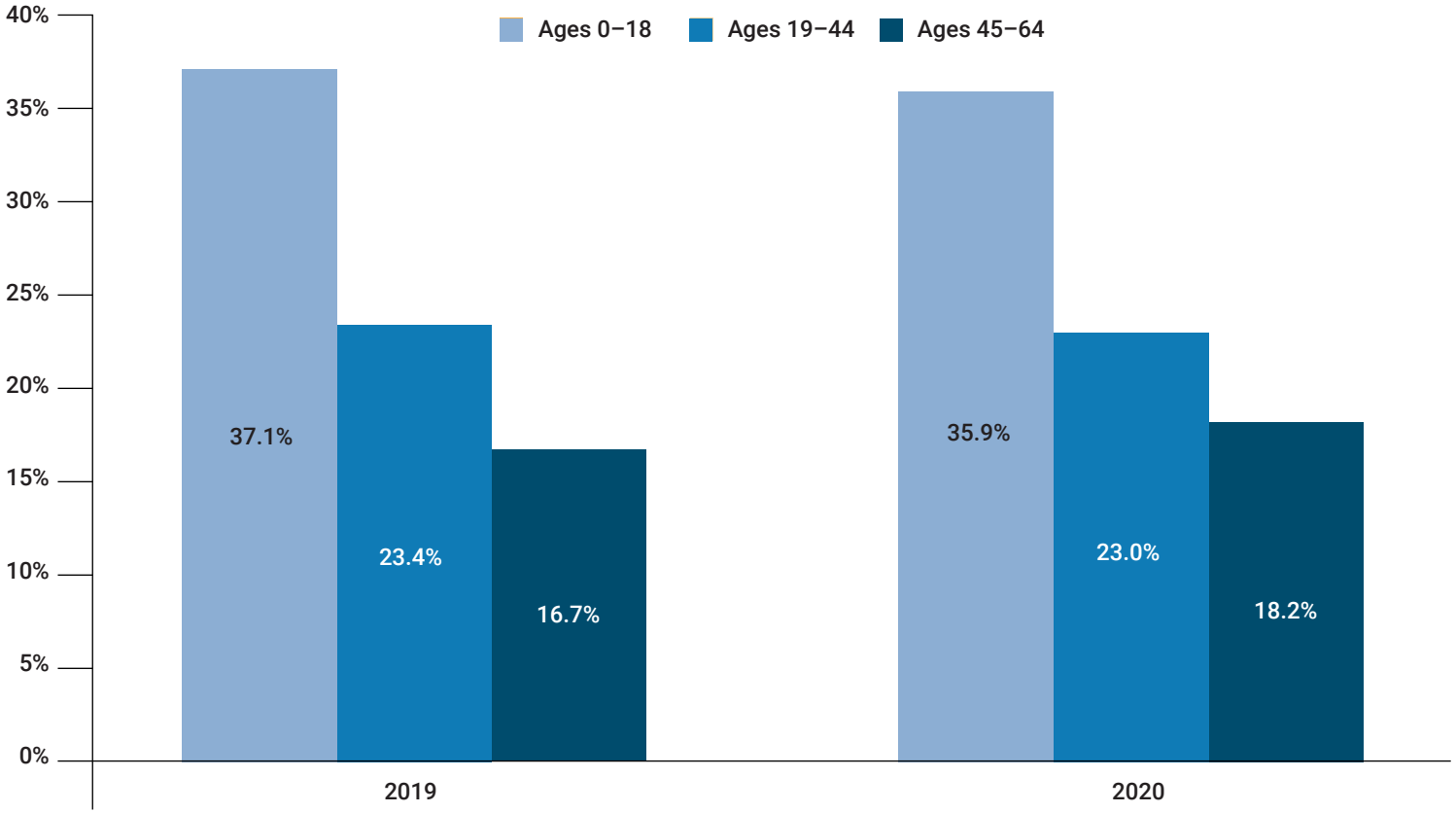
Exhibit 3.1 Rates of Public Coverage Among Adults and Children by County, Ages 0–64, California, 2020



Note: "Public coverage" includes Medi-Cal; the small number of adults under age 65 and children with both Medicare and Medi-Cal; and those with Healthy Families/CHIP.

Source: 2020 California Health Interview Survey

Exhibit 3.2 Rates of Public Coverage by Age Group, Ages 0–64, California, 2019 and 2020



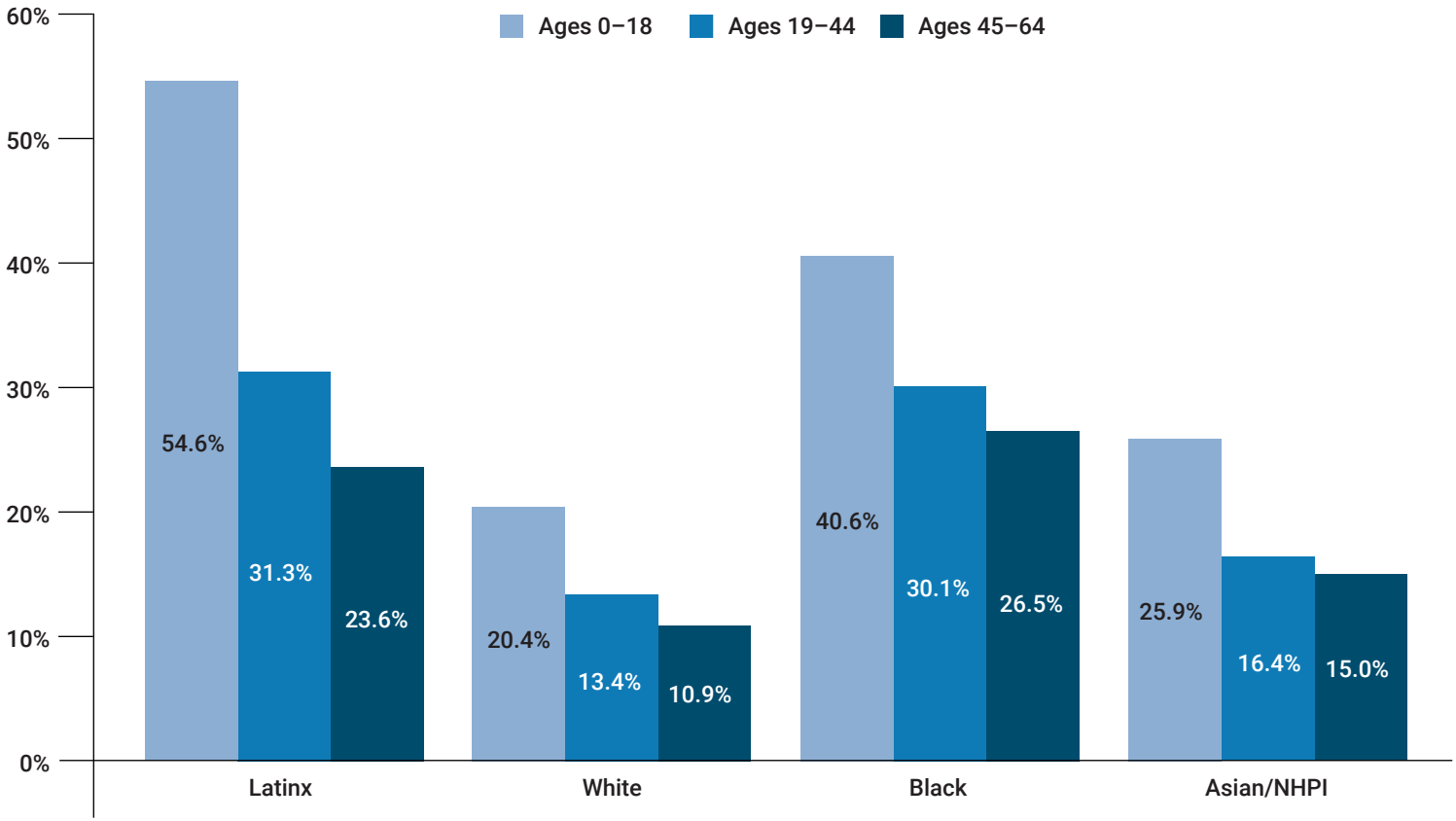
Note: "Public coverage" includes Medi-Cal; the small number of adults under age 65 and children with both Medicare and Medi-Cal; and those with Healthy Families/CHIP.

Sources: 2019 and 2020 California Health Interview Surveys

More than one-third of children ages 0–18 had public coverage in 2019 (37.1%) and 2020 (35.9%).

Children had the highest rates of public coverage among all racial/ethnic groups, with more than half of Latinx children in California (54.6%) enrolled in Medi-Cal or Healthy Families.

Exhibit 3.3 Rates of Public Coverage by Age and Racial/Ethnic Group, Ages 0–64, California, 2019–2020

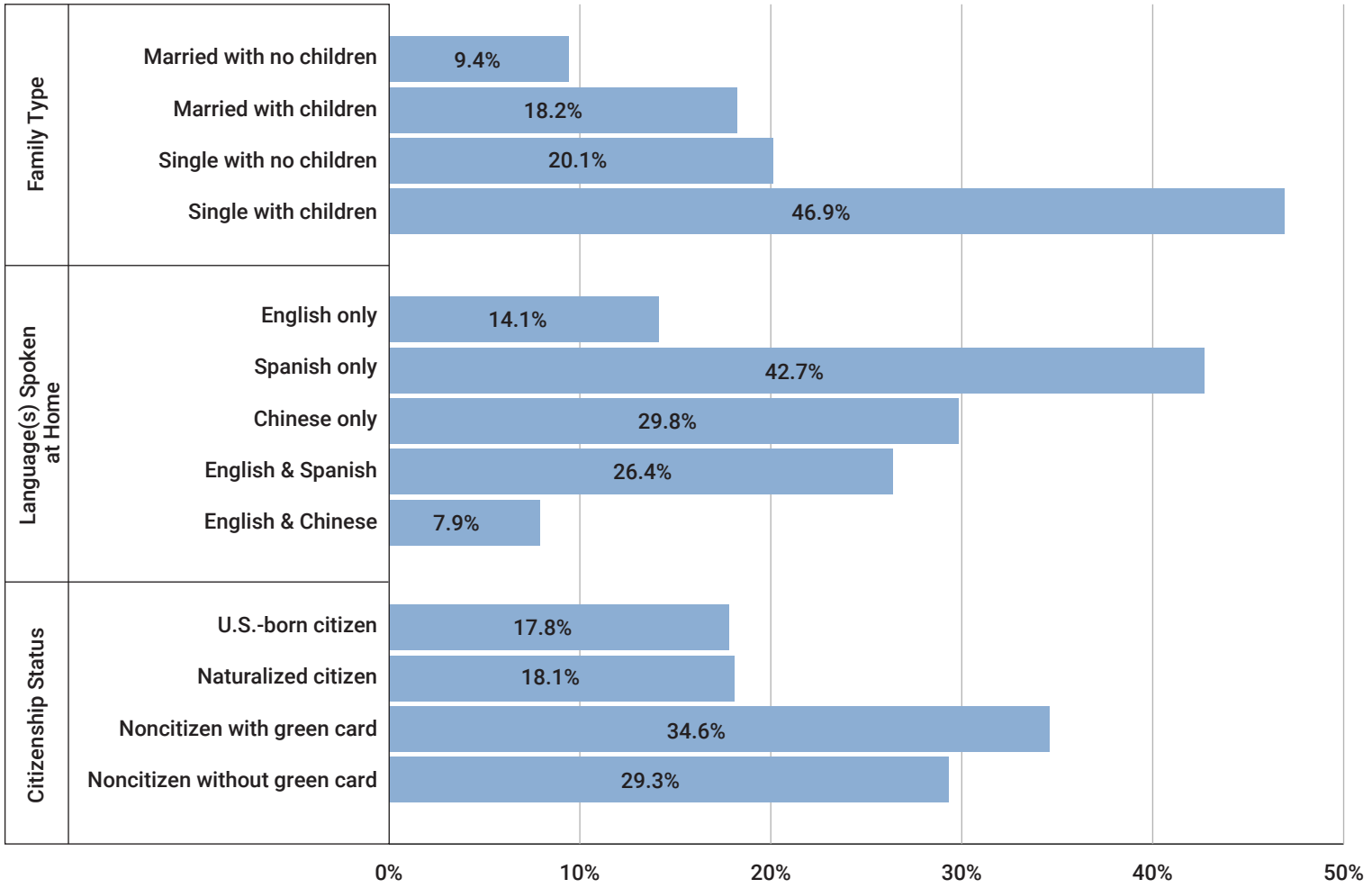


Notes: "Public coverage" includes Medi-Cal; the small number of adults under age 65 and children with both Medicare and Medi-Cal; and those with Healthy Families/CHIP.

NHPI=Native Hawaiian or Pacific Islander

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 3.4 **Rates of Medi-Cal Enrollment by Citizenship, Language Spoken at Home, and Family Type, Ages 19–64, California, 2020**

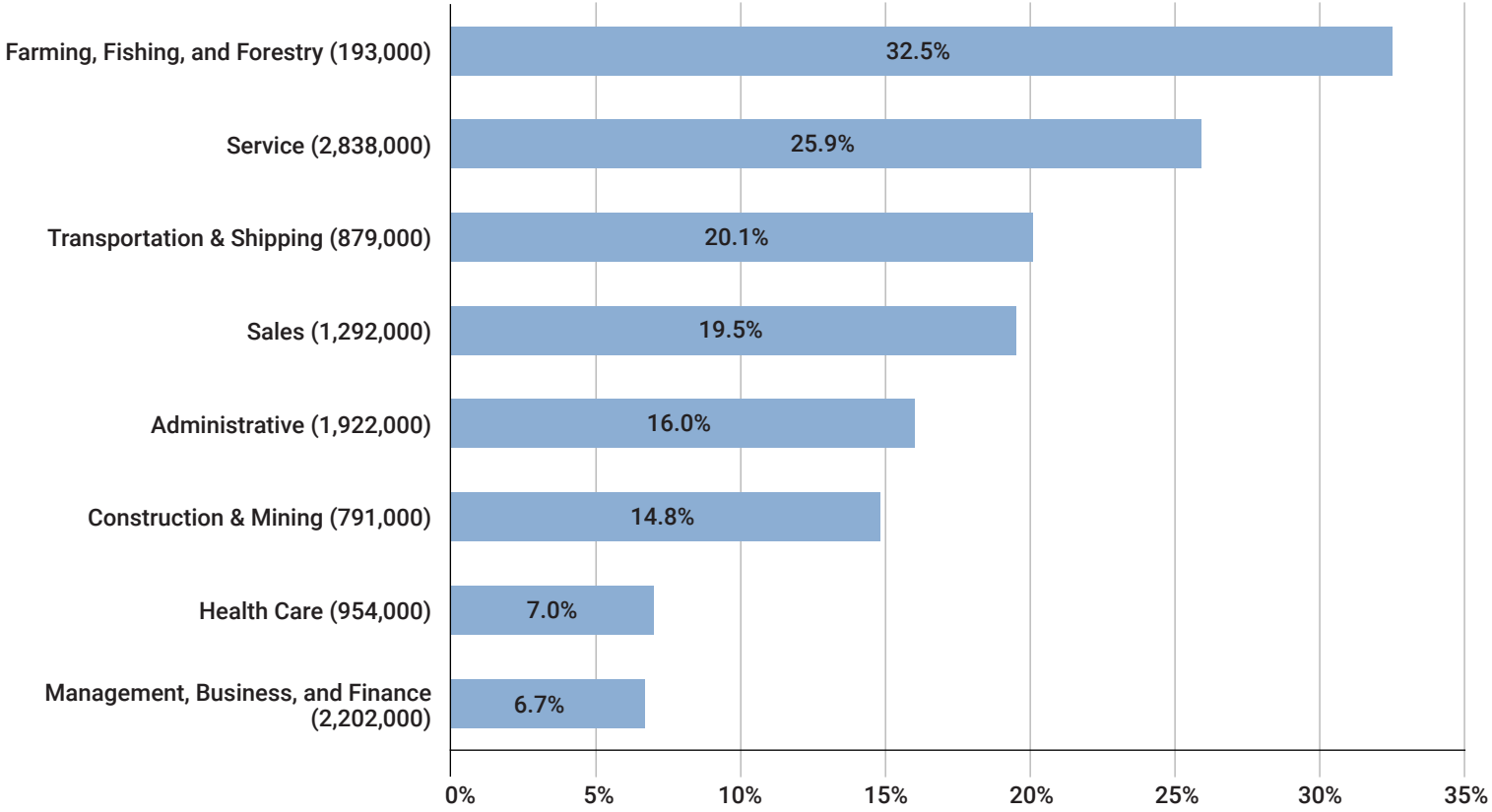


Source: 2020 California Health Interview Survey

Among adults under age 65, those who were single with children (46.9%), spoke only Spanish at home (42.7%), or were noncitizens with a green card (34.6%) had the highest rates of Medi-Cal coverage, indicating the importance of inclusive outreach.

One-third of farm workers (32.5%) and one-fourth (25.9%) of service industry workers in California had Medi-Cal coverage.

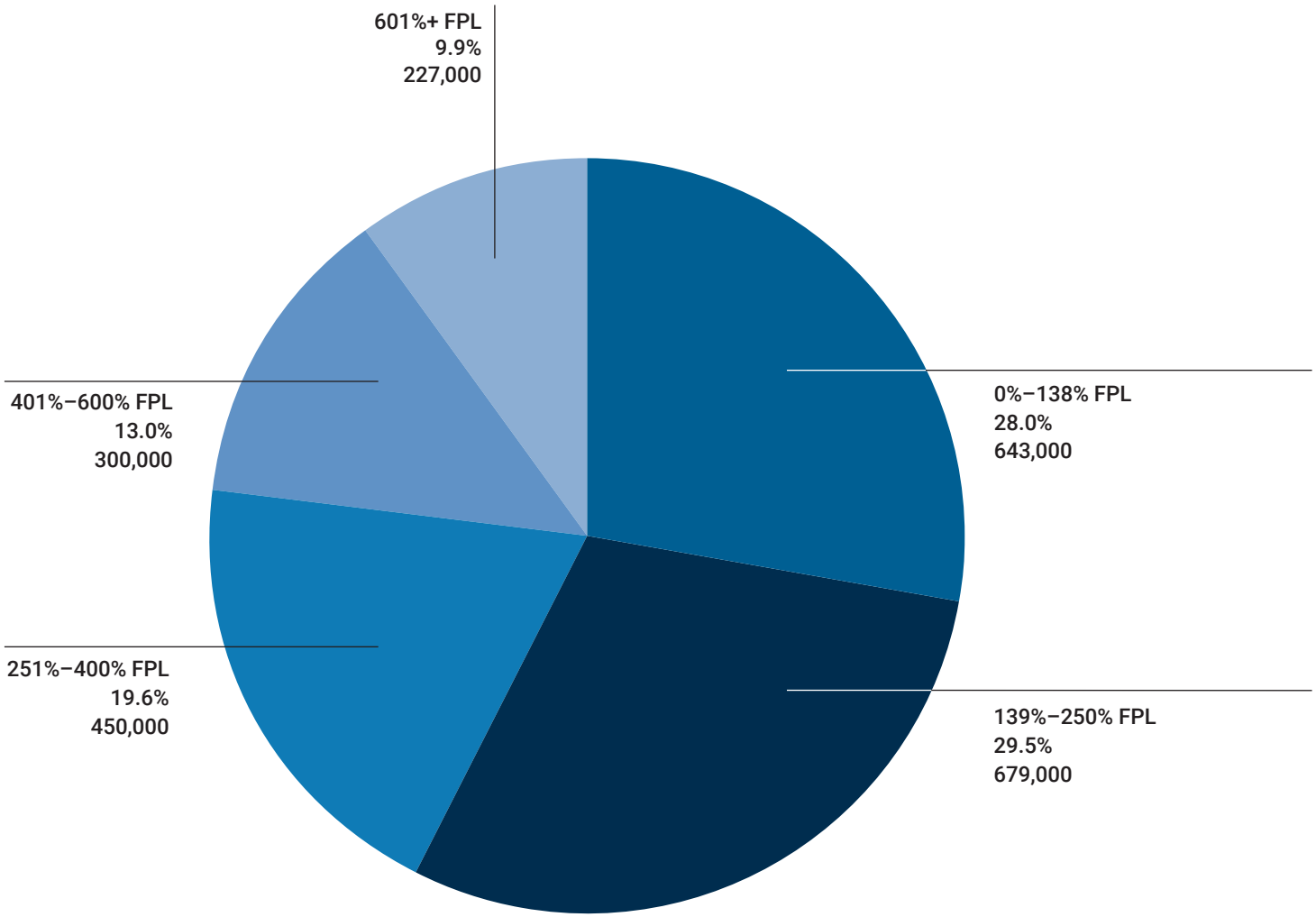
Exhibit 3.5 Rates of Medi-Cal Enrollment by Industry of Main Employment, Employed Adults Ages 19–64, California, 2019



Note: Not all industries are included in this chart; only the largest and most illustrative of comparative industries are presented. CHIS 2020 data for industry are not yet available.

Source: 2019 California Health Interview Survey

Exhibit 3.6 **Household Income as a Percentage of the Federal Poverty Level (FPL) Among Uninsured Adults and Children, Ages 0–64, California, 2020**



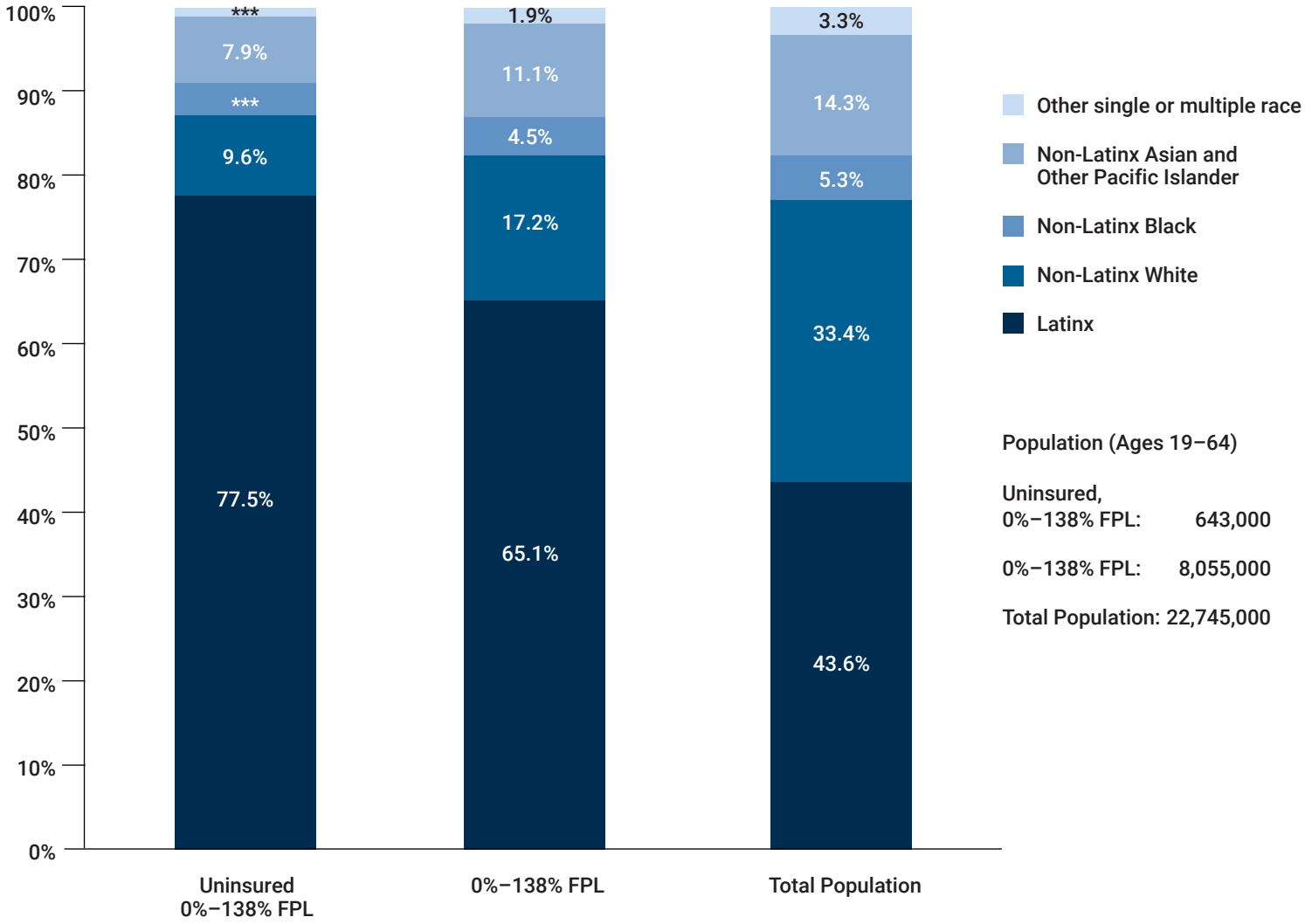
Note: The Federal Poverty Level (FPL), updated annually, reflects the household incomes that are included in the eligibility cutoffs for public coverage or subsidies for purchasing private coverage through Covered California. Households with ≤138% FPL are eligible for no-cost Medi-Cal, while those in the ranges up to 600% are eligible for progressive subsidies to purchase their own insurance. Households with incomes at 601% FPL or above are not eligible for assistance of any kind.

Source: 2020 California Health Interview Survey

The Medi-Cal expansion over the past decade aimed to reduce the rates of uninsurance by covering low-income childless adults as well. Still, low-income families that could have qualified for Medi-Cal (that is, those with incomes less than or equal to 138% FPL) made up more than one-fourth of the population under age 65 without insurance.

More than three-fourths of the remaining uninsured adults who may have been eligible for Medi-Cal because of household income were of Latinx descent (77.5%).

Exhibit 3.7 **Distribution of Racial and Ethnic Groups Among Uninsured With Household Income of 0%–138% FPL Compared to All With Income of 0%–138% FPL and Total Population, Ages 19–64, California, 2019–2020**

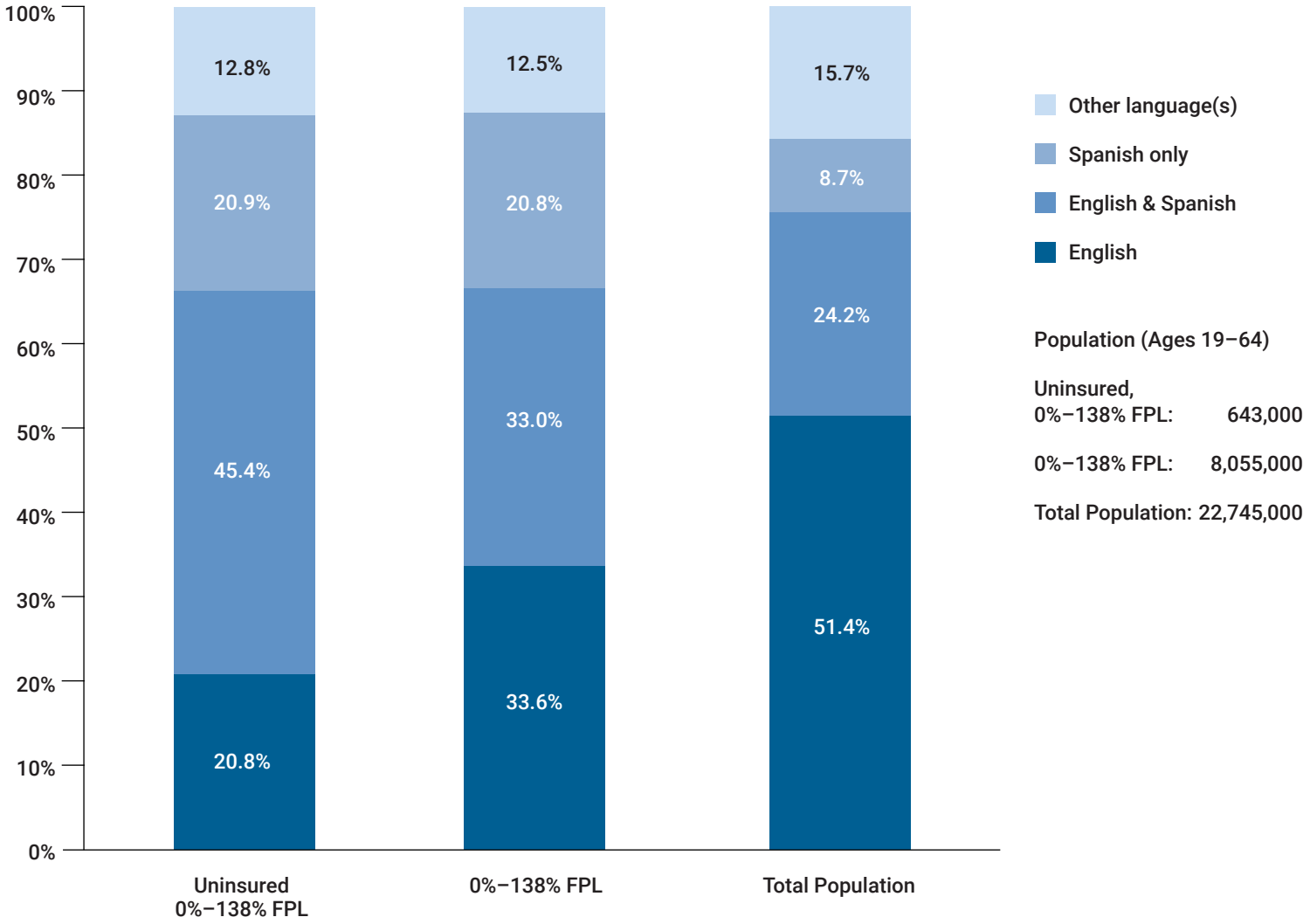


Note: The Federal Poverty Level (FPL), updated annually, reflects the household incomes that are included in the eligibility cutoffs for public coverage or subsidies for purchasing private coverage through Covered California. Households with income ≤138% FPL are eligible for no-cost Medi-Cal, while those in income ranges up to 600% FPLare eligible for progressive subsidies to purchase their own insurance. Households with incomes of 601% FPL or above are not eligible for assistance of any kind.

*** Estimate is unstable because the coefficient of variation is above 30%. Data for "Uninsured, 0%-138% FPL" are pooled for 2019 and 2020 to provide stable percentages.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 3.8 **Distribution of Language Spoken at Home Among Uninsured With Household Income of 0%–138% FPL Compared to All With Income of 0%–138% FPL and Total Population, Ages 19–64, California, 2020**



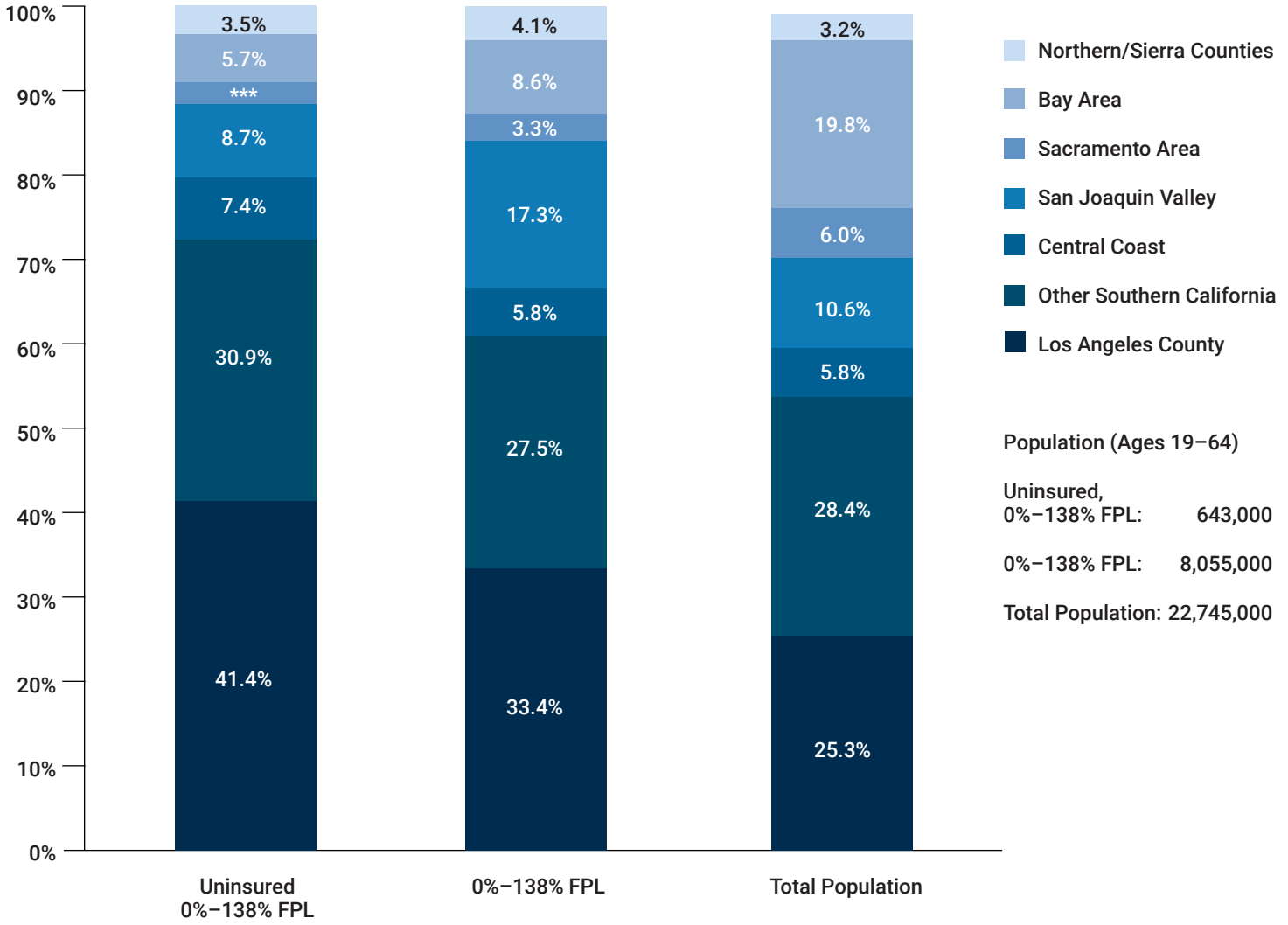
Note: The Federal Poverty Level (FPL), updated annually, reflects the household incomes that are included in the eligibility cutoffs for public coverage or subsidies for purchasing private coverage through Covered California. Households with ≤138% FPL are eligible for no-cost Medi-Cal, while those in the ranges up to 600% FPL are eligible for progressive subsidies to purchase their own insurance. Households with incomes of 601% FPL or above are not eligible for assistance of any kind.

Source: 2020 California Health Interview Survey

Nearly half of all uninsured adults who may have been eligible for Medi-Cal due to household income (45.4%) spoke both English and Spanish at home, and an additional one in five (20.9%) spoke only Spanish.

More than seven in 10 uninsured adults who may have been eligible for Medi-Cal due to household income lived in a Southern California county (72.3%), including 41.4% in Los Angeles County alone.

Exhibit 3.9 **Distribution of Region of Residence Among Uninsured With Household Income of 0%–138% FPL Compared to All With Income of 0%–138% FPL and Total Population, Ages 19–64, California, 2019–2020**



Note: The Federal Poverty Level (FPL), updated annually, reflects the household incomes that are included in the eligibility cutoffs for public coverage or subsidies for purchasing private coverage through Covered California. Households with ≤138% FPL are eligible for no-cost Medi-Cal, while those in the ranges up to 600% are eligible for progressive subsidies to purchase their own insurance. Households with incomes of 601% FPL or above are not eligible for assistance of any kind.

*** Estimate is unstable because the coefficient of variation is above 30%. Data for "Uninsured, 0%–138% FPL" were pooled for 2019 and 2020 to provide stable percentages.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

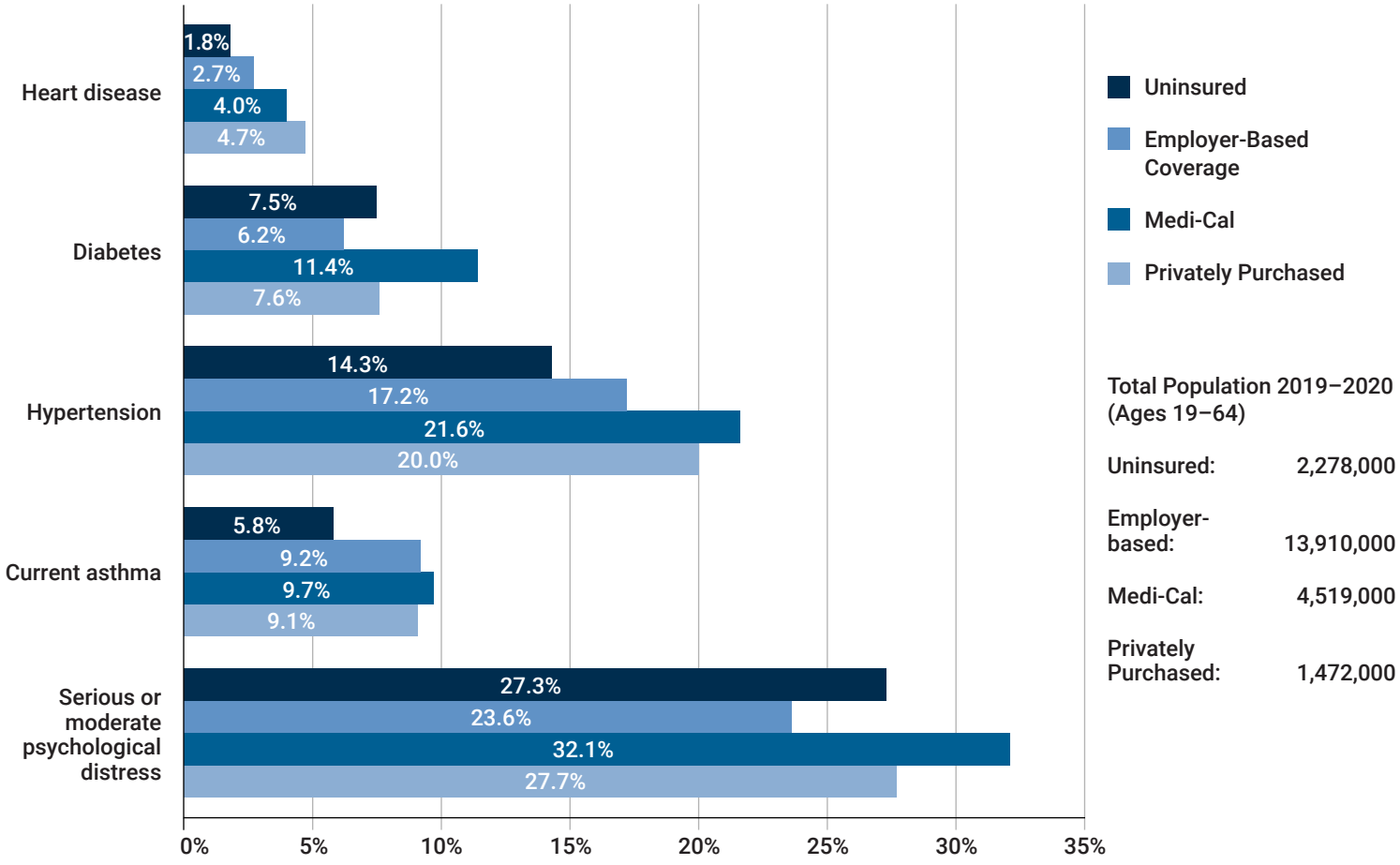
Chapter 4

Access to Care and Health Insurance in California

Many Californians do not get the health care they need. Insurance coverage is an important determinant of access to health care because it makes health care more affordable. Access to timely and appropriate health care can help individuals prevent illness as well as manage chronic conditions, thus avoiding potential complications. Having insurance improves access to care, but access can also vary by type of insurance. This may be due to a number of factors, including eligibility requirements for certain types of coverage, along with the out-of-pocket costs that are included in the insurance plan or policy — e.g., co-payments, deductibles, and caps on the amount of coverage. Additionally, although the mandated essential health benefits have increased comparability across insurance products, there is still some variation in the breadth of benefits packages.

Adults insured with Medi-Cal had a higher prevalence of hypertension, heart disease, diabetes, and serious or moderate psychological distress than adults covered by employer-based insurance or those with no insurance.

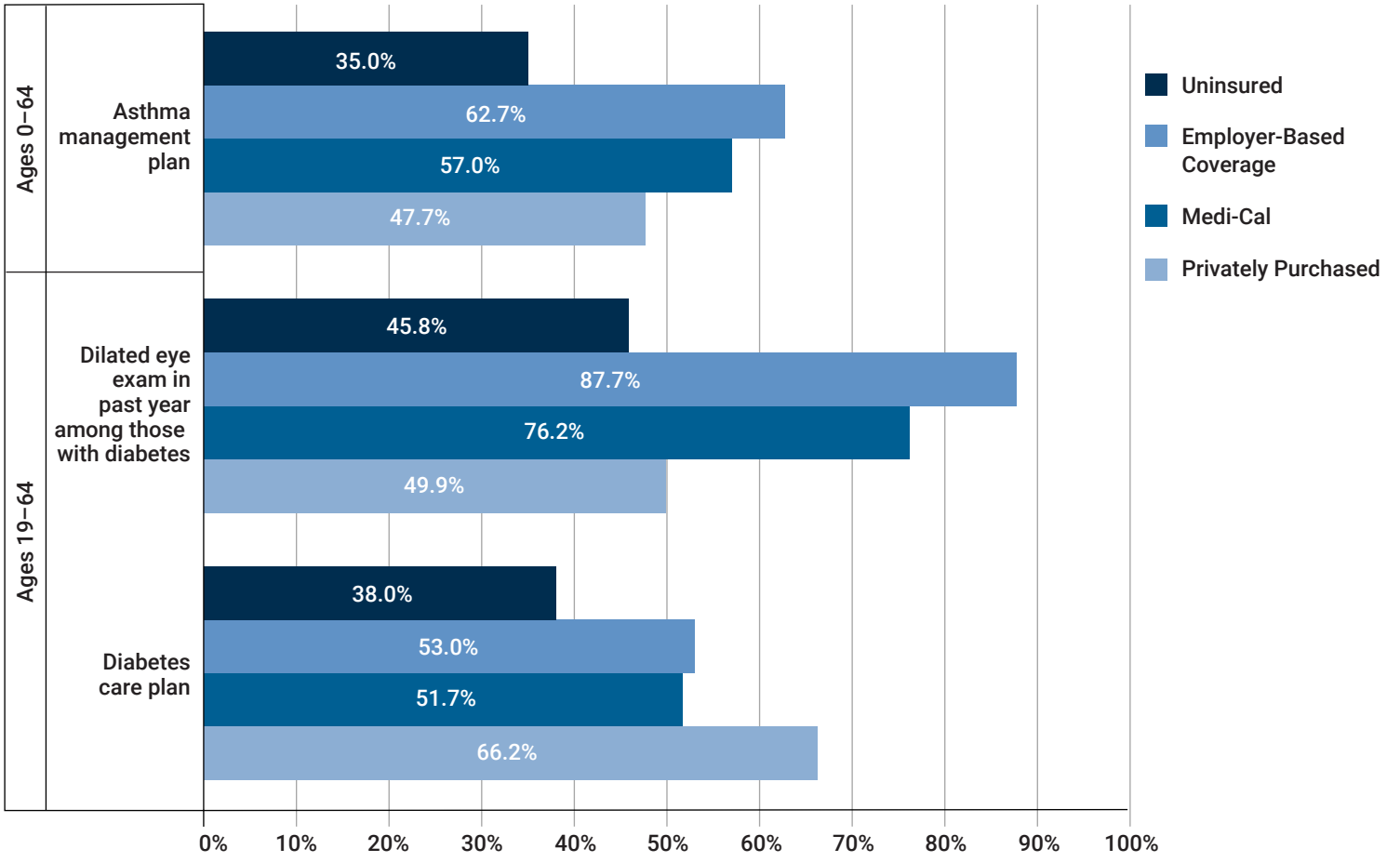
Exhibit 4.1 **Prevalence of Self-Reported Diagnosed Chronic Conditions by Health Insurance Type, Adults Ages 19–64, California, 2019–2020**



Note: Heart disease, diabetes, hypertension, and asthma are self-reported based on being diagnosed by a medical provider. Psychological distress is assessed with a series of questions assessing number and frequency of symptoms experienced in the past year to determine clinically relevant levels of distress. Adults without insurance do not have a higher prevalence of diagnosed heart disease, diabetes, hypertension, or current asthma. Two factors likely contribute to this: (1) People who know they have chronic conditions tend to seek out insurance, and (2) those without insurance may be more likely to have undiagnosed conditions because they have less access to health care. Interestingly, the prevalence of psychological distress was not lower, and this was the only indicator measured by asking about symptoms rather than through a diagnosis given by a provider.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 4.2 Receipt of Condition-Specific Care by Insurance Type, California, 2019–2020



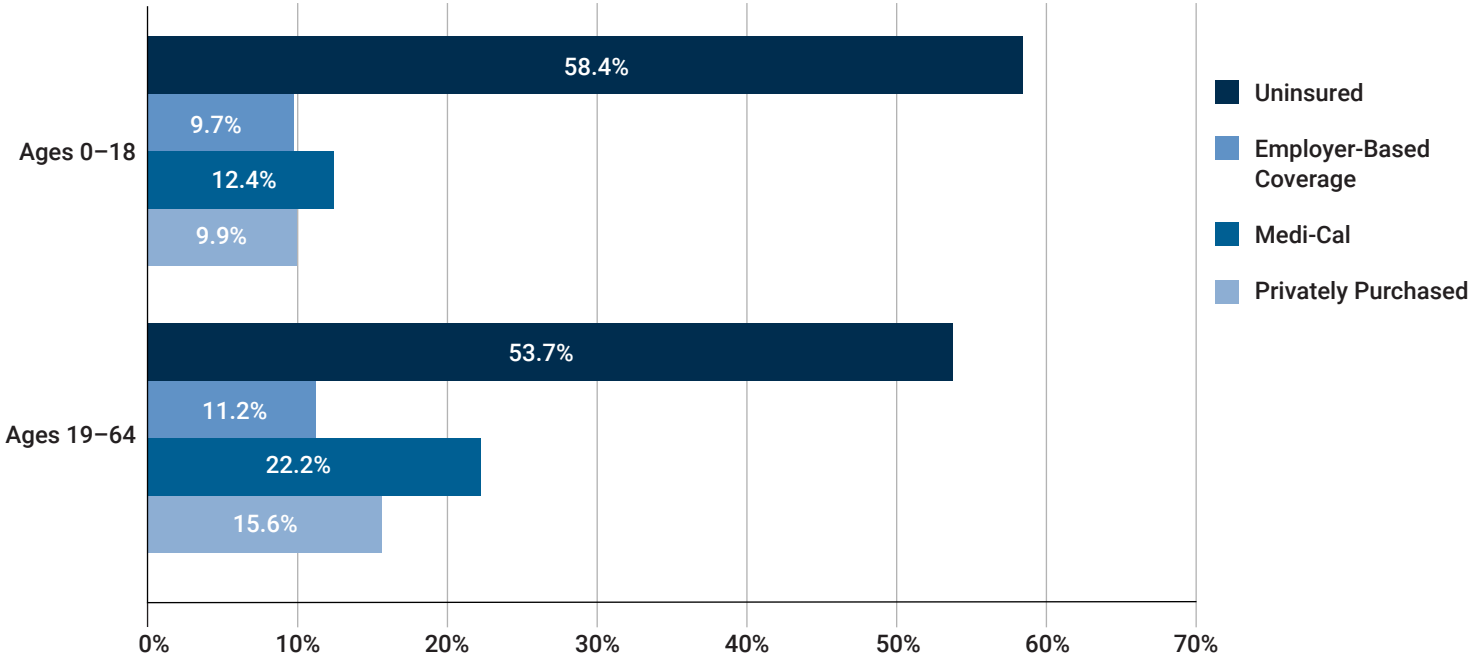
Notes: "Asthma management plan" is among children and adults ages 0–64 with asthma, and "diabetes care plan" and "dilated eye exam" are among adults ages 19-64 with diabetes.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Fewer than half of those without insurance received an asthma management plan (35%), a diabetes care plan (38%), or a dilated eye exam (45.8%), compared to more than half of those with employer-based insurance or Medi-Cal.

More than half of children (58.4%) and adults (53.7%) with no insurance coverage lacked a usual source for health care, figures significantly higher than for those with any type of insurance. However, children and adults with Medi-Cal were still more likely to have no usual source of care than those with employer-based insurance (EBI) (12.4% compared to 9.7% for children, and 22.2% compared to 11.2% for adults).

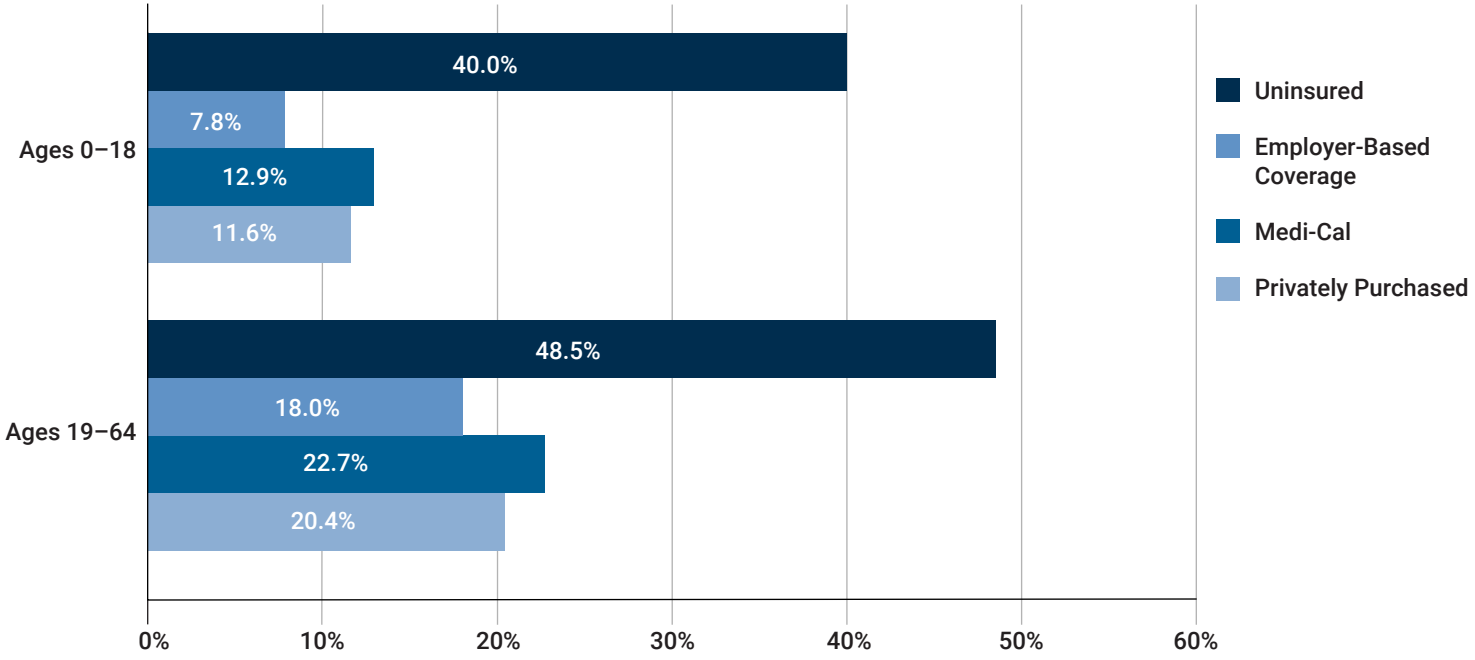
Exhibit 4.3 **Rate of Having No Usual Source of Care by Insurance Type and Age Group, Ages 0–64, California, 2019–2020**



Notes: "No usual source of care" includes those who reported that urgent care or an emergency department were their usual place to receive care.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 4.4 **Rate of Having No Doctor Visit in Past Year by Insurance Type and Age Group, Ages 0–64, California, 2019–2020**

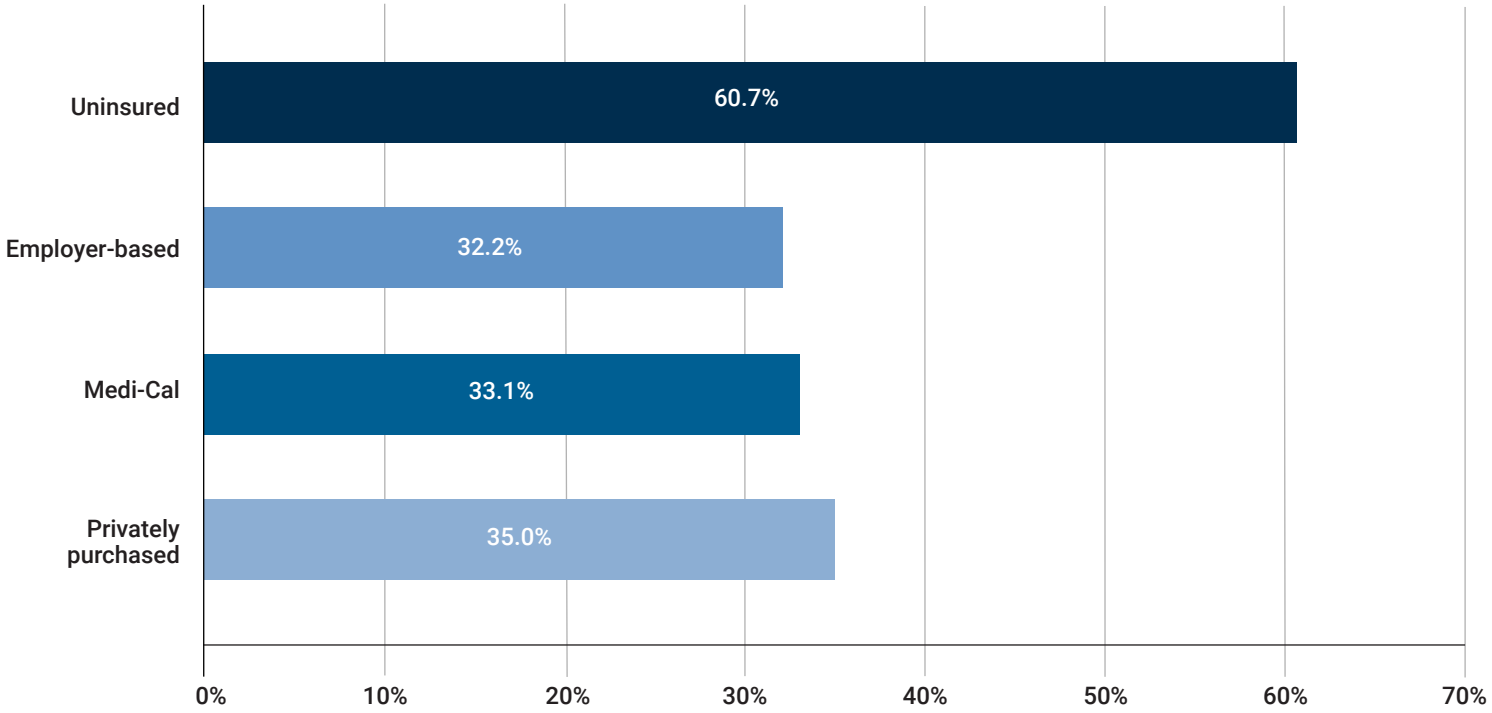


Sources: Pooled 2019 and 2020 California Health Interview Surveys

More than 40% of children and adults who lacked insurance coverage had had no doctor visit in the past year, significantly higher than the percentage among those with any type of insurance. Higher proportions of people with Medi-Cal had had no doctor visit in the past year compared to those with EBI.

More than 60% of adults without insurance had had no preventive care visit in the past year, a percentage significantly higher than percentages for all other categories.

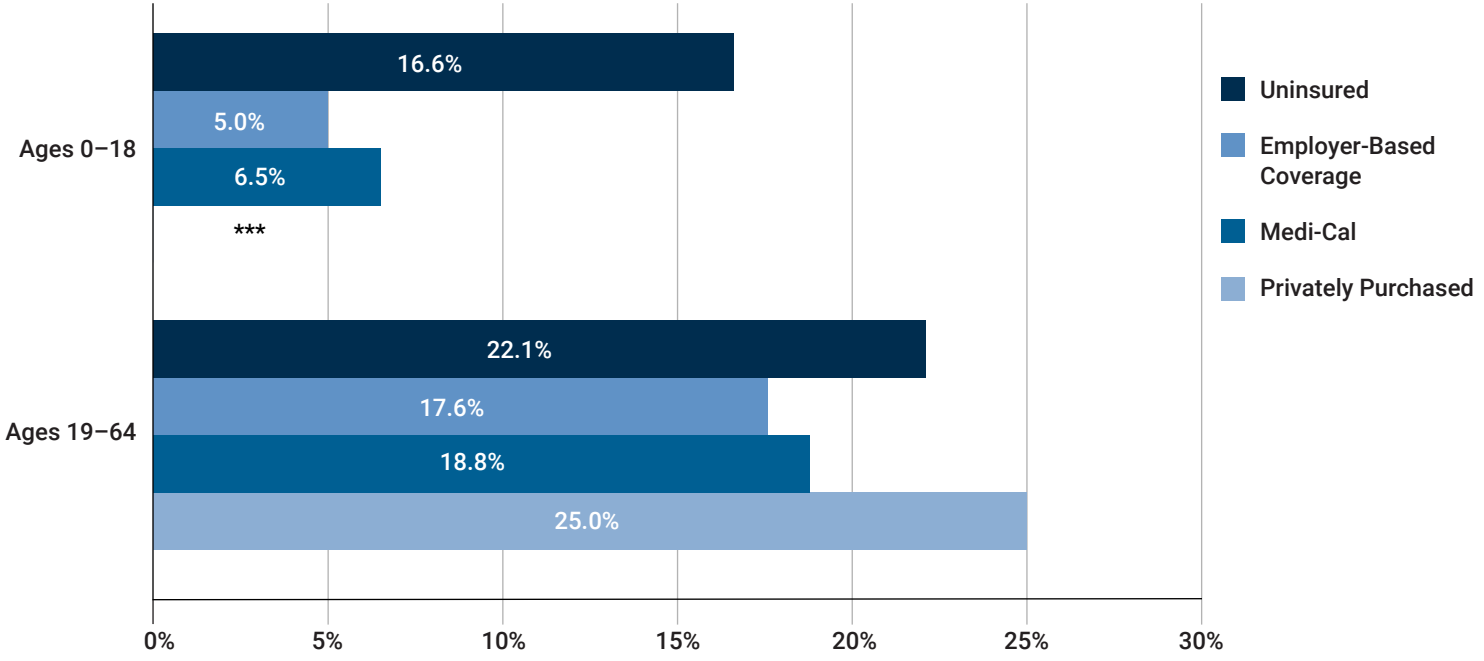
Exhibit 4.5 **Rate of Having No Preventive Care Visit in Past Year by Insurance Type, Ages 19–64, California, 2019–2020**



Notes: Adult respondents were asked how long it had been since they had seen a provider for a routine check-up. Those who reported a routine check-up in the past 12 months were considered to have had a preventive care visit in the past year.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 4.6 **Rate of Delaying Needed Medical Care in Past Year by Insurance Type and Age Group, Ages 0–64, California, 2019–2020**



Notes: Respondents were asked if they had delayed or not received any medical care they felt they needed in the past year.

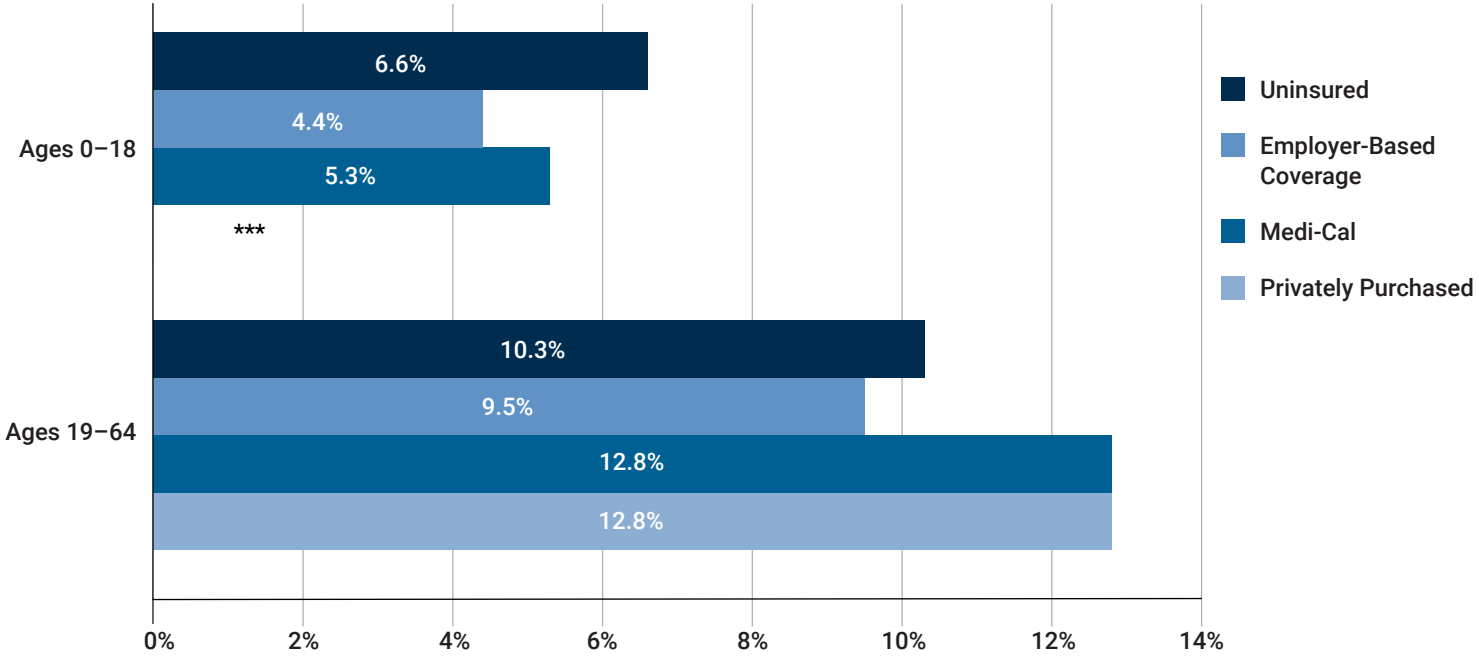
*** Estimate is unstable because the coefficient of variation is above 30%.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

One in seven (16.6%) children with no insurance experienced a delay in needed medical care. Among adults ages 19–64, one-fourth of those with privately purchased insurance (25%) and more than one-fifth of those with no insurance (22.1%) reported experiencing a delay in receiving needed medical care in the past year.

Among children, there was little variation in the percentage who had experienced delays in filling a prescription across the primary insurance types of EBI, Medi-Cal, and privately purchased insurance. Among adults, a higher percentage of those enrolled in Medi-Cal had experienced a delay in getting a prescription compared to those with EBI (12.8% vs. 9.5%). Those with no insurance may have had lower rates of delaying getting prescription medication because they were less likely to have received a prescription for medication.

Exhibit 4.7 Rate of Delaying Prescription Medication in Past Year by Insurance Type and Age Group, Ages 0–64, California, 2019–2020

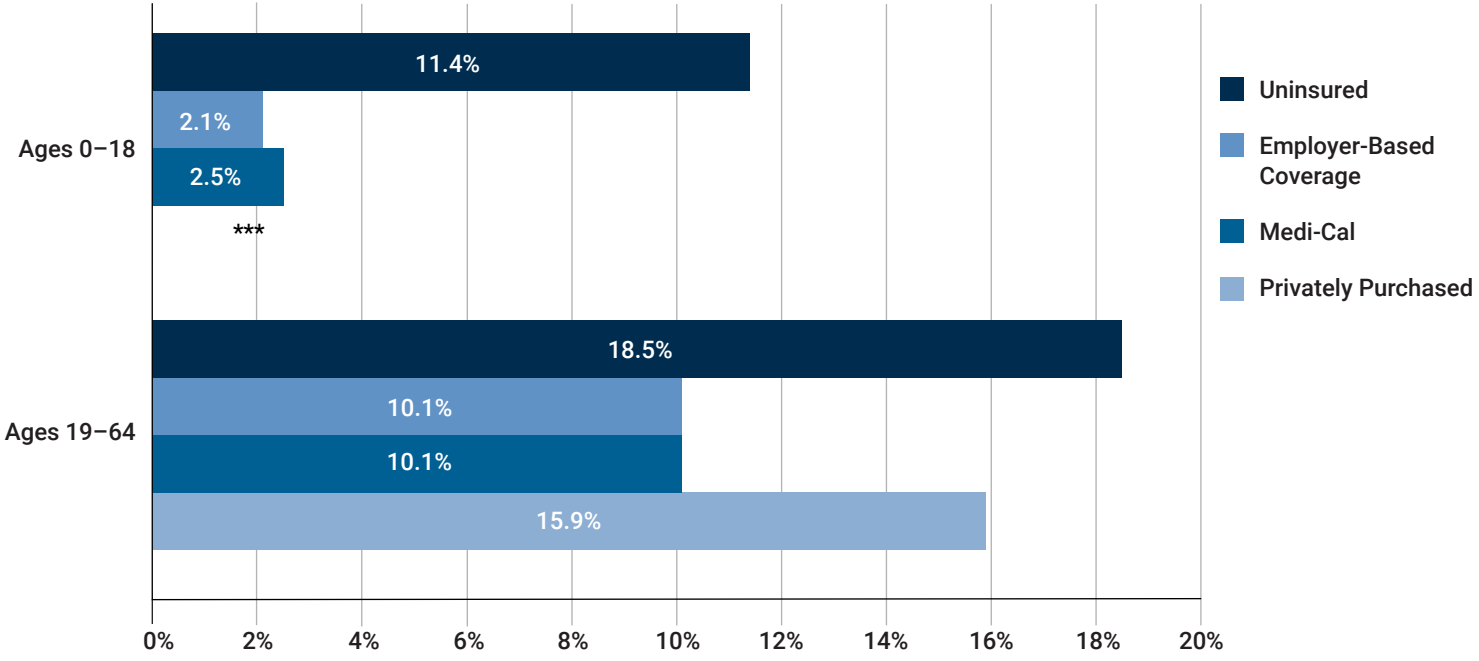


Notes: Respondents were asked if they had delayed getting or did not get any medicine that was prescribed for them in the past year

*** Estimate is unstable because the coefficient of variation is above 30%.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 4.8 **Rate of Forgoing Necessary Care in Past Year by Insurance Type and Age Group, Ages 0–64, California, 2019–2020**



Notes: "Forgoing necessary care" refers to those who experienced delays in needed medical care and who never received the delayed care.

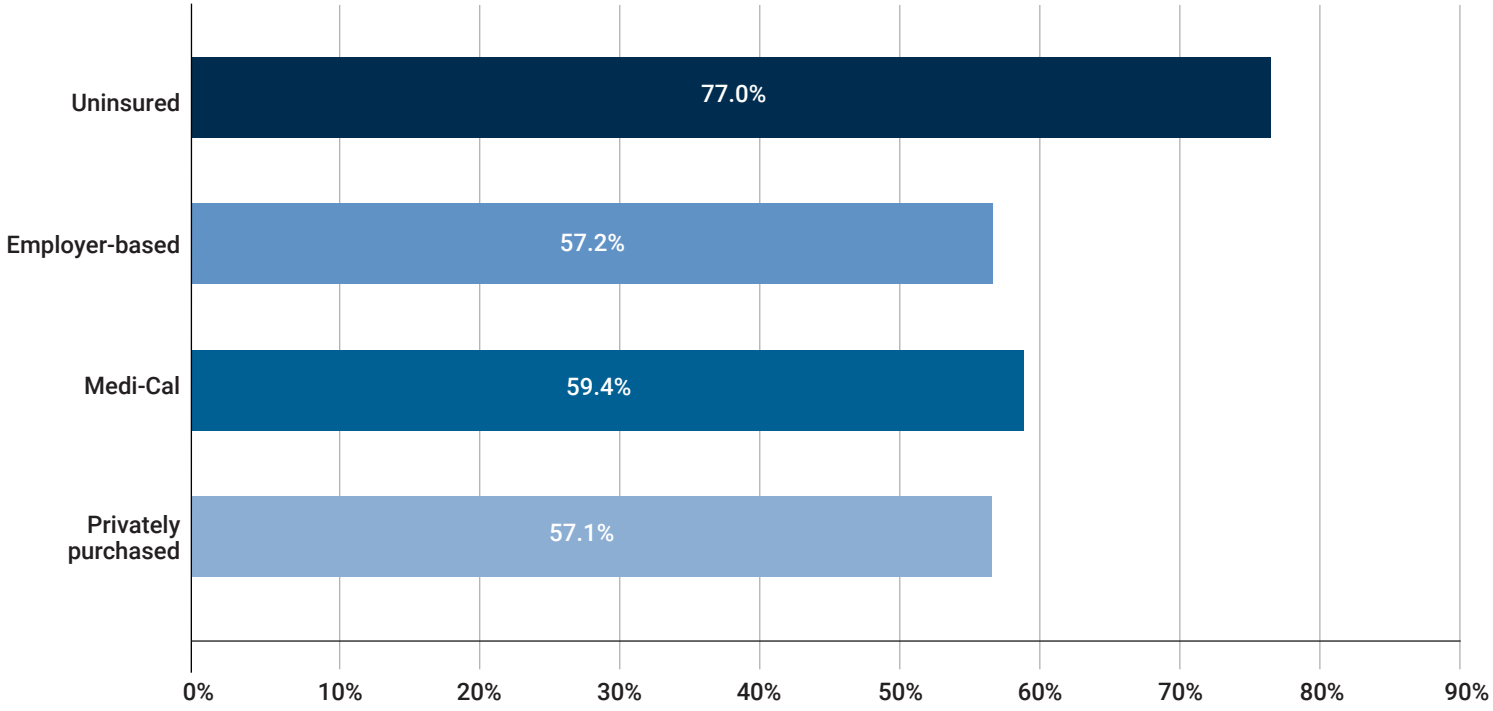
*** Estimate is unstable because the coefficient of variation is above 30%.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

One in 10 uninsured children (11.4%) and nearly one in five uninsured adults (18.5%) had to forgo needed care in the past year, figures significantly higher than among those with Medi-Cal (2.5% among children and 10.1% among adults) and those with EBI (2.1% among children and 10.1% among adults).

More than three-quarters of adults with no insurance (77%) had an unmet need for mental health care in the past year, along with more than half of those with Medi-Cal, EBI, or private insurance.

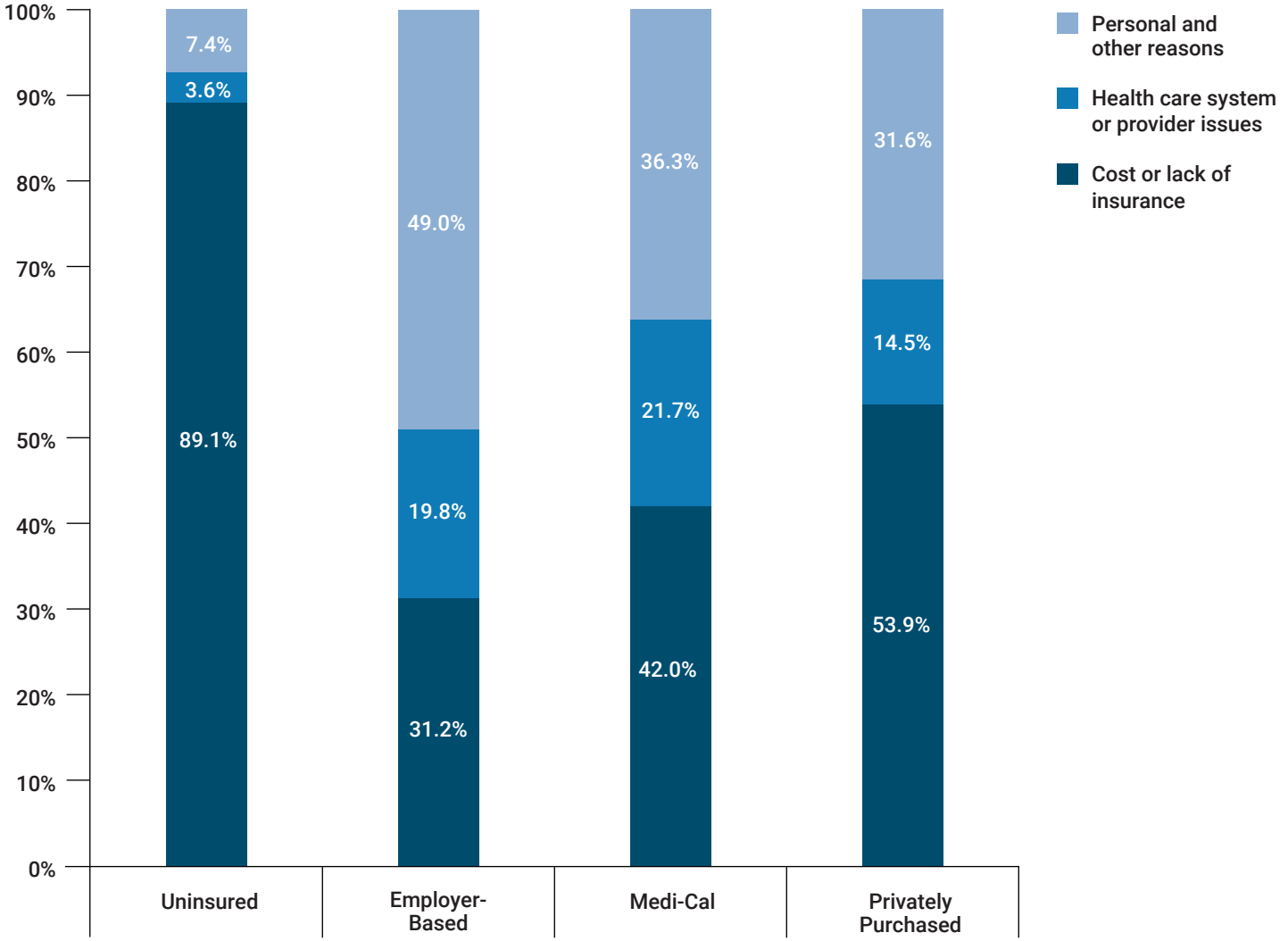
Exhibit 4.9 **Rate of Having an Unmet Need for Mental Health Care in Past Year by Insurance Type, Ages 19–64, California, 2019–2020**



Notes: "Unmet need for mental health care" refers to adults who had serious or moderate psychological distress or who reported needing care for mental health or substance abuse issues in the past year, and who also reported that they had not seen any health care provider for mental health or substance abuse issues in the past year.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Exhibit 4.10 **Main Reason for Delaying Care Among Those Who Experienced Delays in Needed Care, by Insurance Type, Ages 0–64, California, 2019–2020**



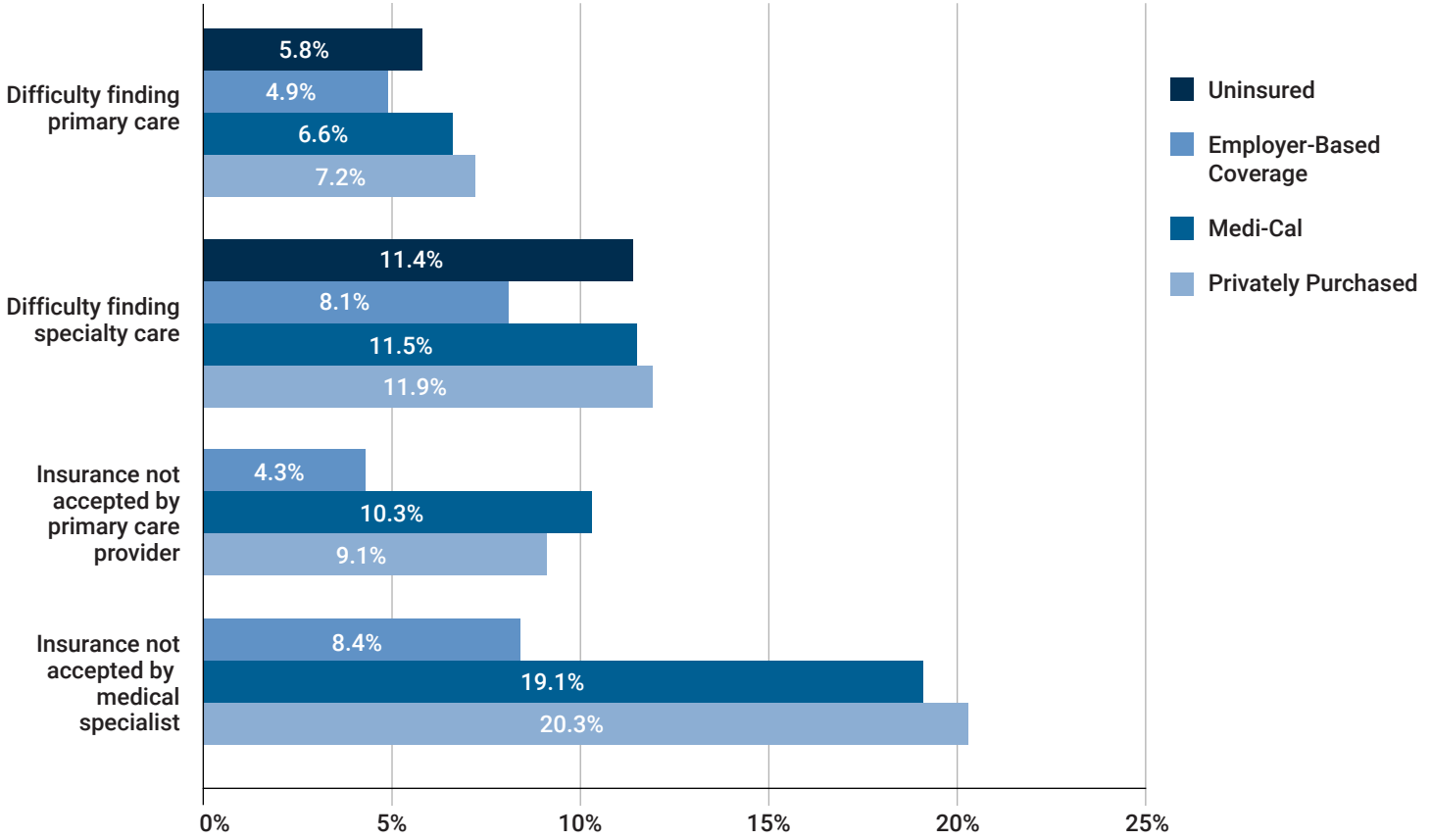
Notes: Respondents who experienced delays in needed medical care were asked about their main reasons for delaying care.

Sources: 2019–2020 pooled California Health Interview Surveys

The vast majority (89.1%) of those without insurance who experienced delays in needed care reported that cost or lack of insurance was the main reason for delaying care, a figure more than twice that for those with either Medi-Cal or EBI.

Adults with EBI had the lowest reported difficulty in finding primary care (4.9%), difficulty in finding specialty care (8.1%), having insurance not accepted by a primary care provider (4.3%), and having insurance not accepted by a specialty care provider (8.4%).

Exhibit 4.11 Rate of Reported Barriers to Accessing Primary and Specialty Care by Insurance Type, Ages 19–64, California, 2019–2020



Notes: Respondents who answered yes to either "During the past 12 months, did you have any trouble finding a general doctor who would see you?" or "During the past 12 months, did a doctor's office tell you that they would not take you as a new patient?" were considered to have had difficulty finding primary care. Respondents responding yes to "In the past 12 months, did you or a doctor think you needed to see a medical specialist?" were asked the following: "During the past 12 months, did you have any trouble finding a medical specialist who would see you?" and "During the past 12 months, did a medical specialist's office tell you that they would not take you as a new patient?" Those answering yes to either were considered to have had difficulty obtaining specialty care. Respondents were also asked whether a doctor's office or specialist's office would not accept their insurance. Respondents without insurance were not asked whether they were ever told their insurance would not be accepted.

Sources: Pooled 2019 and 2020 California Health Interview Surveys

Conclusion

In our previous *State of Health Insurance in California* report, we noted that for the first time in decades, true universal coverage seemed possible. This seemed feasible in part due to California's efforts to stabilize and expand the ACA marketplace in the face of ongoing political and judicial challenges. But we also noted that health insurance coverage stood at a crossroads, with the next report likely to either (1) document the further successes in and remaining challenges to establishing true universal coverage, or (2) be a postmortem on the ACA that documented the damage done to health coverage.

The data in this chartpack indicate that health insurance expansion has continued in California, including the growth of subsidies and coverage, despite rollbacks and roadblocks posed by the federal government from 2017 to 2020. Despite the successes, this chartpack also shows that many challenges to health coverage remain. More than 2.5 million California adults, adolescents, and children have no health insurance coverage; racial and ethnic disparities persist; many small businesses struggle to even offer health insurance to employees; more than half a million low-income people who could be eligible for Medi-Cal remain uninsured; and being uninsured remains a significant barrier to accessing health care.

While previous expansions in health coverage are good news for residents, California has more work to do to reduce racial and ethnic disparities, reduce or eliminate uninsurance, and remove barriers to accessing health care. Several proposals have been put forward in California as well as at the federal level to further expand coverage. Even incremental expansions to health insurance eligibility would help California meet some of the remaining challenges, although a more comprehensive overhaul of the health care financing system would also address underinsurance among those with current coverage. It remains to be seen whether California will have both the political will and the public financing needed to take these steps forward, as well as how far Californians are willing to go to improve coverage for all residents.

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Issue Brief:
California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits

January 2022

Prepared by
California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2022). Issue Brief: California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits. Berkeley, CA*

KEY FINDINGS

Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) of 2010 required some (but not all) forms of health insurance to cover a set of Essential Health Benefits (EHBs). EHBs are 10 statutory categories of tests, treatments, and services for which coverage is required by federal regulation based on a state plan benchmark.[1]

For 2022, the California Health Benefits Review Program (CHBRP) estimated that 10.8% of Californians are enrolled in commercial health insurance that must cover EHBs.[2]
This issue brief provides:

- Background on EHBs in California and how they interact with current and proposed state benefit mandates.
- California's current options for altering its EHBs and how a number of other states have done so.
- How (although CHBRP is unaware of any that have been determined to have done so) a state benefit mandate could exceed EHBs and potentially trigger a requirement to defray the additional cost.

Essential Health Benefits: Overview

In California, commercial health insurance required to cover EHBs include non-grandfathered commercial plans and policies sold in the individual and small-group markets, the majority of which are sold through Covered California, California's health insurance marketplace.[3]

According to the ACA, although there can be some variation between states as to the details of EHBs, EHBs must include the following broad categories of benefits: (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services and devices, (8) Laboratory services, (9) Preventive and wellness services and chronic disease management and (10) Pediatric services, including oral and vision care.[4]

To comply with the ACA and federal guidance by 2014, each state was required to define EHBs based on one of ten possible benchmark plan options already offered in the state, and to add any EHB category not included in the chosen option (but now required by federal law, such as pediatric vision care). As a benchmark plan option, California selected the "largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market." For California, that was the Kaiser Foundation Health Plan Small Group HMO 30 plan, which was supplemented with additional benefits in order to meet the broad requirements of EHBs.[5]

State benefit mandates that exceed essential health benefits

For plans and policies required to cover EHBs, the ACA allows a state to require coverage for additional benefits. However, if the state does so, the state may be required to make payments to the enrollee or to their qualified health plan defray the cost of those additionally mandated benefits. State benefit mandates

[1] Refer to CHBRP's full report below for full citations and references.
[2] See CHBRP's resource, *Estimates of Sources of Health Insurance in California*, available at: https://chbrp.org/other_publications/index.php
[3] Medi-Cal, California's Medicaid program, is also required by the ACA to cover a set of benefits referred to as EHBs, but, as discussed in Appendix B, Medi-Cal EHBs are separate from and function independently from the EHBs commercial health insurance is required to cover.
[4] 42 U.S.C. §18022
[5] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on December 16, 2019 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb

enacted before December 31, 2011 are considered part of that state's EHBs and the requirement that the state defray the costs of these mandated benefits is waived.[6]

For a state benefit mandate to exceed EHBs in California, the following must be true:

(1) The state benefit mandate applies to qualified health plans or their off-exchange mirror equivalent plans or policies). Qualified health plans are the plans and polices sold through a state marketplace, such as Covered California. Mirror equivalents are plans and policies substantively the same as those sold by a plan or insurer through Covered California.
(2) The state benefit mandate is not covered in the Kaiser Foundation Health Plan Small Group HMO 30 plan that defines the current EHB benchmark package in California or in the additional specified benefits.
(3) The state benefit mandate is not covered under basic health care services, as required by the Knox-Keene Health Care Service Plan Act of 1975.[7]
(4) The state benefit mandate is specific to care, treatment, and/or services, thus meeting the federal definition of a benefit mandate that could exceed EHBs.

Changes to service delivery method, provider types, cost sharing, or reimbursement methods do not fall under category (4) and therefore would not trigger the requirement for the state to defray the cost.

Federal regulations state the "State" is responsible for determining whether a benefit exceeds EHBs, subject to federal oversight. However, the regulations do not designate this responsibility to a specific agency or individual and. At this time, CHBRP is not aware that California has officially determined who or which agency would be responsible. Additionally, although CHBRP has analyzed bills that could have done so, CHBRP is unaware of any state mandate passed into law that has been determined to exceed EHBs.

Altering Essential Health Benefits

The Department of Health and Human Services (HHS) issued a final rule in 2018 (and a similar final rule in 2019) which provided new flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan, beginning with the 2020 plan year.[8] States could: (1) select an EHB benchmark plan used by another state for the 2017 plan year, (2) replace one or more of the 10 EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan, or (3) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of 10 previous 2017 benchmark comparison plan options.

Other States

A number of other states have secured approval to alter their EHBs.[9] For Illinois, changes were approved for 2020 plan year. For South Dakota changes were approved for the 2021 plan year. For three states, Michigan, New Mexico, and Oregon, changes were approved for the 2022 plan year. For Colorado, changes were approved for the 2023 plan year.

The details of the changes varied. For example, Illinois modified the prescription drug category and mental health substance use disorder services category by altering pain treatment options and expanding

[6] 42 U.S.C. §18031(d)(3)(B) and 45 CFR §155.170(b).
[7] The Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.
[8] 83 FR 16930 and 84 FR 17454
[9] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on January 3, 2022 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb

access to mental health services and South Dakota supplemented its habilitation services category with Applied Behavioral Analysis treatment for Autism Spectrum Disorder.

To obtain approval, states were required to submit actuarial analyses demonstrating that these EHB additions would not exceed the most generous comparison plan, thus satisfying the generosity test.

States that opted not to seek approval for change have continued to use the same EHB-benchmark plan from plan years 2017-2019.

California Options

By selecting some or all categories from another state's EHB benchmark plan or otherwise selecting a set of benefits, California could include new services that are not currently covered under the California benchmark plan. CHBRP is aware of three specific benefits that are covered by the majority of other state EHB benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan: chiropractic care services, hearing aids, and infertility services and treatments (most incorporating utilization management and other limits to these benefits).[10]

Conclusion

HHS's regulations provide an opportunity for states to modify or select a new EHB benchmark plan. Though the regulations allow for considerable flexibility, HHS maintains a minimum scope of benefits floor as well as a "generosity test" ceiling. Within these confines, California can look to states that have already done so and could alter its EHBs for a future plan year.

[10] See the Cigna document, *Essential Health Benefits: Benchmark Plan Comparison 2021 and Later*, access on January 3, 2022, accessible at:: https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf

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CALIFORNIA STATE BENEFIT MANDATES AND THE AFFORDABLE CARE ACT'S ESSENTIAL HEALTH BENEFITS

Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) of 2010 required some (but not all) forms of health insurance to cover a set of Essential Health Benefits (EHBs).[11] The EHB coverage requirement interacts with California's existing laws and may interact with proposed health insurance benefit mandate (or repeal) legislation. The California Health Benefits Review Program (CHBRP)[12] produced this issue brief to provide background on EHBs in California and how they could change in future years. Specifically, this brief provides:

- A description of state benefit mandates and enrollees with health insurance subject to state benefit mandates in California; and
- An overview of how EHBs are defined at the federal level and in California, including how federal Department of Health and Human Services regulations allow a state to alter its selection of an EHB benchmark plans and so alter its definition of EHBs.

What Are State Health Insurance Benefit Mandates?

As defined by CHBRP's authorizing statute,[13] California's health insurance benefit mandate laws can require health insurance products to provide coverage or offer coverage for any of the following: (1) coverage for screening, diagnosis, or treatment of a specific disease or condition; (2) coverage for specific types of health care treatments or services; (3) coverage for services by specific types of health care providers; and/or (4) the provision of coverage with specified terms that may affect cost sharing, prior authorization requirements, or other aspects of benefit coverage. As of 2022, CHBRP is aware of 82 health insurance benefit mandate laws in California.[14]

Health Insurance Subject to State Benefit Mandates in California

California's state benefit mandates only apply to the benefit coverage of enrollees with health insurance regulated by either the California Department of Managed Health Care (DMHC), which regulates *health care service plans*, or the California Department of Insurance (CDI), which regulates *health insurance policies*.[15] This accounts for approximately 56% of Californians (21.9 million) in 2022.[16]

State benefit mandates in Covered California

The ACA requires the establishment of health insurance marketplaces that sell health insurance in the small-group and individual markets.[17] California chose to set-up its own state-run marketplace, but states also have the option of allowing the federal government to run the state marketplace or selecting a hybrid partnership alternative with the federal government. Plans and policies certified and sold through the

[11] 42 U.S.C. § 18022
[12] The California Health Benefits Review Program (CHBRP), established in 2002, responds to requests from the California State Legislature for independent, evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Additional information about the program is available on CHBRP's website at: www.chbrp.org.
[13] Available at: http://chbrp.com/about_chbrp/index.php.
[14] Annually updated, the CHBRP resource *Health Insurance Benefit Mandates in California State Law* lists state and federal benefit mandate laws applicable to health insurance in California. It is available at: www.chbrp.org/other_publications/index.php.
[15] California has a bifurcated system of regulation for health insurance. DMHC regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers, which offer benefit coverage to their enrollees through health insurance policies.
[16] See the CHBRP resource, *Estimates of Sources of Health Insurance*. Available at: http://chbrp.org/other_publications/index.php
[17] 42 U.S.C. § 18031

marketplace are called qualified health plans (QHPs). QHPs sold through Covered California, California's insurance marketplace,[18] are regulated by DMHC or CDI, and thus are subject to the state's benefit mandates.

Federal Benefit Mandates

In addition to state benefit mandates, there are also federal benefit mandates, some of which interact with state benefit mandates and EHB coverage requirements (discussed below). Like state benefit mandates, federal benefit mandates generally apply to both the individual and group market, unless a market is specifically excluded. However, federal benefit mandates may also apply to Medicare or to self-insured plans, which are not subject to state benefit mandates. For more detailed information on current federal benefit mandates, see *Appendix A: Federal Benefit Mandates*, as well as CHBRP's resource *Federal Preventive Services Mandate and California Mandates* and *Health Insurance Benefit Mandates in California State Law*.[19]

Essential Health Benefits: Overview

Essential Health Benefits Defined: Federal Requirements and Guidance

The ACA requires the Secretary of the U.S. Health and Human Services (HHS) to define EHBs through regulation, but requires that at least some items and services within 10 specific categories of benefits be included.[20] See Exhibit 1 for the full list.

Exhibit 1: The 10 Essential Health Benefit Categories

1) Ambulatory patient services;
2) Emergency services;
3) Hospitalization;
4) Maternity and newborn care;
5) Mental health substance use disorder services, including behavioral health treatment;
6) Prescription drugs;
7) Rehabilitative and habilitative services and devices;
8) Laboratory services;
9) Preventive and wellness services and chronic disease management; and
10) Pediatric services, including oral and vision care.

When defining EHBs within the 10 EHB categories, the Secretary of HHS must ensure that the EHB floor "is equal to the scope of benefits provided under a typical employer plan."[21] The Secretary of HHS is required to take into account: the need for balance between the 10 ACA-specified EHB categories; the needs of diverse segments of the population; and the need to not discriminate against individuals because of age, disability, or expected length of life.

For plan years 2014 through 2019, EHBs for nongrandfathered plans and policies in the small-group and individual markets were defined in a manner that allows for state flexibility.[22] States selected from four benchmark plan options that reflect the scope of services offered by a typical employer plan and then supplemented it to ensure it includes all 10 EHB categories and met the other ACA requirements (e.g., balance between the 10 EHB categories, nondiscrimination). A health plan or policy is required to offer benefits that are "substantially equal" to the benefits of the selected benchmark plan. Plans or policies can substitute coverage within a benefit category, with the exception of the prescription

[18] The California Health Benefits Exchange, Covered California, Authorizing Statute is available here: http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.html and here: http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html
[19] Available at: www.chbrp.org/other_publications/index.php.
[20] 42 U.S.C. §18022(b).
[21] 42 U.S.C. §18021(b)(2)(A).
[22] Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. *Federal Register*, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accessed August 27, 2019.

drug benefits category, so long as they do not reduce the value of coverage; the substituted benefits must be actuarially equivalent to the benefits being replaced. States can enforce stricter requirements on benefit substitution or prohibit it entirely.[23]

The rest of this section discusses initial choices defining EHBs. Further regulation that allows modification of the EHB benchmark plan for later plan years is discussed in a later section of this document.

Exhibit 2. Choosing the Initial "EHB-Benchmark Plan" for Plan Year 2014

To begin to define EHBs, states selected a benchmark plan sold in 2012 from one of several options that reflected the scope of services offered by a typical employer plan.

- The largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employee Health Benefits Plan (FEHBP) options by enrollment; or
- The largest insured commercial non-Medicaid HMO operating in the state.

If a state did not select a benchmark plan, the default benchmark plan was the largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market. Enrollment for selection of a benchmark plan was based on the first quarter of calendar year 2012. The benchmark plan selected by a state, or the federal government for a state, is known as the "base-benchmark plan." The initial base-benchmark plan chosen in 45 states and the District of Columbia is the largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market. (a)

As needed, the base-benchmark plan must be supplemented to ensure it includes all 10 EHB categories. If a base-benchmark plan does not provide services within a specific EHB category, it has to be supplemented "by adding that particular category in its entirety from another base-benchmark plan option." Further, the base-benchmark plan must be assessed to ensure it has a balance between the 10 EHB categories and meets the standards for nondiscrimination, as required by the ACA. The resulting supplemented package is known as the "EHB-benchmark plan."

Notes: (a) Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accessed August 28, 2019.

Health Insurance Subject to the Essential Health Benefits Coverage Requirement

As of January 1, 2014, the ACA required most health insurance products in individual and small-group markets to cover EHBs.[24] The ACA requires coverage of EHBs for almost all enrollees in the individual and small-group markets, both inside and outside Covered California (Table 1).[25] Inside Covered California, all QHPs are required to provide coverage of EHBs,[26] while outside Covered California, nongrandfathered plans and policies in the individual and small-group market are required to cover EHBs.[27] Large group, self-insured and grandfathered plans and policies are exempt from the EHB

[23] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[24] 42 U.S.C. §300gg-6.
[25] 42 U.S.C. §18022.
[26] 42 U.S.C. §18021.
[27] 42 U.S.C. §300gg-6.

requirements.[28] For 2022, CHBRP estimated that 10.8% of Californians are enrolled in commercial health insurance that must cover EHBs.[29] Medi-Cal, California's Medicaid program, is also required by the ACA to cover a set of benefits referred to as EHBs, but, as discussed in Appendix B, Medi-Cal EHBs are separate from and function independently from the EHBs commercial health insurance is required to cover.

Exhibit 3. Additional Guidance on the Initial "EHB-Benchmark Plan"

For defining and meeting the requirements for the EHB-benchmark plan for the 10 EHB categories, HHS provided the following additional guidance:

- **Pediatric services, including oral and vision care:** HHS defined pediatric care as up to age 19, but allowed state flexibility to extend pediatric coverage beyond this age limit. In regards to the benefits covered, HHS found that pediatric oral and vision services were generally not covered in the benchmark plan options. Therefore, HHS guidance identified two options states could use to supplement their base-benchmark plan to meet this coverage requirement: (1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) plan with the largest enrollment; or (2) the state's separate Children's Health Insurance Program (CHIP). (a)
- **Habilitative services:** Habilitative services was another area HHS found was not covered as a distinct group of services by insurers. If the base-benchmark plan needed to be supplemented to meet the habilitative services EHB coverage requirement, HHS guidance allowed for one of the following to define habilitative services: (1) states could define the benefits that should be included in this category; or (2) if a state does not define habilitative services, a health insurance issuer must either provide coverage for habilitative services in parity with rehabilitative services or decide what habilitative services to cover.
- **Mental health and substance use disorder services:** Coverage within this EHB category must meet the Mental Health Parity and Addiction Equity Act (MHPAEA), which previously did not apply to the individual market and small group market in California. (b)
- **Preventive and wellness services:** The ACA requires nongrandfathered group and individual market plans and policies to cover certain preventative services without cost sharing. (c) The guidance on EHBs requires coverage of these services to be included to meet the definition of EHBs.

Notes: (a) For more detail, CHBRP has a Policy Brief focused on pediatric oral and vision care component of EHBs, available here: www.chbrp.org/other_publications/index.php.
(b) The MHPAEA previously only applied to group plans and policies with more than 50 employees (www.dol.gov/ebsa/newsroom/fsmhpaea.html). California defines the small group as 50 or fewer employees.
(c) ACA Section 1001, modifying Section 2713 of the Public Health Service Act. CHBRP has a Resource looking at the preventive services coverage requirement in the ACA, available here: www.chbrp.org/other_publications/index.php. Also, see Appendix A: Federal Benefit Mandates.

[28] A grandfathered health plan is defined as: "A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers" (www.healthcare.gov/glossary/grandfathered-health-plan/).
[29] See CHBRP's resource, *Estimates of Sources of Health Insurance in California*, available at: https://chbrp.org/other_publications/index.php

Table 1. Required Coverage of Essential Health Benefits (EHBs) in California for Privately Purchased Health Insurance

	Inside Covered California	Outside Covered California
Individual Market		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes
Small-Group Market(b)		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes

Notes: (a) Qualified health plans cannot be grandfathered plans or policies, therefore there are not grandfathered plans or policies sold through Covered California.
(b) Large-group market plans and policies are not currently offered through Covered California. Per 42 U.S.C. §18042, states had the option starting in 2017 to include the large-group market in the state's marketplace, but California did not chose to do so.

Essential Health Benefits Defined: California

The base-benchmark plan California selected for 2014 (Kaiser Foundation Health Plan Small Group HMO 30 plan) was the largest plan by enrollment in one of the three largest small-group insurance products in the state's small-group market.[30] California chose to supplement this plan with the pediatric oral benefit from its separate CHIP program,[31] and the pediatric vision benefits from the FEDVIP plan.[32] If the selected benchmark plan did not include habilitative services, states or insurers must supplement the benchmark plan to cover this EHB category. California chose to define habilitative services[33] and required that these services be provided "under the same terms and conditions applied to rehabilitative services."[34]

In addition, the Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.[35]

[30] California Health & Safety Code 1367.005 and Insurance Code 10112.27.
[31] In 2014, California completed transitioning enrollees in Healthy Families, its Separate Children's Health Insurance Program (CHIP) program, into Medi-Cal, becoming a Medi-Cal Expansion CHIP program. The EHB pediatric oral benefits are based on the benefits covered in the Healthy Families Program in 2011–2012, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. (H&SC Section 1367.005; IC Section 10112.27)
[32] H&SC Section 1367.005; IC Section 10112.27.
[33] California defined habilitative services as: "Habilitative services means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment." (H&SC Section 1367.005; IC Section 10112.27)
[34] California Health & Safety Code 1367.005 and Insurance Code 10112.27.
[35] Starting in 2014, CDI-regulated policies subject to the EHB coverage requirement—nongrandfathered small-group and individual market policies—are required to cover basic health care services.

Exhibit 4. California's EHB Benchmark Plan, Plan Years 2014-2019

In plan years 2014, 2015 and 2016, the EHB benchmark plan was a plan that was sold in 2012, while in plan years 2017, 2018 and 2019, the benchmark EHB plan was a plan that was sold in 2014. California chose the Kaiser Foundation Health Plan Small Group HMO 30 HMO, the largest plan by enrollment of the three largest small-group plans. This plan did not include the full scope of pediatric benefits, so California selected the pediatric oral benefit from the state CHIP plan and the pediatric vision benefit from the FEDVIP plan. (a)

The EHB benchmark plan options for later years are discussed in a later section of this document.

Notes: (a) Details can be found here: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf and here: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_CA.zip .

State Benefit Mandates That Exceed Essential Health Benefits

The ACA allows a state to require health plans and policies subject to EHBs to cover additional benefits.[36] If the state does so, the state must make payments to defray the cost of the additionally mandated benefits, either by paying the enrollee directly or by paying the QHP. However, application of this requirement can vary. First off, this requirement is not applicable to health plans and policies sold outside of Covered California. In addition, state benefit mandates enacted by December 31, 2011 are considered part of the state's EHBs, and so the requirement to defray is not applicable for those mandates. State benefit mandates enacted after December 31, 2011 that meet the federal definition of a state benefit mandate would be subject to the requirement that a state defray the costs for enrollees in QHPs (plans and policies sold through Covered California). The federal definition of a state benefit mandate that can exceed EHBs is "specific to the care, treatment, and services that a state requires issuers to offer to its enrollees."[37] State rules around service delivery method (e.g., telemedicine), provider types, cost sharing, or reimbursement methods are not considered state benefit mandates that would trigger the requirement for the state to defray the costs even though plans and policies in a state must comply with these requirements.

Exhibit 5. Key Points: State Benefit Mandates That Would Exceed Essential Health Benefits

- Enacted after December 31, 2011;
- Apply to the nongrandfathered small-group and individual markets inside a state's health insurance marketplace; and
- Are specific to care, treatment, and services.

For California, it is unclear which entity or person would be responsible for this determination. Federal guidance established the "State" as the entity that would identify when a state benefit mandate exceeds EHBs, however the state entity would be subject to federal oversight.[38] There are no federal guidelines that specifically designate this responsibility. Additionally, California has not officially determined who or which agency would be the responsible party for determining whether a benefit exceeds EHBs. For mandates that do exceed, federal guidance established QHPs as the responsible entity for calculating the

[36] 42 U.S.C. §18031(d)(3)(B).
[37] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[38] Frequently Asked Questions on Defrayal of State Additional Required Benefits. *Centers for Medicare and Medicaid Services*. October 23, 2018. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.

marginal cost that must be defrayed. However, federal guidance left state flexibility in how this would be calculated; it could be based on "either a statewide average or each QHP issuer's actual cost."[39]

As of this time, CHBRP is unaware of any state with a state benefit mandate that have been determined to exceed EHBs.

As this brief will discuss further in a later section, states now have additional flexibility with regard to EHB benchmark plan options. Despite the increased flexibility, the election of alternative EHB benchmark plans will not alleviate a state of defrayal requirements for state benefit mandates that exceed EHBs. Benefits mandated via state legislative or regulatory action after December 31, 2011 will continue to require defrayal if they are included in a new EHB benchmark plan. However, if a new EHB benchmark plan includes additional benefits beyond a previous EHB benchmark plan, these additional benefits would not require defrayal unless the benefits were mandated via state legislative or regulatory action after December 31, 2011. [40]

How a state benefit mandate could exceed essential health benefits in California

For a state benefit mandate to exceed the definition of EHBs in California, thus triggering the requirement that the state defray the costs, the following must be true:

- The state benefit mandate would apply to QHPs sold through Covered California;
- The state benefit mandate is not covered in the Kaiser Foundation Health Plan Small Group HMO 30 plan that defines the EHB benchmark package in California;
- The state benefit mandate is not covered under basic health care services, as required by the Knox-Keene Health Care Service Plan Act of 1975; and
- The state benefit mandate is specific to care, treatment, and/or services, thus meeting the definition of a benefit mandate that would exceed EHBs.[41]

Inclusion of whether a bill exceeds EHBs in CHBRP Reports

The Legislature has requested CHBRP include whether a bill is likely to exceed EHBs within each CHBRP report. Because federal and state regulations are unclear as to who would make the final determination, CHBRP queries both state regulators (DMHC and CDI) and reports their conclusions. CHBRP also examines the EHB benchmark plan, but because not all benefits are explicitly defined in the Explanation of Benefits or Scope of Benefits, CHBRP relies heavily on the regulators.

Since 2013, California enacted multiple health insurance benefit mandates, none of which appears to exceed EHBs.

However, multiple bills have been introduced that, if passed, could have exceed EHBs. Exhibit 6 notes one example of such a bill.

[39] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[40] Frequently Asked Questions on Defrayal of State Additional Required Benefits. *Centers for Medicare and Medicaid Services*. October 23, 2018. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.
[41] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

Exhibit 6. A California Bill with Potential to Exceed Essential Health Benefits

In 2019, CHBRP analyzed Assembly Bill 767 (Wicks), which would have required DMHC-regulated plans and CDI-regulated policies in the large and small group markets to cover infertility treatments (including in vitro fertilization) and mature oocyte cryopreservation. As analyzed by CHBRP, AB 767 likely would have exceeded EHBs because infertility treatment and mature oocyte cyropreservation:

- Are not included in the Kaiser Foundation Health Plan Small Group HMO 30 plan;
- Are not required coverage under (state) basic health care services; and
- Meet the federal definition of a state benefit mandate that would exceed EHBs.

CHBRP estimated the marginal change in the per member per month (PMPM) premium that would result from AB 767 and that the state would be responsible for defraying for each enrollee in a small-group QHP in Covered California would have been $3.72. For further information, see CHBRP's 2019 report on AB 767 available here: www.chbrp.org/completed_analyses/index.php.

Essential Health Benefits and Cost Sharing

Annual out-of-pocket maximums

The ACA places an annual limitation, or annual out-of-pocket maximum, on plans and policies required to provide coverage for EHBs.[42] The annual out-of-pocket maximum for 2020, as set by the federal government, is $8,150 for self-only coverage or $16,300 for family coverage, and includes deductibles, copayments, and other forms of cost sharing but does not include the cost of premiums.[43,44] In California, the annual out-of-pocket maximum may be lower depending on an enrollee's income and on the metal coverage level or the plan or policy.[45] Important to note is that the ACA allows the pediatric dental benefit to be covered either through a stand-alone dental insurance carrier or through an enrollee's health insurance carrier.[46] Further guidance from HHS has allowed stand-alone pediatric dental insurance to have a separate annual limit from the annual limit for health insurance.[47,48]

The ACA also requires that "group health plans" adhere to this annual out-of-pocket maximum.[49] Although no large-group market plans or policies are not subject to EHB coverage requirements in California at this time, federal guidance has clarified that the annual out-of-pocket maximum applies to the large group.[50] In California, statute also requires nongrandfathered large group plans and policies that cover EHBs to maintain an annual out-of-pocket maximum that only applies to EHBs.[51]

[42] 42 U.S.C. §18022(c) references Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, which defines maximum annual out-of-pocket expenses for high deductible health plans (HDHPs). The dollar values provided here are the limits set by the Department of Health and Human Services for 2020.
[43] Available at: https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.
[44] [42 U.S.C. §18022 (c)]
[45] More information is available at: www.healthexchange.ca.gov/Pages/Default.aspx.
[46] 42 U.S.C. §18022 (d)(2)(B)(ii).
[47] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[48] For more information on the EHB pediatric oral and vision coverage requirement, standalone dental plans, and the annual limit requirements for these plans, see CHBRP's Policy Brief on this issue, available here: www.chbrp.org/other_publications/index.php.
[49] 42 U.S.C. §300gg-6.
[50] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[51] California Health & Safety Code 1367.006(2) and Insurance Code 10112.28(2).

Deductibles

While the ACA initially included limits on the deductible for plans offered through the small group market, a law signed in 2014 removed these limits.

Changes in Essential Health Benefits Regulation

HHS issued a *Notice of Benefit and Payment Parameters* final rule on April 9, 2018, which contained a number of changes and updates, including some pertaining to EHB benchmark plan selection.[52] This final rule marked the first substantial changes within the EHB realm since the enabling rules were promulgated earlier in the decade. This rule provided for new flexibility for states by allowing three new options for selecting an EHB base-benchmark plan, in addition to the option of retaining the current EHB benchmark plan, beginning with the 2020 plan year. These new options maintain a minimum scope of benefits standard and established a generosity ceiling to limit the range and cost of benefits that could be considered. This section discusses the related changes and how California could access them to alter its definition of EHBs.

Essential Health Benefits: Scope of Benefits

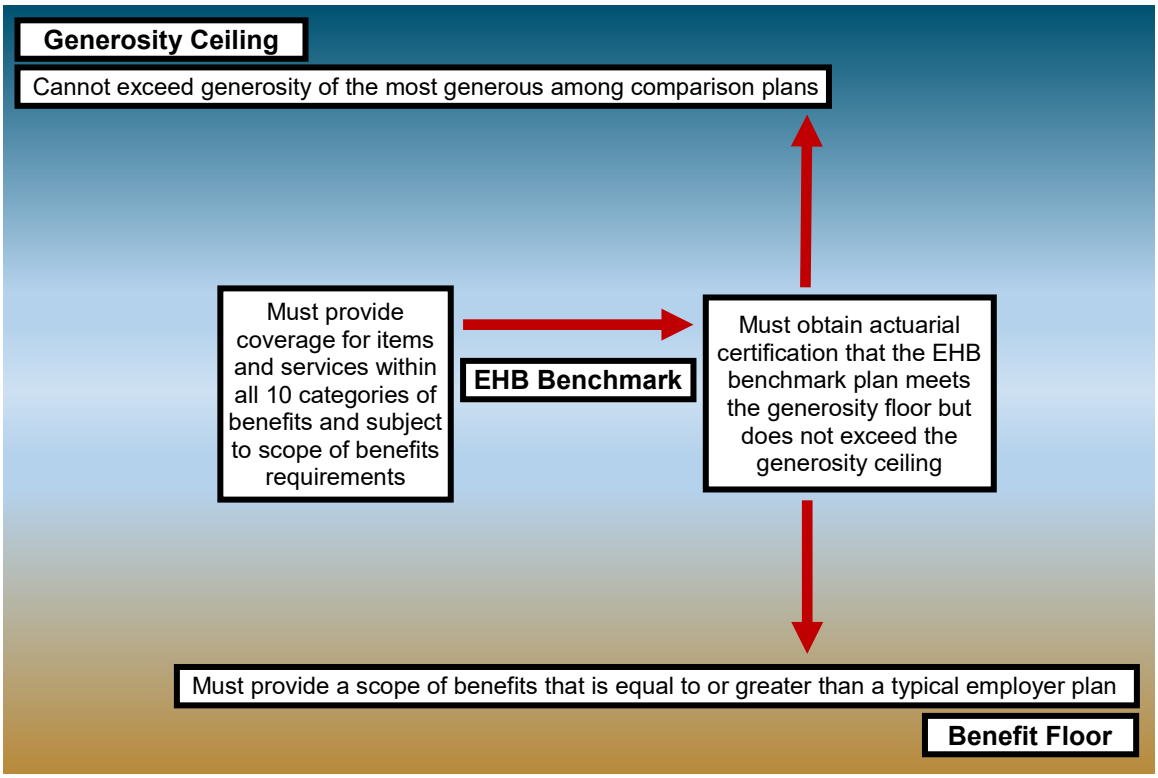
Regardless of the option chosen by a state, the EHB benchmark plan must still provide coverage for items and services within all 10 categories of benefits.[53] The EHB benchmark plan is also subject to the scope of benefits requirements that provide both a floor and ceiling. The five scope of benefits requirements include:

1) Scope of benefits equal to or greater than the scope of benefits provided under a typical employer plan, which is defined as either:
   a) One of the state's 10 benchmark plan options described previously, as sold in 2017
   b) The largest health insurance plan by enrollment within one of the five largest group health insurance products in the state, provided that: (1) the product has at least 10% of the total enrollment of the 5 largest large group health insurance products in the state, (2) the plan provides a minimum value of 60% of total allowed cost of benefits, (3) the benefits are not excepted benefits (such as workers' compensation, disability income, liability and travel insurances) and (4) the benefits are from a plan year beginning in 2014 or later
2) Cannot exceed the generosity of the most generous among a set of comparison plans, including:
   a) The state's EHB benchmark plan utilized for the 2017 plan year
   b) Any of the state's benchmark plan options for the 2017 plan year
3) Cannot have benefits unduly weighted towards any of the 10 categories of benefits
4) Must provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups
5) Cannot include discriminatory benefit designs that violate the non-discrimination standards (age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions)

[52] 83 FR 16930
[53] As explained previously and in 45 CFR § 156.110(a), these include (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services and devices, (8) Laboratory services, (9) Preventive and wellness services and chronic disease management and (10) Pediatric services, including oral and vision care.

While a state will confirm in writing that a selected EHB benchmark plan option fulfills the above scope of benefits requirements, the state also must obtain actuarial certification that the EHB benchmark plan meets the generosity floor but does not exceed the generosity ceiling. The certified actuarial report must affirm that the EHB benchmark plan provides a scope of benefits equal to or greater than the typical employee plan (described in item 1 above) without exceeding the generosity of the most generous among the plans listed in item 2 above (Figure A).

Figure A. Essential Health Benefits Benchmark Scope of Benefits Requirements



Though the new EHB benchmark plan options provide a means for states to add additional services or treatments to EHB categories, there are important limitations in the rules. The chosen EHB benchmark plan must provide a scope of benefits that is equal to or greater than a typical employer plan, as explained above.[54] In addition to meeting this benefit floor, the EHB benchmark plan cannot exceed a generosity ceiling, as shown in Figure A.

In addition to submitting required documents to HHS, states proposing to use a new EHB benchmark plan were required to provide public notice and an opportunity for public comment on the potential EHB benchmark plan change.

HHS issued a subsequent Notice of Benefit and Payment Parameters final rule on April 25, 2019.[55] Unlike the final rule issued in 2018, 2019's final rule did not lead to any changes in EHB benchmark plan selection. Instead, this rule maintained the previous changes and issued a deadline of May 6, 2019 for states to submit a new EHB benchmark plan for the 2021 plan year. In the April 25, 2019 *Notice of Benefit and Payment Parameters* final rule,[56] HHS issued a deadline of May 8, 2020 for states to submit a new EHB benchmark plan for the 2022 plan year.

[54] 45 CFR 156.111(a)
[55] 84 FR 17454
[56] 84 FR 17454

The 2019 final rule continues to allow states to select from the three EHB benchmark plan option alternatives, in addition to the option of maintaining the same EHB benchmark plan from plan years 2017-2019.[57]

The final rule emphasized the statutory prohibition on EHB discrimination contained in 45 CFR 156.125, which is also summarized in item 5 of *Essential Health Benefits: Scope of Benefits*. This means that any reduction in the generosity of an EHB for subsets of individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory and is thus prohibited.[58] The final rule explained this by discussing the example of an EHB plan inappropriately excluding a particular treatment for an opioid use disorder when the same treatment is covered for other medically necessary purposes. This example and other mentions of the opioid use disorder demonstrate that HHS is particularly concerned by continued discrimination with regard to treatment of this specific disorder. Noting that not all QHPs cover all forms of Medication-Assisted Treatment (MAT) for opioid use disorder, HHS encourages "…every health insurance plan to provide comprehensive coverage of MAT, even if the applicable EHB-benchmark plan does not require the inclusion of all four MAT drugs…"[59]
If a state does not make an active EHB selection by May 8, 2020, the state's EHB benchmark plan for the applicable year will be the state's EHB benchmark plan from the prior year.[60]

A number of states have used the new flexibility and have secured approval from HHS to alter their EHBs.[61] For Illinois, changes were approved for 2020 plan year. For South Dakota changes were approved for the 2021 plan year. For three states, Michigan, New Mexico, and Oregon, changes were approved for the 2022 plan year. For Colorado, changes were approved for the 2023 plan year.

The details of the changes varied. For example, as discussed in Exhibit 7, South Dakota chose to enhance their existing EHB benchmark plan starting in 2021 by adding Applied Behavior Analysis Habilitative Services for enrollees with Autism Spectrum Disorder. As required by statute, South Dakota commissioned an actuarial analysis of this additional benefit in the context of the new generosity test.[62] The actuarial analysis revealed that this new benefit would increase the relative EHB benefit value by 0.3% annually, however several comparison benchmark EHB benchmark plans also had +0.3% relative benefit value, as compared to the existing EHB benchmark plan. As such, this actuarial analysis determined that the additional EHB benefit would not exceed the most generous comparison plan, thus satisfying the generosity test.

[57] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on December 16, 2019 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb
[58] Ibid.
[59] ibid
[60] 45 CFR 156.111
[61] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on January 3, 2022 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb
[62] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SD-Plan-Documents.zip

Exhibit 7. Examples of Essential Health Benefit Changes

Two states submitted a request to change their EHB benchmark plan in 2020 and/or 2021, both of which were approved by HHS. Both utilized the option of "selecting a set of benefits that would become the state's EHB benchmark plan." Using this option, both states maintained their current EHB benchmark plan while supplementing their EHBs with an additional set of benefits.

- **Illinois: 2020-2021**(a): Within the prescription drug category and mental health substance use disorder services category, instituted a new Access to Care and Treatment (ACT) Plan to reduce opioid addiction and expand access to mental health services:
  - Cover alternative therapies for pain like topic anti-inflammatories
  - Limit opioid prescriptions for acute pain to 7 days maximum
  - Remove barriers to obtaining Buprenorphine products for medically assisted treatment (MAT) of opioid use disorder
  - Cover prescriptions for naloxone when high opioid doses are prescribed
  - Cover tele-psychiatry care by both a prescriber and a licensed therapist
- **South Dakota 2021**: Within the "Habilitation Services" category of the 10 EHB categories:
  - Treatment for Autism Spectrum Disorder with Applied Behavioral Analysis (ABA) is covered with the following limits: up to 1300 hours/year through age 6, up to 900 hours/year for ages 7-13, up to 450 hours/year for ages 14-18

Notes: (a) https://www2.illinois.gov/IISNews/18098-DOI_Essential_Health_Benefit-benchmark_plan_Release.pdf
(b) https://dlr.sd.gov/insurance/documents/SD_proposed_EHB_benchmark_summary_04292019.pdf

Potential Changes for Essential Health Benefits: California Options

For California, as no new EHB benchmark plan was submitted, the Kaiser Foundation Health Plan Small Group HMO 30 plan continues to serve as the state's EHB benchmark plan.

In the future, California could choose to utilize one of the original options, outlined in Exhibit 2, or select one of the new options, described above, to alter its EHB benchmark plan. By selecting some or all categories from another state's EHB benchmark plan, California could include new services not currently in the California benchmark plan. For example, CHBRP is aware of three specific benefits that are covered by many other state EHB benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan:

- **Chiropractic care** services are not currently covered in California's EHB benchmark plan. Among the 50 state and District of Columbia EHB benchmark plans for the 2019 plan year, 46 of these 51 plans covered chiropractic care services to some extent.[63] Many of these plans incorporated utilization management, such as referrals, prior authorizations or annual visit maximums (i.e. 10 or 25 chiropractic visits per year) to limit the benefit. Chiropractic care services are typically included under the Rehabilitative and Habilitative Services category of EHBs.

- **Hearing aids**, aside from cochlear implants, are not currently covered in California's EHB benchmark plan. As of the 2019 plan year, 25 states and the District of Columbia include hearing

[63] As the 2017 EHB benchmark plan remained for years 2018 and 2019, this analysis of 2017 EHB benchmark plan covered benefits is still accurate for the 2019 plan year: https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf

aids in their current EHB benchmark plan.[64] Nearly all of these plans include age limits, typically covering hearing aids only among enrollees under age 18 or 21. While all of these 25 state plans and the District of Columbia's cover removable hearing aids, several other plans only cover bone-anchored hearing aids. Hearing aids are included under the Rehabilitative and Habilitative Services category of EHBs.

- **Infertility services and treatments**, including in-vitro fertilization (IVF), are not currently covered in California's EHB benchmark plan. As of the 2019 plan year, 25 states and the District of Columbia include some level of infertility services in their current benchmark plan.[65] However, the covered infertility services are almost always limited to diagnostic services and a select few infertility treatment medications. Only a few states, such as Connecticut, Hawaii and Illinois, are known to cover IVF. Among the states that cover IVF, enrollees are limited in the number of covered IVF cycles, often two cycles. When covered, infertility services and treatments are typically incorporated among one or more EHB categories, including Ambulatory Patient Services, Prescription Drugs and Maternity and Newborn Care.

Should California desire to include any of these above benefits, the state could select another state's EHB benchmark plan in whole or in part. California could replace its plan entirely with another state's plan or only replace one category, such as Rehabilitative and Habilitative Services. California could also choose the option of "selecting a set of benefits that would become the State's EHB-benchmark plan,"[66] as Illinois and South Dakota did to alter their EHB benchmark plans.

Conclusion

HHS's recent regulations provide options for states to modify or select a new EHB benchmark plan. Though the regulations allow for considerable flexibility, HHS maintains a minimum scope of benefits floor as well as a Generosity Test ceiling. Within these confines, California could use one of the three new EHB benchmark plan options to supplement the set of benefits that make up its EHBs. Other states have already done so and so California can look to those states experiences as it decides whether to change its EHB benchmark plan.

[64] ibid
[65] ibid
[66] 45 CFR 156.111(a)

APPENDIX A FEDERAL BENEFIT MANDATES

Federal benefit mandates, like state benefit mandates, may apply to both the individual and group markets. However, federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. There were federal benefit mandates in place prior to the passage of the ACA, and the ACA added federal benefit mandates that apply to many, but not all, DMHC-regulated plans and CDI-regulated policies in the individual and group markets in California. CHBRP's document *Health Insurance Benefit Mandates in California State and Federal Law*[67] lists the federal benefit mandates currently known to CHBRP.

Federal Benefit Mandates Prior to the Affordable Care Act

CHBRP is aware of four federal benefit mandates that were in effect prior to the ACA:[68]

- The Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act (Pregnancy Discrimination Act);
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act);
- The Women's Health and Cancer Rights Act (WHCRA) of 1998; and
- The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

The first three apply to the group market[69] while the fourth applies to the group and individual markets. Also, the mandates may apply only *if* coverage for the service or treatment is part of the health plan or policy. For example, the Newborns' Act does not require that a group plan or policy cover maternity, but, if maternity is covered, coverage for a minimum length of stay in a hospital following childbirth is required.

Federal Benefit Mandates in the Affordable Care Act

The passage of the ACA added additional federal benefit mandates to products in the individual and group market, with the exception in some cases of grandfathered health plans and policies.[70] These new federal benefit mandates include:

- Prohibitions on lifetime and annual limits on the dollar value of benefits for any individual.[71]
- Where emergency services are provided, requirements that the services are provided: regardless of whether the provider is in or out of network; with the same cost-sharing levels in network as out of network; and without prior authorization.[72]
- Prohibition on requiring prior authorization or referral before covering services from a health care professional who specializes in obstetrics or gynecology.[73]
- Prohibition on denying coverage for children with preexisting conditions.
- Prohibition on denying coverage to anyone with a preexisting condition.[74]

[67] The resource is available at: www.chbrp.org/other_publications/index.php.
[68] There may be other federal benefit mandates that are not included in this list. The federal health insurance benefit mandates discussed in this Issue Brief most closely align with the definition of benefit mandates in CHBRP's authorizing statute.
[69] How the group market is defined for federal benefit mandates does not always align with how the group market is defined for state benefit mandates. For example, the Newborns' Act applies to group plans with 15 or more people.
[70] Some of the new federal benefit mandates in the ACA do not apply to grandfathered health plans (ACA Section 1251).
[71] ACA Section 1001 modifying Section 2711 of the PHSA.
[72] ACA Section 1001 modifying Section 2719A of the PHSA.
[73] Ibid.
[74] ACA Section 1201 modifying Section 2704 of the PHSA.

- Requirements for coverage of specified preventive health services without cost sharing, including:[75,76]
  - Evidence-based items or services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF)[77];
  - Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[78];
  - Infants, children, and adolescents of evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);[79] and
  - Preventive care and screenings for women provided for in comprehensive guidelines supported by HRSA.[80]

In addition to these new federal benefit mandates in the ACA, the ACA also expands the Mental Health Parity and Addiction Equity Act by applying it to QHPs offered through state marketplaces, like Covered California, "in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."[81] The ACA further expands MHPAEA to include the individual market and the small-group market, which were previously excluded from this parity requirement.[82]

The Interaction of Federal and State Benefit Mandates

Just as state benefit mandates vary and may overlap with each other, federal benefit mandates and state benefit mandates also vary and may overlap across products and markets, as well as the conditions and disorders addressed by the benefit mandates. For example, the federal Newborns' Act requiring a minimum length of stay in a hospital following childbirth, if maternity services are covered, is very similar to a California state benefit mandate.[83] Both the federal and state benefit mandates affect group DMHC-regulated plans and CDI-regulated policies, however, the state benefit mandate affects individual-market DMHC-regulated plans and CDI-regulated policies, whereas the federal benefit mandate does not. It is important to note that plans and policies subject to both state and federal benefit mandates must meet or exceed the more demanding benefit mandate, whether that is the state benefit mandate or the federal benefit mandate.

[75] ACA Section 1001 modifying Section 2713 of the PHSA.
[76] CHBRP has a Resource looking at the preventive services coverage requirement in the ACA, available at: www.chbrp.org/other_publications/index.php.
[77] A list of the USPSTF A and B recommendations is available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ .
[78] A list of the immunizations recommended by the ACIP is available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
[79] Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts: the periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at http://https://www.aap.org/en-us/documents/periodicity_schedule.pdf, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at: https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/rusp-uniform-screening-panel.pdf.
[80] A list of the guidelines supported by HRSA for women's preventive care and screening is available at: https://www.hrsa.gov/womens-guidelines/index.html.
[81] ACA Section 1311(j).
[82] ACA Section 1563(c)(4) modifying Section 2726 of the PHSA.
[83] California Health and Safety Code 1367.62 and Insurance Code 10123.87

APPENDIX B MEDICAID AND ESSENTIAL HEALTH BENEFITS

Since 2006, states have had the option to identify Medicaid benchmark plans for certain groups of enrollees under section 1937 of the Social Security Act.[84] The ACA renamed Section 1937 Medicaid benchmark or benchmark-equivalent plans "Alternative Benefit Plans" (ABPs), and specified that they must cover the 10 Essential Health Benefits (as defined in section 1302 of the ACA) to which some commercial health insurance, as specified earlier in this brief, is subject.[85] Adults in the Medicaid Expansion population (i.e. persons eligible under the "modified adjusted gross income standard") must be covered under ABPs, and states may use an ABP for coverage of any other groups of individuals eligible for Medicaid, which is called Medi-Cal in California.[86]

Section 1937 of the Social Security Act provides the following options for selection of ABPs:[87]

- The benefit package provided by the Federal Employees Health Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option;
- State employee health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- (Federal Health and Human Services) Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage.

The benefits included in California's ABP (currently Blue Cross Blue Shield/CareFirst Preferred Option 1) are the same benefits as full-scope Medi-Cal benefits, discussed in Attachment 3.1-A and 3.1-B of California's State Plan.[88]

If state or federal law adds or changes a benefit, Medi-Cal would either need to cover the benefit or list an actuarially equivalent benefit.[89] In that case, the Department of Health Care Services would submit a State Plan Amendment to draw down federal funding for providing these services to beneficiaries.[90]

It is important to note that while Medi-Cal is also required to cover the 10 EHB categories, the specific benefits included in the chosen Medi-Cal benchmark plan may be different from the specific benefits included in the commercial benchmark plan because the EHB benchmark plan is different from the ABP in California.

[84] 42 U.S.C. §1396u-7.
[85] Like the State Plan, the ABP is a contract between the Department of Health Care Services and the Center for Medicare and Medicaid Services for Title XIX funding for Medicaid Services.
[86] Alternative Benefit Plan Final Rule. *Federal Register*, Vol. 78, No. 135. July 14, 2013. Available at: https://www.govinfo.gov/content/pkg/FR-2013-07-15/pdf/2013-16271.pdf.
[87] 42 U.S.C. §1396u-7, as described by the Alternative Benefit Plan Final Rule, cited above.
[88] California's state plan can be found online at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx. This is also consistent with WIC § 14132.02.
[89] As required by 42 U.S.C. §18022(d).
[90] Communication between CHBRP and the Department of Health Care Services. October 14, 2019.

ABOUT CHBRP

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

Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at http://www.chbrp.org/

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Adara Citron, MPH, Principal Policy Analyst
Sabrina Woll, Policy Associate
Karen Shore, **PhD,** Contractor*
An-Chi Tsou, PhD, Contractor*

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org
www.chbrp.org
(510) 664-5306

*Independent Contractor working with CHBRP to support analyses and other projects.

CHBRP is an independent program administered and housed by the University of California, Berkeley, in the Office of the Vice Chancellor for Research.

Acknowledgements

This issue brief was prepared by Jeffrey Rollman, MPH, PhD candidate, of the University of California, Los Angeles, and Adara Citron, MPH, of CHBRP staff. Ana Ashby, MPP, Garen Corbett, MS, and John Lewis, MPA, all of CHBRP staff and Dylan Roby, PhD, reviewed this issue brief for its accuracy, completeness, and clarity.

The 2022 update was prepared by John Lewis, MPA, of CHBRP staff.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

Garen Corbett, MS
Director

Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org

CHCF

The 2022 CHCF California Health Policy Survey

JANUARY 2022

AUTHORS
Rebecca Catterson, Lucy Rabinowitz, Emily Alvarez, NORC at the University of Chicago

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About the Authors

Rebecca Catterson, MPH, is a senior research director at NORC at the University of Chicago; Lucy Rabinowitz, MPH, is a research scientist at NORC; Emily Alvarez, MA, is a senior research scientist at NORC; and Karen Diep, MPH, is a senior research associate at NORC. NORC at the University of Chicago is a nonprofit public opinion research center.

About the Foundation

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

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

For more information, visit www.chcf.org.

About the Survey

The California Health Care Foundation / NORC Health Policy Survey was conducted September 27 through November 17, 2021, among a random representative sample of 1,681 adults age 18 or older living in California. Interviews were administered in English (n = 1,647) and Spanish (n = 34). For the purposes of the survey, Spanish speakers (n = 255) are defined as those who took the survey in Spanish (n = 34) or took the survey in English and reported that they spoke Spanish at home (n = 221). A multistage weighting design was applied to ensure accurate representation of the California adult population. Additional detail on survey methodology is available in Appendix A.

Where comparisons are made by income groups, “people with lower incomes” refers to those with household incomes below 200% of the federal poverty level (e.g., $42,440 for a family of three). “People with higher incomes” refers to those with household incomes at 200% or above the federal poverty level. Any result reported as “different from,” “more than,” or “less than” another result is a statistically significant difference at $p < .05$.

Introduction

California is home to a diverse population varying by income, age, region, and racial and ethnic background. Annually since 2019, the California Health Care Foundation has conducted a survey of residents’ views on a variety of health care topics, some of which are tracked over time to detect meaningful differences in public opinion.

The California Health Care Foundation and NORC at the University of Chicago, a nonpartisan research organization, conducted a representative statewide survey of California's residents in late 2021 to understand their views on health care policy, as well as their experiences with COVID-19 and the health care system overall. Results from this survey are reported and, where applicable, compared to the prior annual survey published in early 2021 to understand emerging trends.

Key findings from this year's survey include:

- Half of Californians (49%) have skipped or postponed some type of health care in the last 12 months due to cost. Among those who postponed care, 47% report that their condition worsened as a result, an increase from last year's survey (41%). More than 8 in 10 Californians say it is "extremely" or "very" important for the California governor and legislature to work on "making health care more affordable" in the coming year. It is the second most important priority to Californians.
- One in four Californians (25%) say they or someone in their family had problems paying at least one medical bill in the past 12 months, an increase from 20% in last year's survey. Forty-three percent of Californians with lower incomes report having issues paying for medical bills, an increase from 32% compared to last year.
- One in five Californians (19%) say they or someone close to them has experienced a period of homelessness in the past five years. The same proportion (19%) are "very" or "somewhat" worried about experiencing homelessness themselves. Californians also see a connection between affordable housing and health status, with 80% of Californians saying lack of affordable housing impacts the physical or mental health of people with low incomes "a lot" or "some."
- More Californians are receiving care via telehealth than last year. More than half (55%) report receiving care by phone in the last 12 months, an increase from 45% in last year's poll, and more than 4 in 10 (44%) by video, an increase from 35%. Californians are satisfied with the quality of health care they receive via telehealth, with more than 8 in 10 (83%) "very satisfied" or "satisfied" with their care by video, and a similar proportion (79%) "very satisfied" or "satisfied" with care by phone.
- Nearly 6 in 10 Californians (59%) believe that the health care system treats people unfairly based on their racial or ethnic background — a quarter (26%) "regularly" and a third (33%) "occasionally." Eighty-three percent of Black Californians expressed this belief, a significantly higher percentage than any other racial or ethnic group. In addition, Black and Latinx Californians were more likely than White or Asian Californians to report negative experiences by a doctor or other health care provider.

Section 1. Priorities for California State Government

As in previous years, the survey asks about Californians' priorities for the California governor and legislature to work on in the coming year. Addressing wildfires (included for the first time this year) topped the list, with 54% saying it is an "extremely important" priority. It is followed by making health care more affordable and improving public education, which both had 53% saying it is an "extremely important" priority. Just under half say making housing affordable (49%) and addressing homelessness (48%) is "extremely" important. More than 4 in 10 say addressing COVID-19 (46%), addressing climate change (43%), and attracting and retaining business and jobs (41%) is "extremely" important. Fewer say improving infrastructure (38%), addressing racial inequality (33%), and enforcing immigration laws (29%) is "extremely" important (Figure 1).

Taken together, more than half of Californians think each item is at least “very” important to address. Few see any item as not important at all.

In last year’s survey, addressing COVID-19 was the top priority for Californians. In this year’s poll the percentage of Californians who say that addressing COVID-19 is “extremely” or “very” important fell 17 percentage points from 63% to 46%, the largest decrease across all items. The only other item that saw a decrease in Californians who view it as “extremely” or “very” important was attracting and retaining business and jobs, which fell 5 percentage points from 87% in 2021 to 82% in 2022.

The item that saw the largest increase in Californians who view it as “extremely” or “very” important was making housing more affordable, which increased 9 percentage points from 71% last year to 80% this year. The percentage who say addressing climate change is “extremely” important increased 5 percentage points from 65% last year to 70% this year.

There were no year-over-year differences for the following: addressing racial inequality, addressing homelessness, and making health care more affordable.

Differences emerge by race and ethnicity, income level, and party identification.

Asian, Black, Latinx, and White Californians differ on their top issue of importance. For Asian Californians, making health care more affordable ranks as most important, with 86% saying it is “extremely” or “very” important. For Black Californians, 97% say making housing more affordable is “extremely” or “very” important. For Latinx Californians, 90% say improving public education is “extremely” or “very” important. For White Californians, 93% say addressing wildfires is “extremely” or “very” important (Figure 2).

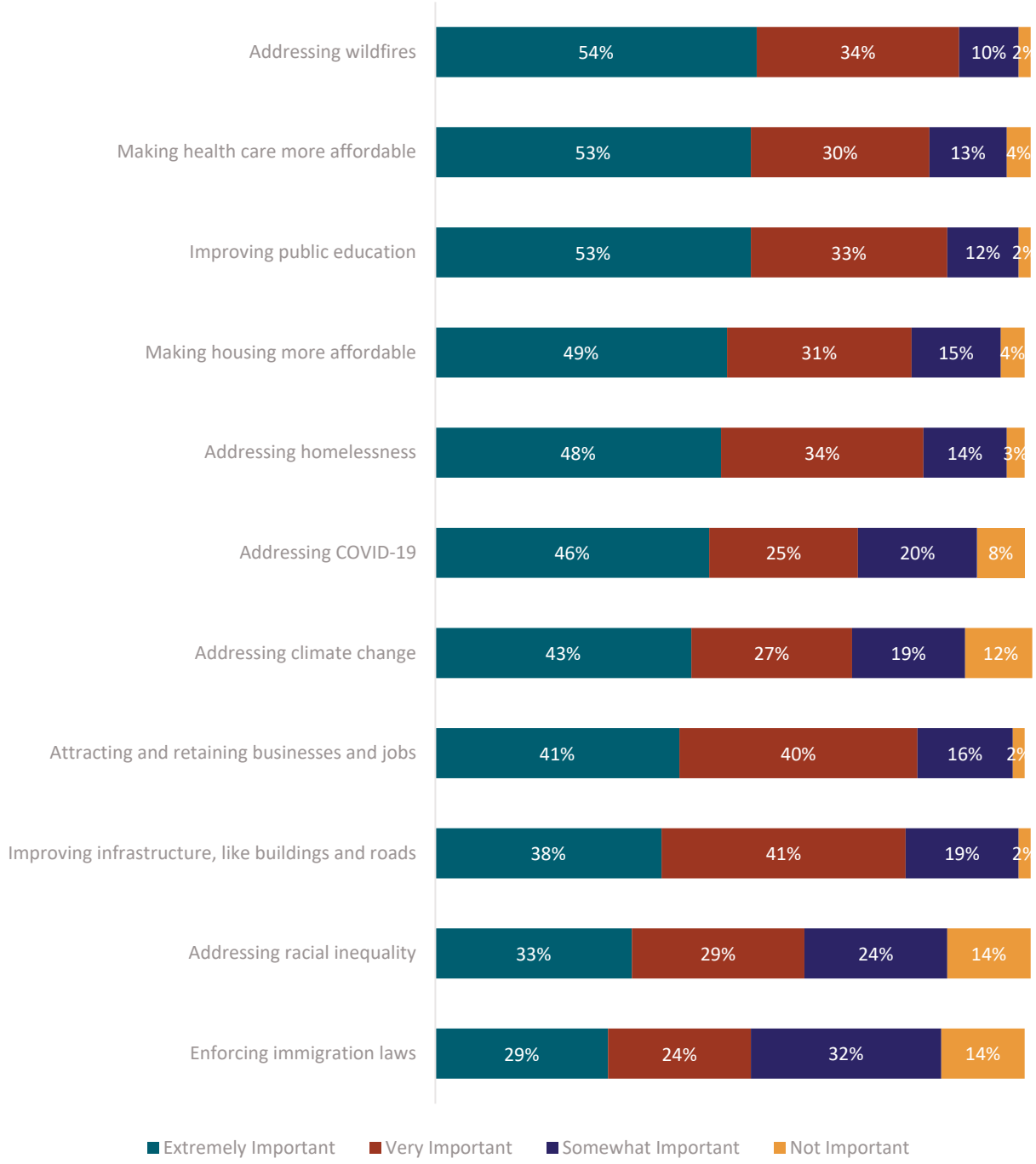
Racial and ethnic differences also emerge for each item. Ninety-five percent of Black Californians say addressing racial inequality is “extremely” or “very” important, more than the 66% of Latinx Californians, 61% of Asian Californians, and 53% of White Californians who responded the same. Other large gaps between Black Californians and others emerge on making housing more affordable, addressing climate change, improving public education, and addressing homelessness. On enforcing immigration laws, Latinx Californians (47%) are less likely than Black Californians (61%), Asian Californians (56%), and White Californians (56%) to say it is “extremely” or “very important” to address.

There are fewer differences by income level. Californians with incomes less than 200% of the federal poverty level are more likely than those with incomes of 200% or more of the federal poverty level to say addressing COVID-19 (75% vs. 70%), making health care more affordable (89% vs. 80%), making housing more affordable (89% vs. 77%) and addressing racial inequality (67% vs. 60%) are “extremely” or “very” important. They are less likely to see improving infrastructure as “extremely” or “very” important (76% vs. 80%) (Figure 3).

Democrats and Republicans differ in their views on the importance of addressing each item except for public education and infrastructure. For those, similar numbers of Democrats and Republicans say they are “extremely” or “very” important to address. The largest gaps occur when it comes to addressing racial inequality (83% of Democrats say it is “extremely” or “very” important compared with 23% of Republicans) and addressing climate change (90% of Democrats say it is “extremely” or “very” important compared with 31% of Republicans). On two items Republicans are more likely than Democrats to say it is “extremely” or “very” important”: enforcing immigration (85% of Republicans say it is “extremely” or “very” important compared with 35% of Democrats) and attracting and retaining businesses and jobs (87% of Republicans say it is “extremely” or “very” important compared with 81% of Democrats) (Figure 4).

Figure 1. Addressing Wildfires, Making Health Care More Affordable, and Improving Public Education Top Californians' Policy Priorities

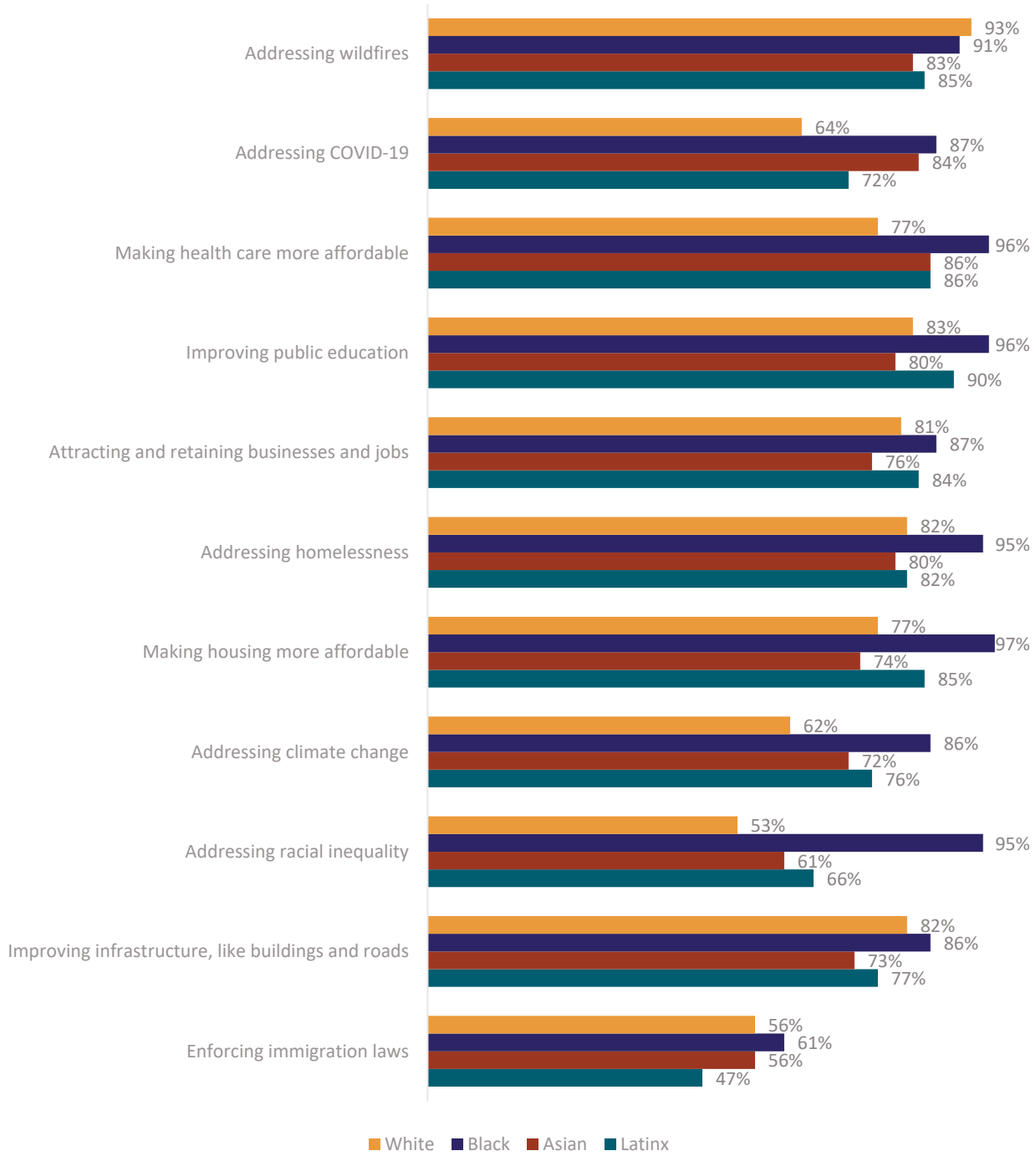
PERCENTAGE WHO SAY IT IS EXTREMELY IMPORTANT, VERY IMPORTANT, SOMEWHAT IMPORTANT, OR NOT IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Figure 2. Black Californians Are More Likely Than Other Racial and Ethnic Groups to Prioritize Addressing Racial Inequality, Making Housing More Affordable, Addressing Climate Change, Improving Public Education, and Addressing Homelessness

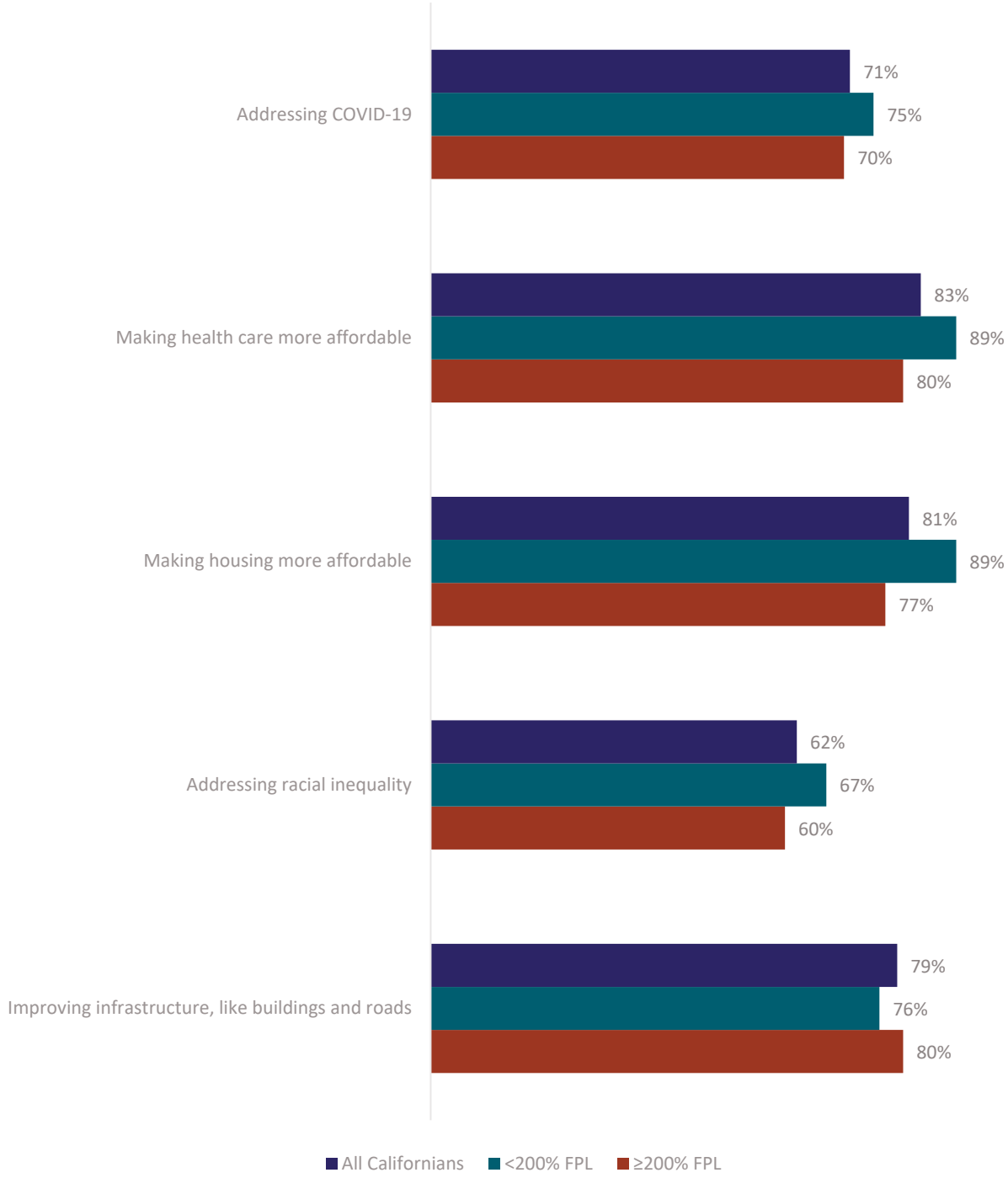
PERCENTAGE WHO SAY IT IS EXTREMELY OR VERY IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Figure 3. Californians with Lower Incomes Are More Likely to Prioritize a Number of Issues — Particularly Making Health Care and Housing More Affordable

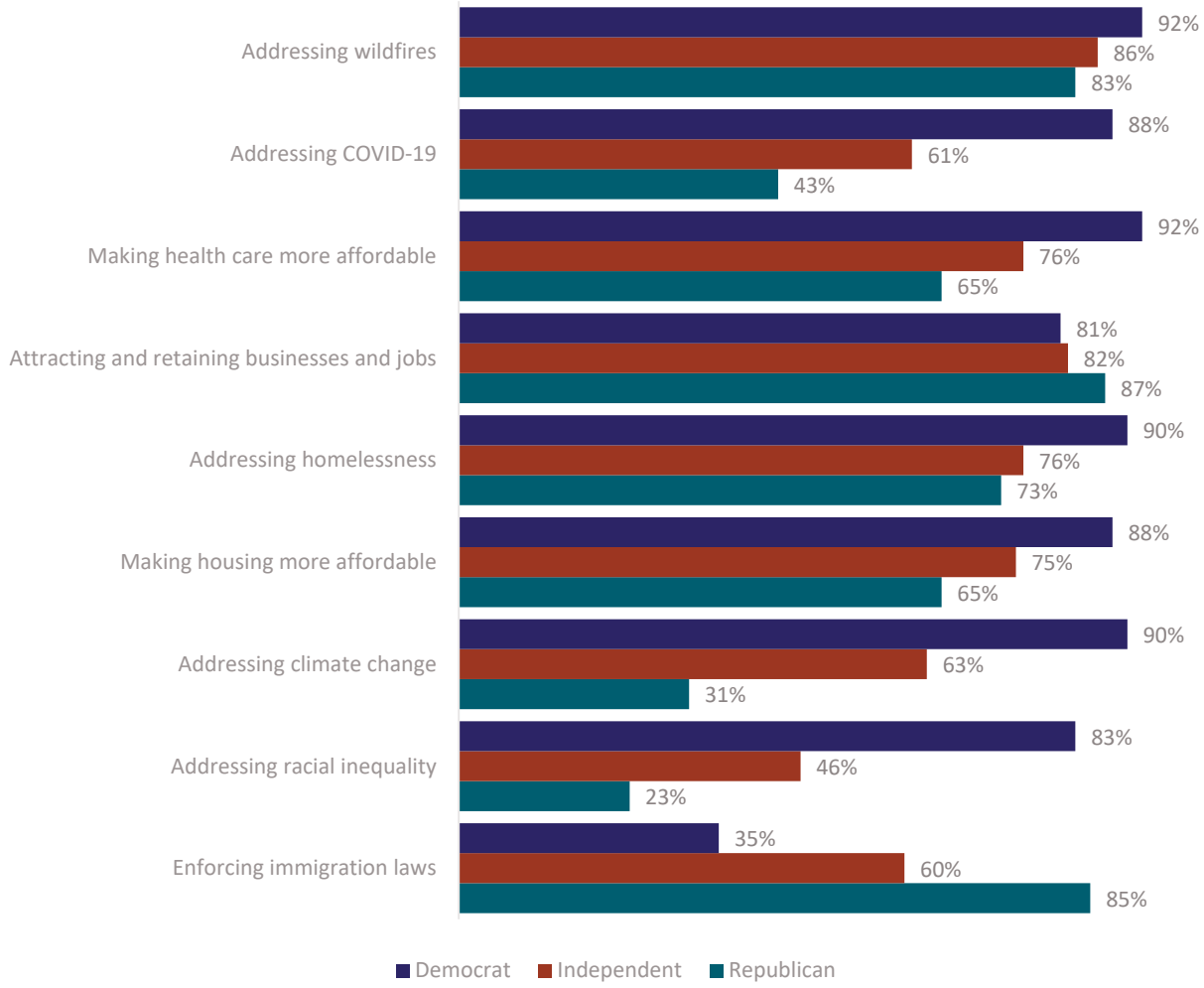
PERCENTAGE WHO SAY IT IS EXTREMELY OR VERY IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Figure 4. Democrats and Republicans Differ on Most Policy Priorities

PERCENTAGE WHO SAY IT IS EXTREMELY OR VERY IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Health Care Priorities

Making sure state and county health departments have the resources they need to respond to emergencies and crises such as pandemics, earthquakes, and fires tops the list of health care priorities for Californians, with 51% saying it is "extremely" important for the California governor and legislature to address in 2022. Close behind is making sure there are enough health care workers across California, with 48% saying it is an "extremely" important issue to address. This issue jumps to the top of the list when combined with the percentage who say it is a "very" important issue (39%). Another 48% say that making sure all Californians have access to health insurance is "extremely" important for the California governor and legislature to address in 2022.

Lowering the amount people pay for health care and making sure people with mental health problems can get the treatment they need are “extremely” important priorities for 47% of Californians. Forty-four percent say lowering the price of prescription drugs is an “extremely” important priority. About one-third say the following topics are “extremely” important: making information about the price of doctors’ visits, tests, and procedures more available to patients (37%); funding health care for people experiencing homelessness (35%); reducing differences in health care quality between racial and ethnic groups (33%); and making sure people with substance abuse problems can get needed treatment (32%). Just 14% say decreasing state government spending on health care is an “extremely” important priority (Figure 5).

The top priority for Black and Latinx Californians is making sure there are enough doctors, nurses, and other health care providers across California, with 99% of Black and 90% of Latinx Californians saying it’s an “extremely” or “very” important issue. For White Californians, making sure state and county public health departments have the resources they need to respond to emergencies and crises is the highest priority with 86% saying it’s “extremely” or “very” important. Asian Californians report two items that tie for the top health priority, with 85% saying making information about the price of doctor visits, tests, and procedures more available to patients and lowering the amount that people pay for health care are “extremely” or “very” important issues to address.

More than half of all racial and ethnic groups say each item is an “extremely” or “very” important priority except for decreasing state funding on health care. For every other item except for making information about the price of doctor visits, tests, and procedures more accessible, Black Californians are more likely than every other group to say it is an “extremely” or “very” important issue to be addressed. One of the biggest gaps in attitudes is on addressing differences in health care quality between racial and ethnic groups, where 92% of Black Californians say it is an “extremely” or “very” important issue to be addressed compared to 74% of Latinx Californians, 58% of Asian Californians, and 58% of White Californians (Figure 6).

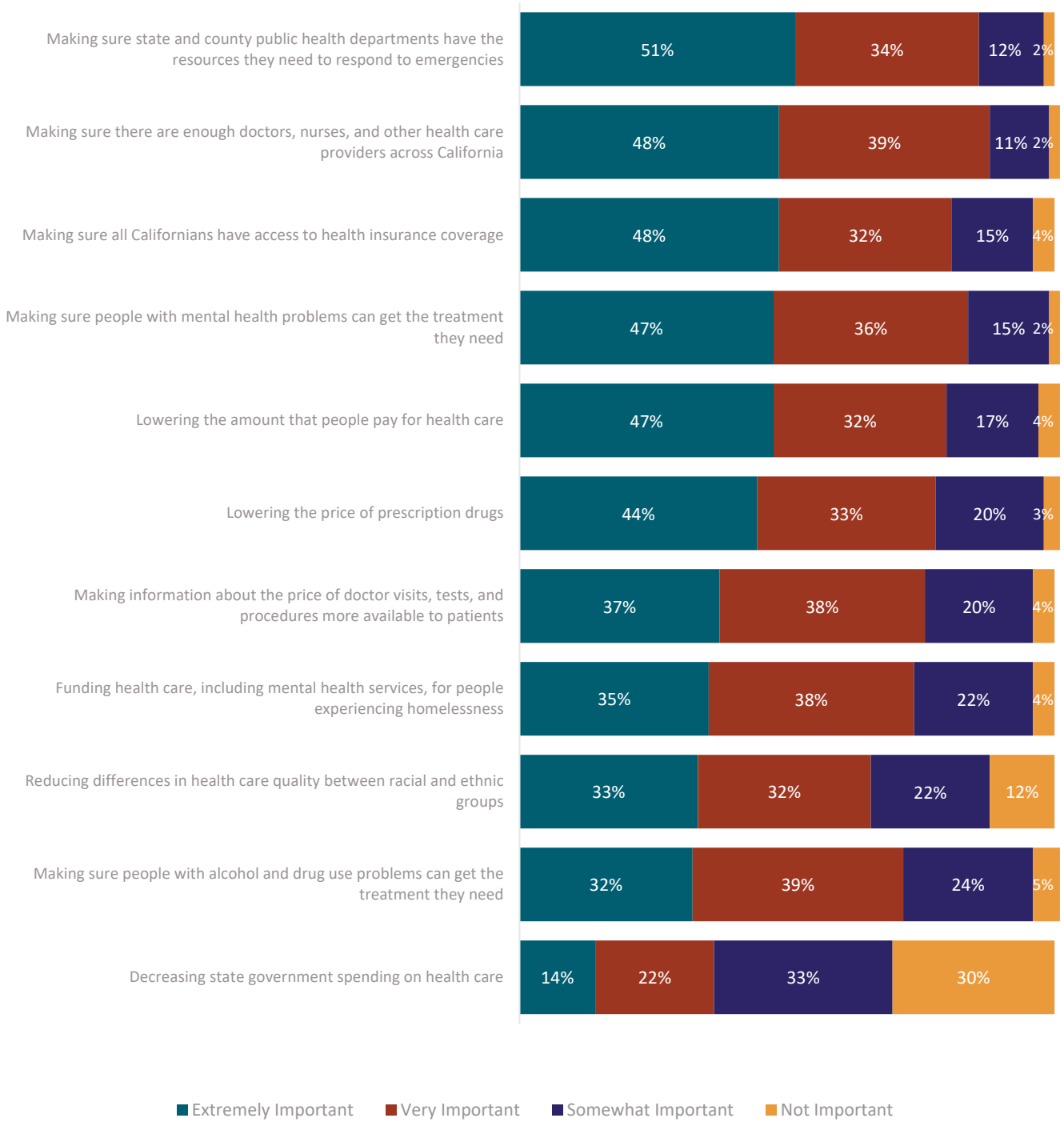
For every item except one, Californians with incomes of less than 200% of the poverty line are more likely than those with incomes of 200% of the poverty line or more to think it is an “extremely” or “very” important issue. The largest difference in attitudes is on funding health care for people experiencing homelessness. Eighty-four percent of Californians with lower incomes say it is an “extremely” or “very” important issue to prioritize compared with 67% of those with higher incomes (Figure 7). One notable item where there aren’t differences by income is decreasing state government spending on health care. Californians with lower incomes are no more or less likely than those with incomes of 200% of the poverty line or more to think decreasing government funding for health care should be prioritized.

Democrats and Republicans differ in attitudes toward every health care item in the list. For most, Democrats are more likely than Republicans to say it should be an “extremely” or “very” important issue to address. When it comes to decreasing state funding for health care, 49% of Republicans say it is an “extremely” or “very” important priority compared with 28% of Democrats. The largest gap in attitudes between Democrats and Republicans is about reducing differences in health care quality between racial and ethnic groups. Eighty-four percent of Democrats say this is an “extremely” or “very” important priority compared with 35% of Republicans, a difference of 49 percentage points (Figure 8).

There are no year-over-year differences for any items.

Figure 5. Californians Prioritize Making Sure State and County Health Departments Have the Resources They Need to Respond to Emergencies and Crises

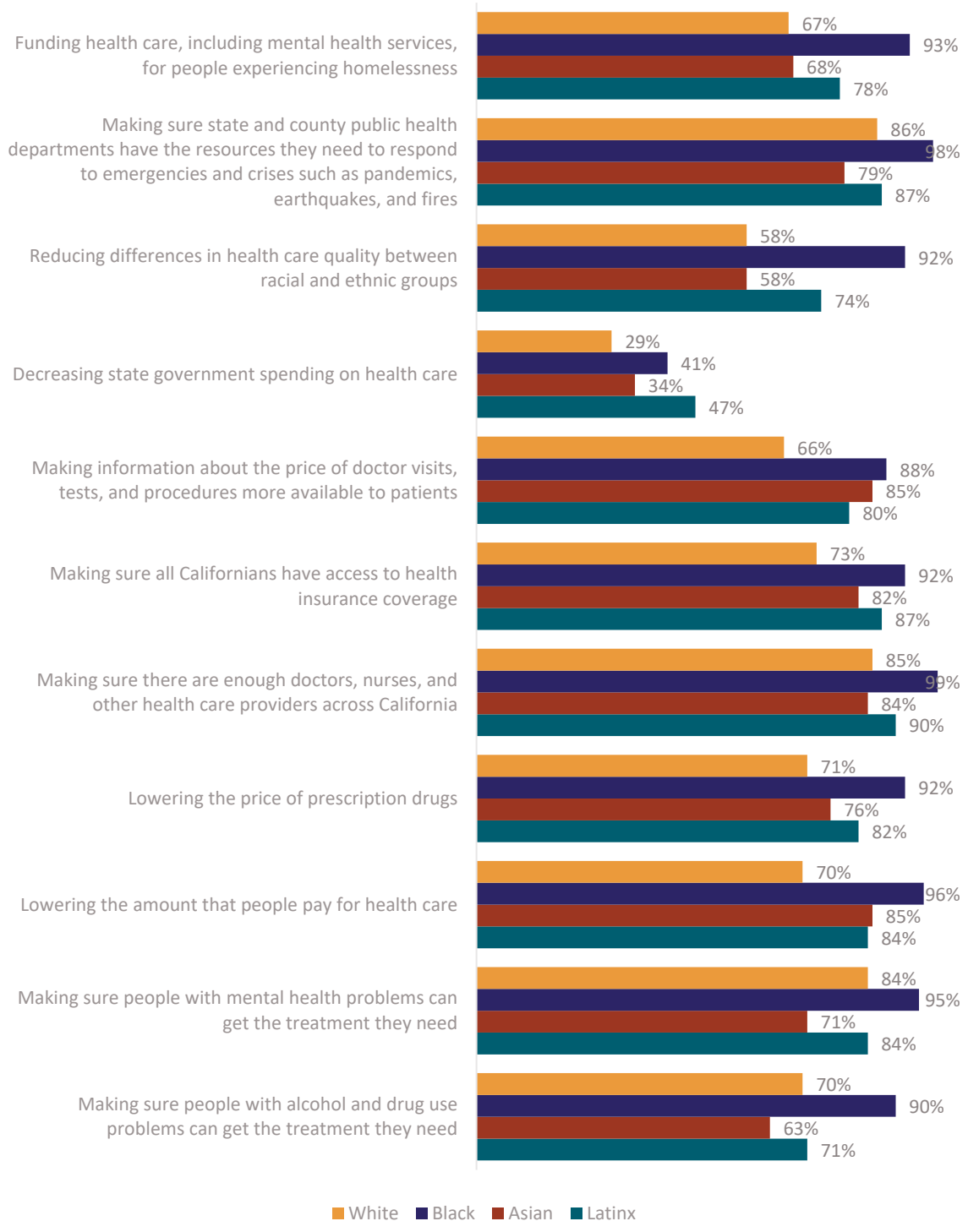
PERCENTAGE WHO SAY IT IS EXTREMELY IMPORTANT, VERY IMPORTANT, SOMEWHAT IMPORTANT, OR NOT IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Figure 6. Californians' Health Care Priorities Differ Between Racial and Ethnic Groups

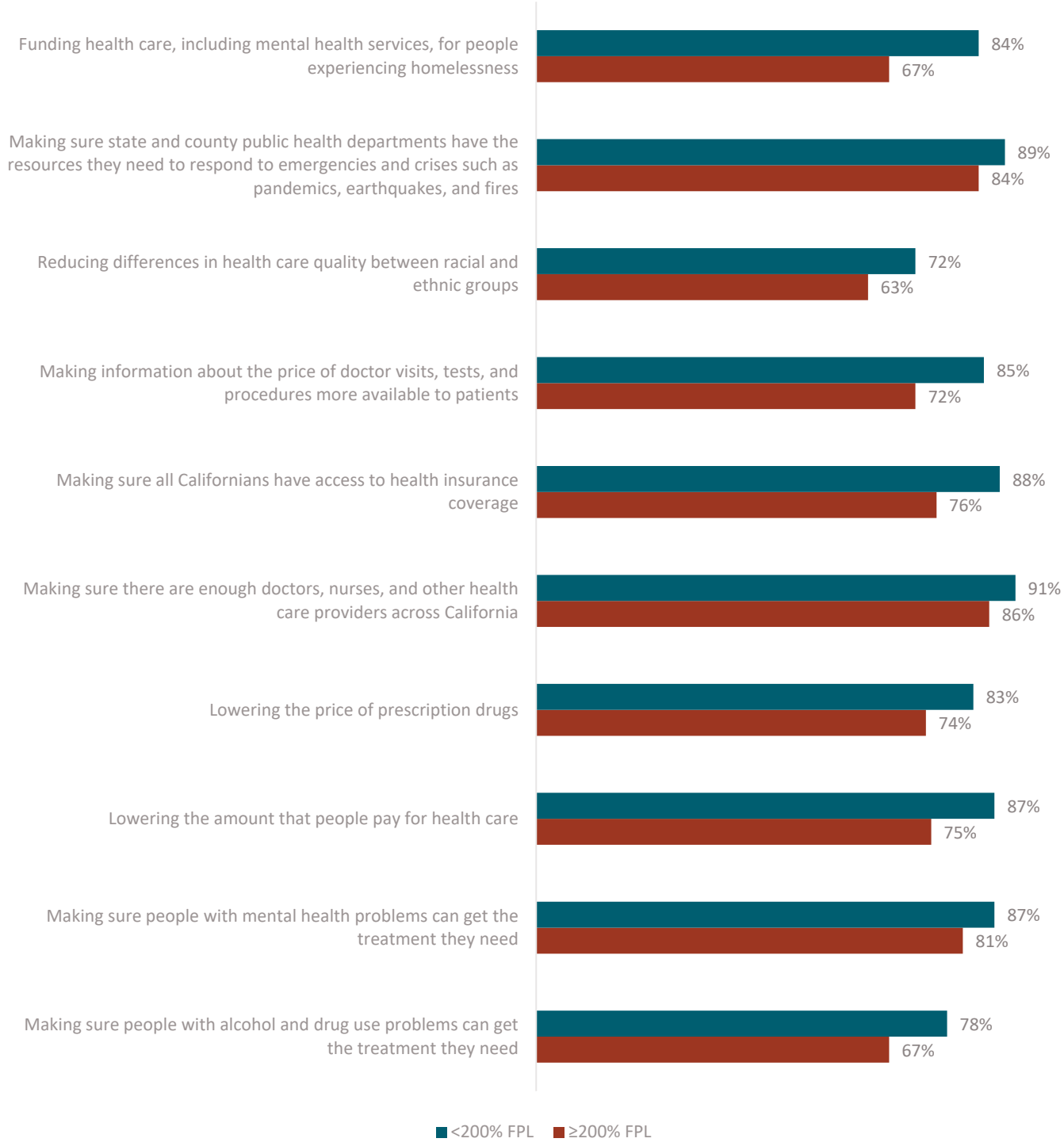
PERCENTAGE WHO SAY IT IS EXTREMELY OR VERY IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Figure 7. Californians of Different Income Levels Differ in How Much They Prioritize Health Care Issues

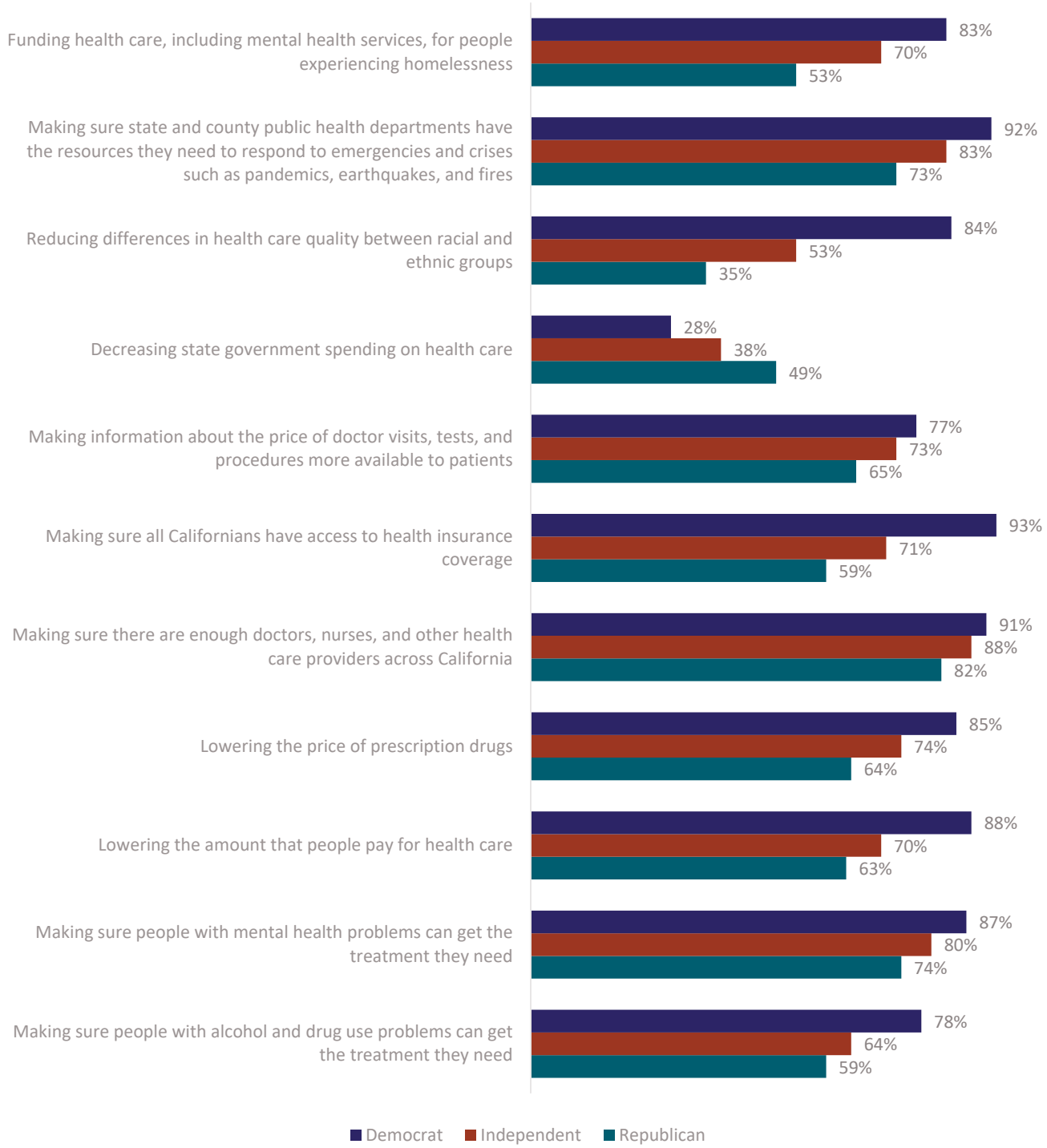
PERCENTAGE WHO SAY IT IS EXTREMELY OR VERY IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Figure 8. Californians' Priorities for the State Vary by Political Party

PERCENTAGE WHO SAY IT IS EXTREMELY OR VERY IMPORTANT FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2022.



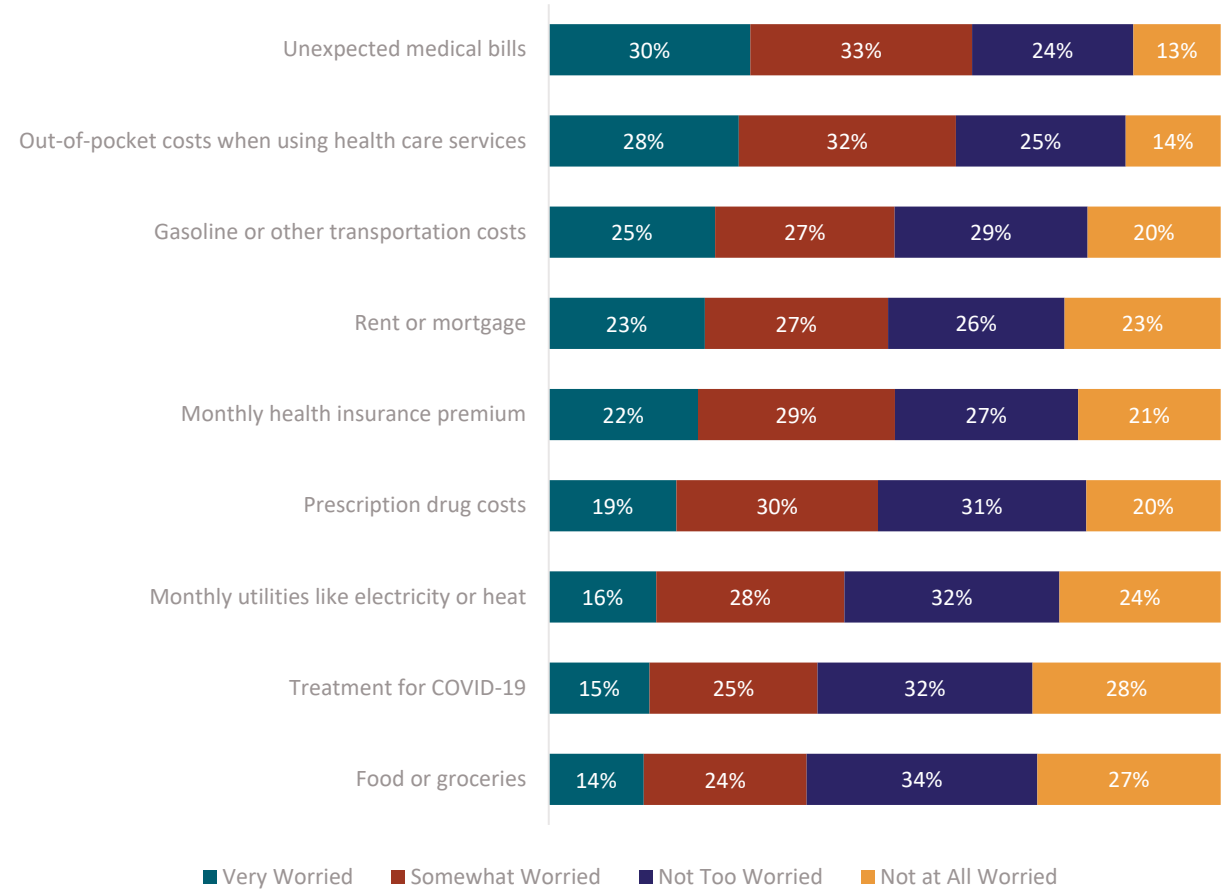
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Section 2. Health Care Affordability

Californians are worried about health care costs. Identical to last year's poll, 83% of Californians report that making health care more affordable is an "extremely" or "very" important priority for California's governor and legislature to work on in 2022. Six in 10 Californians are either "very" or "somewhat" worried about unexpected medical bills (63%; 30% "very") and out-of-pocket health care costs (60%; 28% "very"). Half of Californians are worried about affording monthly health insurance premiums (51%; 22% "very"), prescription drugs (49%; 19% "very"), rent or mortgage (50%; 23% "very"), and gasoline or other transportation costs (52%; 25% "very"). Smaller shares of Californians are worried about affording monthly utilities like electricity or heat (44%; 16% "very"), treatment for COVID-19 (40%; 15% "very"), and food or groceries (38%; 14% "very") (Figure 9). Similar to last year's poll, 4 in 10 Californians with lower incomes are very worried about affording unexpected medical bills (42%), rent or mortgage (41%), and out-of-pocket costs when using health care services (39%). Four in 10 lower-income Californians (40%) are also concerned about affording gasoline or other transportation costs, an increase from last year (28%) (Figure 10).

Figure 9. Unexpected Medical Bills and Out-of-Pocket Costs for Health Care Services Top Californians' Affordability Concerns

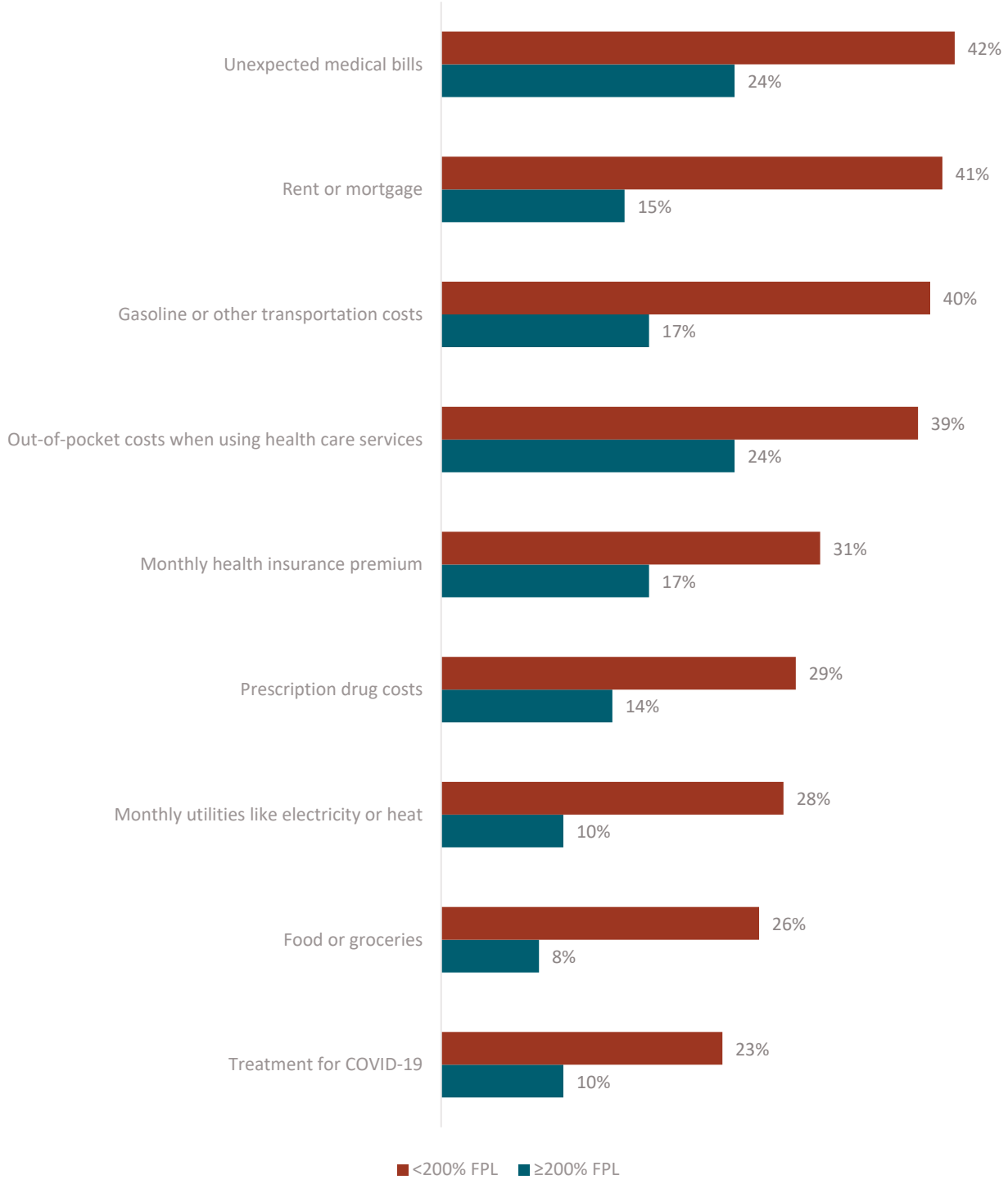
Q: HOW WORRIED ARE YOU ABOUT BEING ABLE TO AFFORD THE FOLLOWING FOR YOU AND YOUR FAMILY?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Figure 10. Californians with Lower Incomes Are More Likely to be Worried About Health Care Costs

PERCENTAGE VERY WORRIED ABOUT BEING ABLE TO AFFORD THE FOLLOWING FOR THEMSELVES OR THEIR FAMILY.

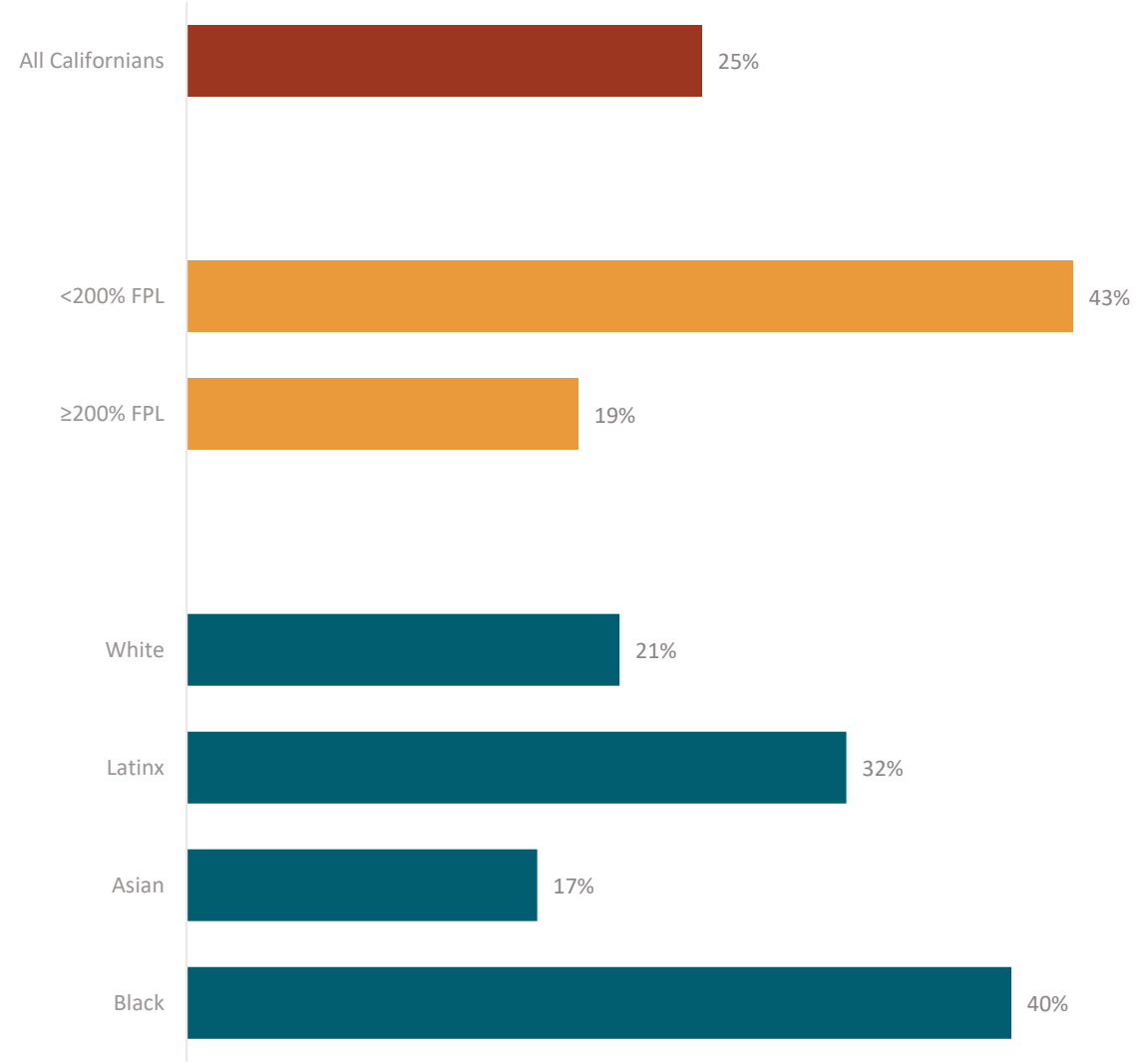


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

One in four Californians (25%) say they or someone in their family had problems paying at least one medical bill, such as a bill for doctors, dentists, medication, or home care in the past 12 months, an increase from 20% from last year's poll. Californians with lower incomes are more than twice as likely to report having problems paying for medical bills compared to Californians with higher incomes (43% compared to 19%). A higher percentage of Californians with lower incomes say they had problems paying medical bills this year compared to last year (43% this year compared to 32% last year). When looking at differences by race and ethnicity, Black Californians are most likely to experience problems paying for medical bills (40%), followed by Latinx (32%), White (21%), and Asian (17%) (Figure 11).

Figure 11. One-Quarter of Californians Report Problems Paying Medical Bills in the Past 12 Months

PERCENTAGE WHO SAY THAT THEY OR SOMEONE IN THEIR FAMILY HAD PROBLEMS PAYING OR AN INABILITY TO PAY ANY MEDICAL BILLS, SUCH AS BILLS FOR DOCTORS, DENTISTS, MEDICATION, OR HOME CARE IN THE LAST 12 MONTHS.

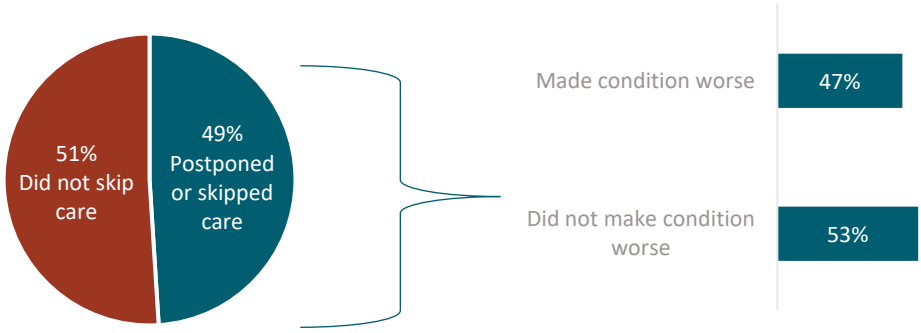


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Like the previous two polls, half of Californians (49%) report skipping or delaying at least one kind of health care due to cost in the past 12 months. Among those who postponed care, 47% report that their condition worsened as a result, an increase from last year (41%) (Figure 12). When observing differences by income, Californians with lower incomes are more likely than those with higher incomes to skip or delay health care due to costs in the past 12 months (67% compared to 42%) (Figure 13). There is no year-over-year difference in the percentage of Californians with lower incomes delaying health care due to costs (2021 poll: 38%).

Figure 12. Half of Californians Say They or a Family Member Skipped Health Care in the Past Year Due to Cost; Many Say This Made Their Health Condition Worse

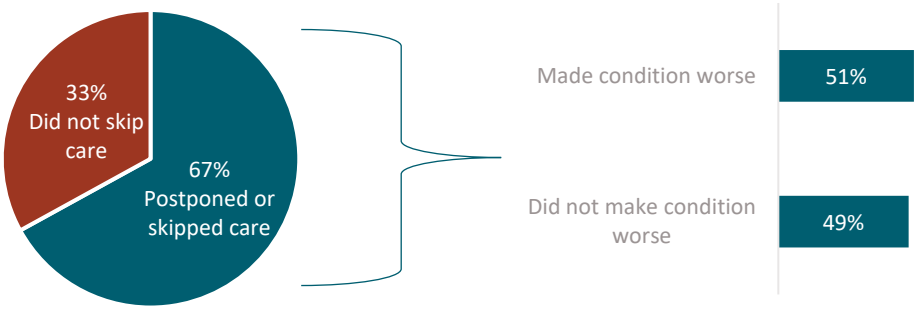
Q: ASKED OF THE 49% WHO POSTPONED OR SKIPPED CARE DUE TO COST: DID ANY OF THE STEPS YOU TOOK BECAUSE OF COST MAKE YOUR CONDITION WORSE?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Figure 13. Two-Thirds of Californians with Lower Incomes Skipped Health Care in the Past Year Due to Cost

Q: DID ANY OF THOSE STEPS MAKE YOUR HEALTH CONDITION WORSE? (ASKED OF THE 67% OF CALIFORNIANS WITH LOWER INCOMES WHO POSTPONED OR SKIPPED CARE DUE TO COST)

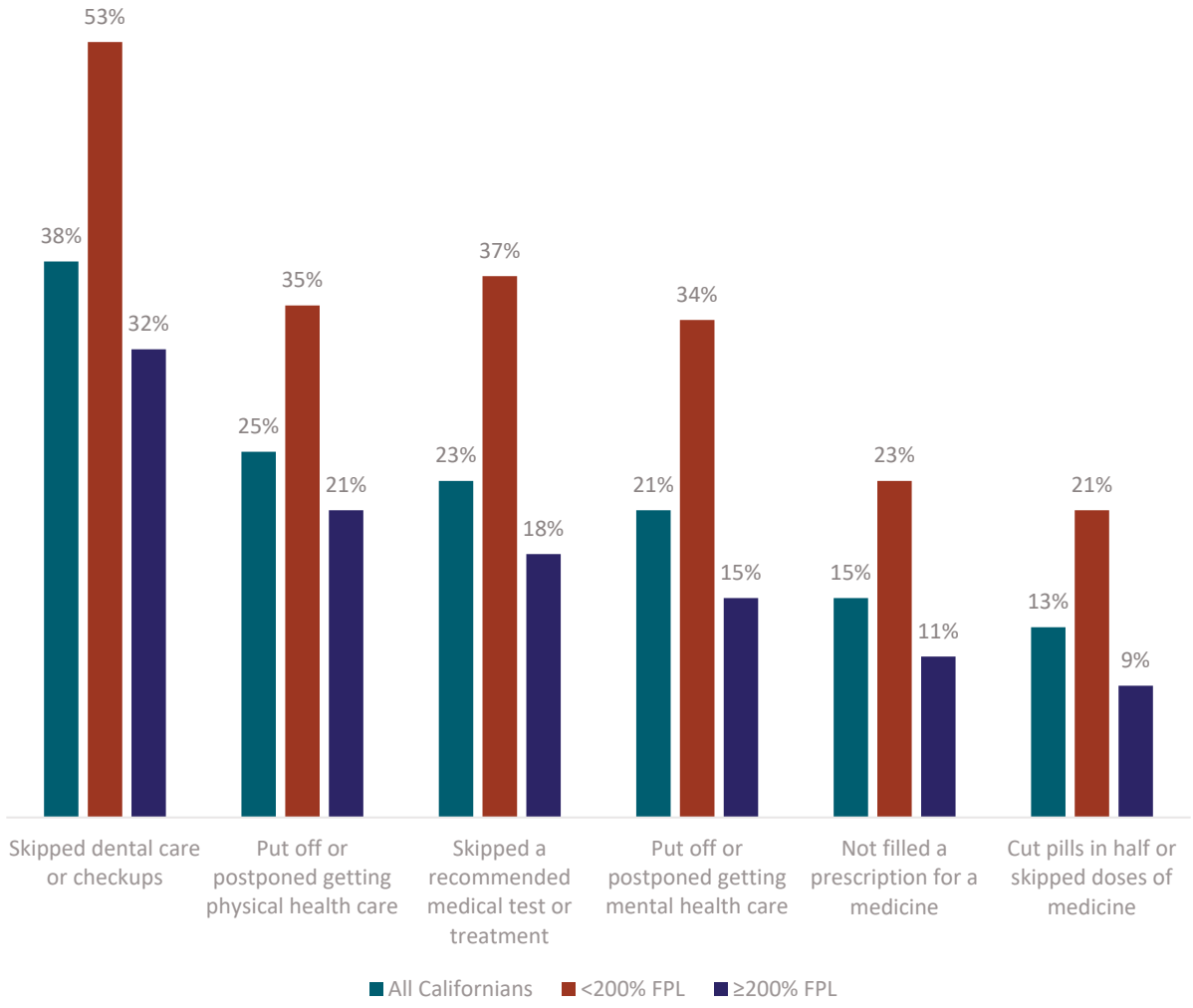


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Commonly skipped health care practices include dental care or checkups (38%), physical health care (25%), recommended medical tests or treatment (23%), and mental health care (21%). When stratifying differences by income, Californians with lower incomes are more likely to skip each of these steps compared to Californians with higher incomes (Figure 14). When looking at differences by race and ethnicity, Black and Latinx Californians report higher rates of postponing almost all these health care steps compared to their White and Asian counterparts (Figure 15). More Californians this year compared to last year (21% compared to 18%) postponed getting mental health care. There are no other year-to-year differences.

Figure 14. Californians with Lower Incomes Are More Likely to Skip Care Because of Cost

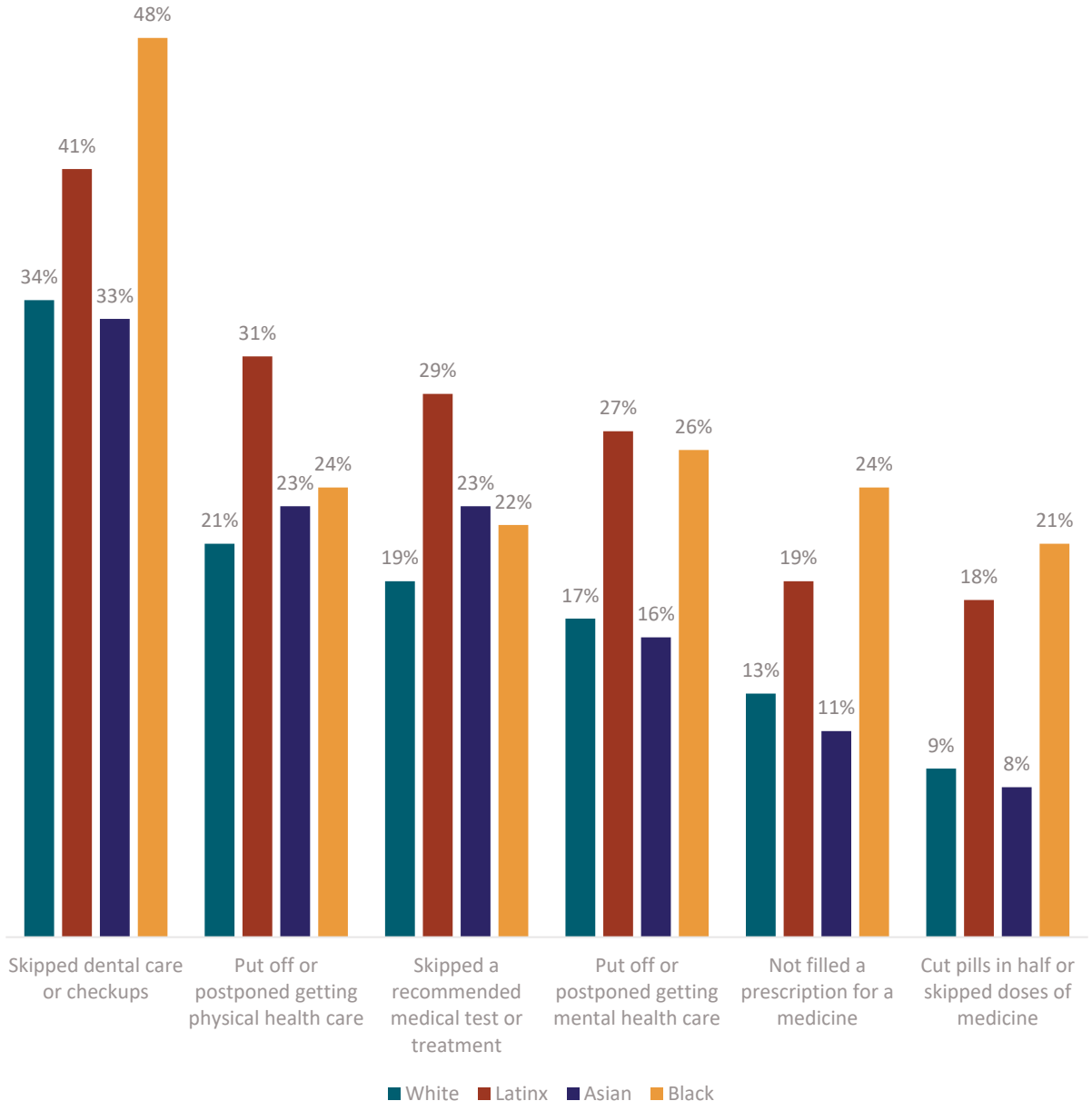
PERCENTAGE WHO SAY THAT THEY OR ANOTHER FAMILY MEMBER DID THE FOLLOWING BECAUSE OF COST IN THE LAST 12 MONTHS.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Figure 15. Black and Latinx Californians Are More Likely to Have Skipped Care Due to Cost

PERCENTAGE WHO SAY THAT THEY OR ANOTHER FAMILY MEMBER DID THE FOLLOWING BECAUSE OF COST IN THE LAST 12 MONTHS.



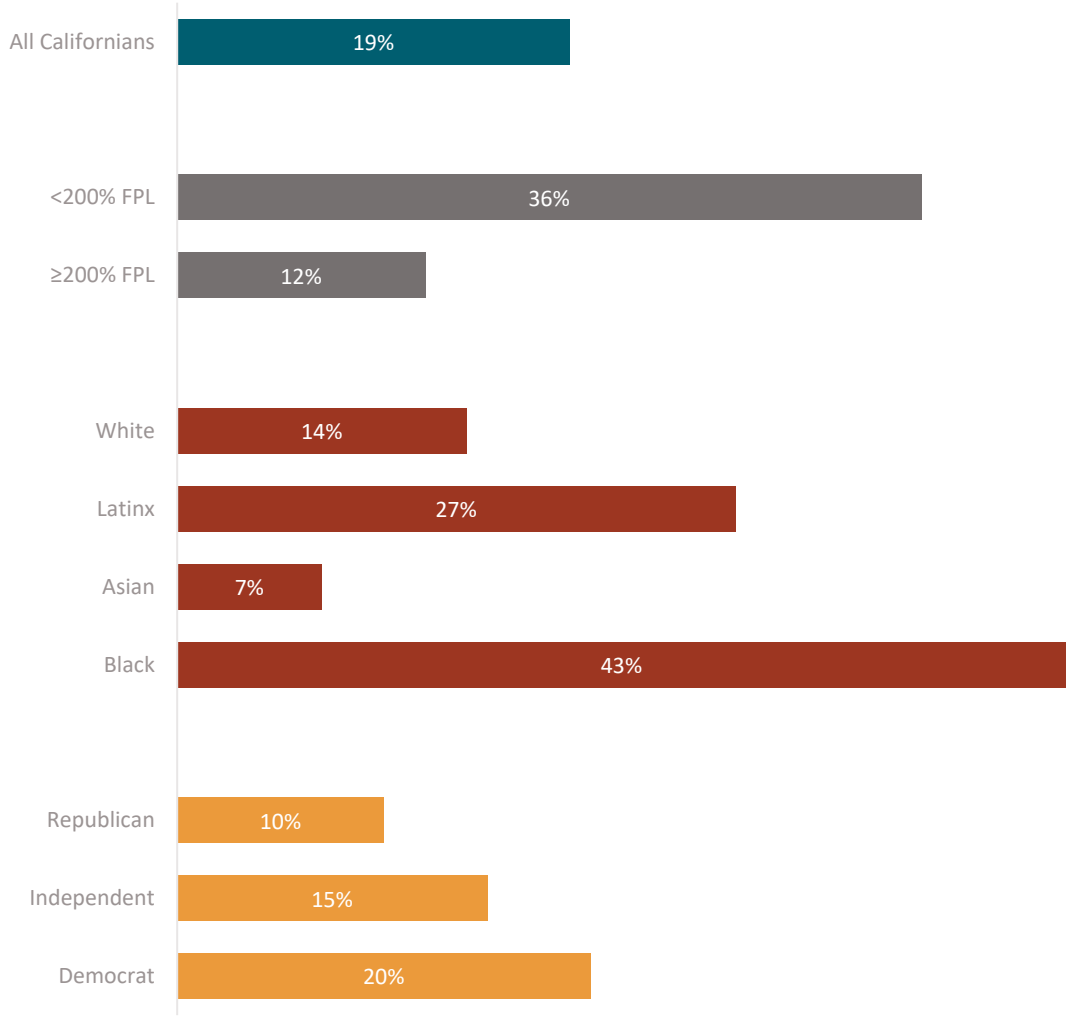
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Section 3. Housing and Homelessness

Nearly one in five Californians (19%) say they or someone close to them has experienced a period of homelessness in the past five years. More than one in three Californians with lower incomes (36%) report experiencing homelessness or knowing someone who did, three times as likely as those with higher incomes (12%). When looking at differences by race, Black Californians (43%) are more likely than those who belong to any other racial or ethnic group to report having experienced or known someone who has experienced a period of homelessness. Latinx Californians (27%) are more likely than White (14%) or Asian Californians (7%) to have experienced or known someone who has experienced homelessness (Figure 16).

Figure 16. One in Five Californians Has — or Knows Someone Who Has — Experienced Homelessness in the Past Five Years

Q: THINKING OF THE LAST FIVE YEARS, HAVE YOU OR ANYONE CLOSE TO YOU EXPERIENCED A PERIOD OF HOMELESSNESS?

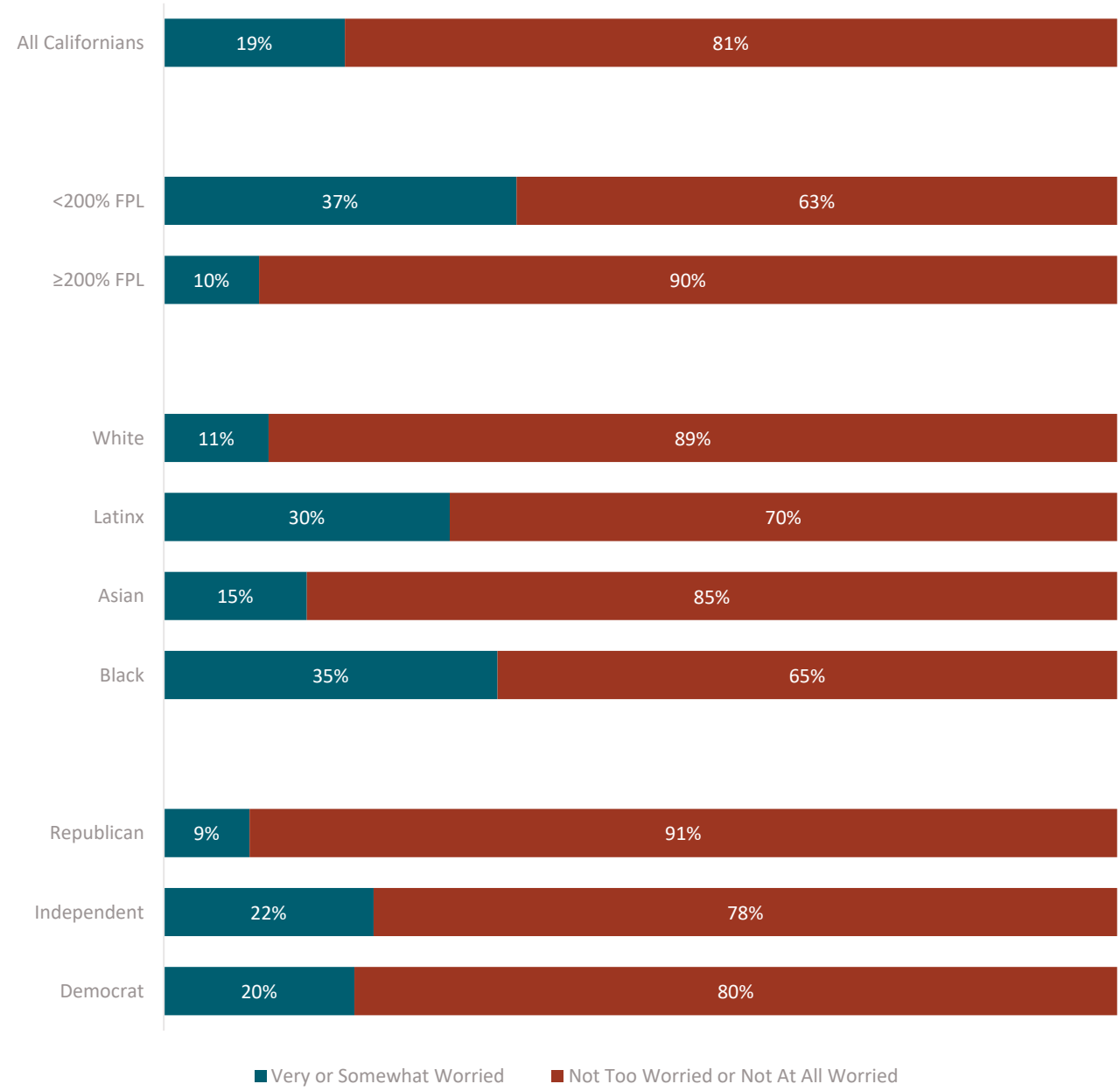


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

One in five Californians (19%) say they are “very” or “somewhat” worried about experiencing homelessness. Californians with lower incomes (37%) are close to four times more likely than those with higher incomes (10%) to be “very” or “somewhat” worried about experiencing homelessness. Black (35%) and Latinx Californians (30%) are more likely than Asian (15%) and White Californians (11%) to report being “very” or “somewhat” worried about experiencing a period of homelessness (Figure 17).

Figure 17. One in Five Californians Is Currently Worried About Experiencing Homelessness

Q: HOW WORRIED ARE YOU *CURRENTLY* ABOUT EXPERIENCING A PERIOD OF HOMELESSNESS?

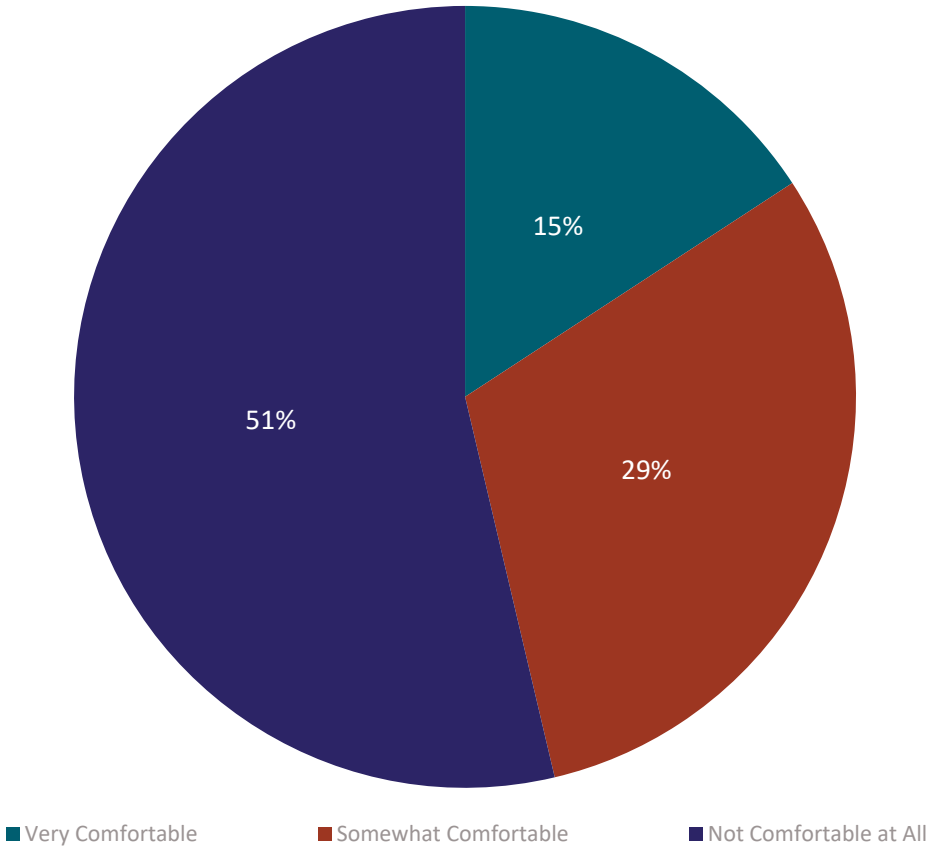


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Californians who are currently worried about experiencing a period of homelessness and who have a primary care provider were asked if they would be comfortable talking to their primary care provider about their housing situation concerns. Half (51%) say they would not be comfortable, and about one-third (29%) would be "somewhat" comfortable (Figure 18). There are no differences across demographic subgroups.

Figure 18. Half of Californians Currently Worried About Homelessness Are Not Comfortable Talking to Their Primary Care Provider About Their Concerns

Q: HOW COMFORTABLE WOULD YOU BE TALKING TO YOUR PRIMARY CARE PROVIDER ABOUT YOUR CONCERNS ABOUT YOUR HOUSING SITUATION?

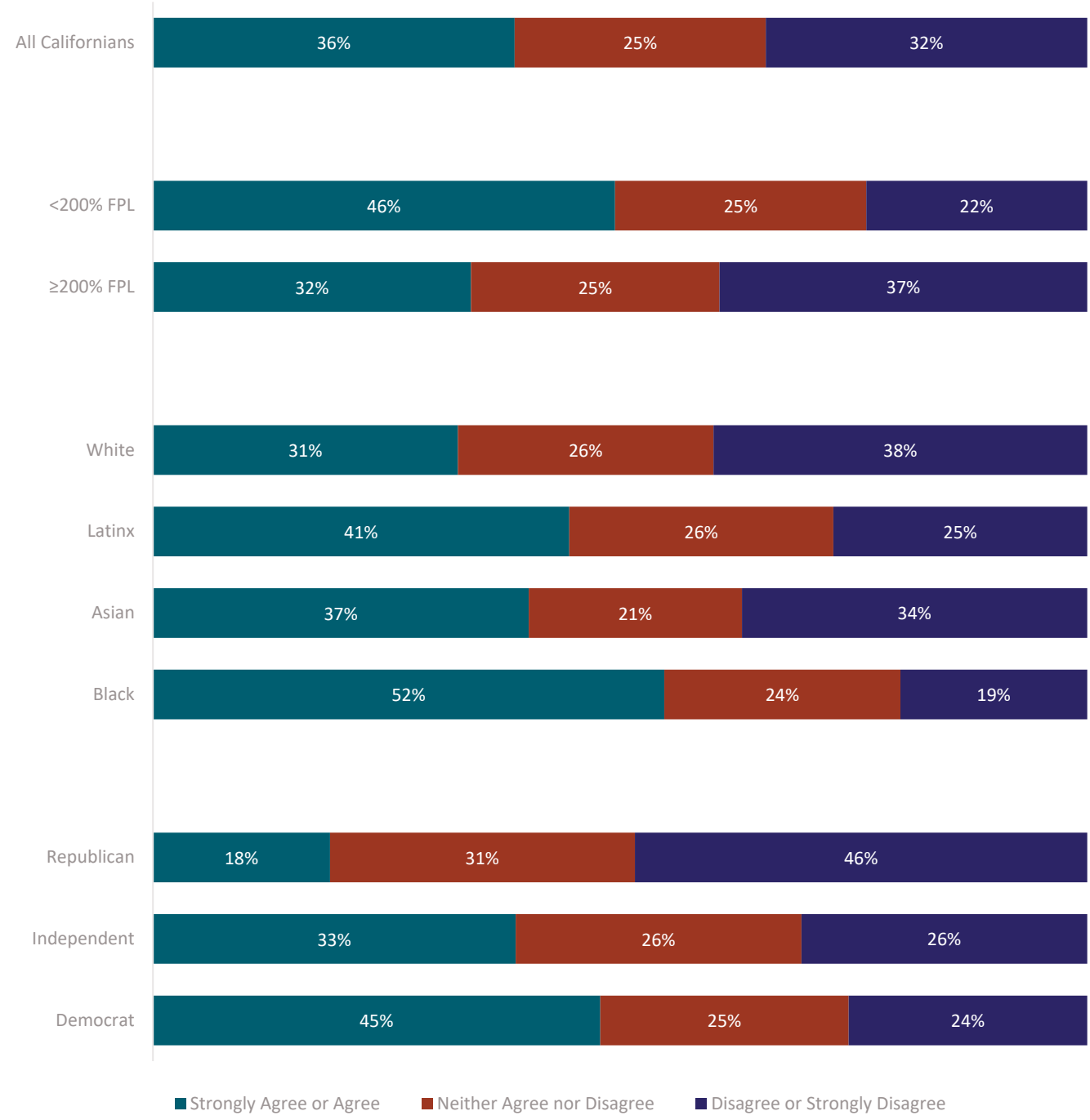


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

More than one-third of Californians (36%) either "agree" or "strongly agree" that the health care system should help patients experiencing homelessness find housing. A higher proportion of Californians with lower incomes than those with higher incomes "agree" or "strongly" support this view (46% compared to 32%). When examining results by race and ethnicity, more than half of Black Californians (52%) believe the health system should help, followed by 41% of Latinx Californians, 37% of Asian Californians, and 31% of White Californians. Democrats in California are more than twice as likely to hold this belief compared to Republicans (45% compared to 18%) (Figure 19).

Figure 19. Californians Are Split on Whether the Health Care System Should Help Patients Experiencing Homelessness Find Housing

DO YOU AGREE, DISAGREE, OR NEITHER AGREE NOR DISAGREE WITH THE FOLLOWING STATEMENT: THE HEALTH CARE SYSTEM SHOULD HELP PATIENTS WHO ARE EXPERIENCING HOMELESSNESS FIND HOUSING.



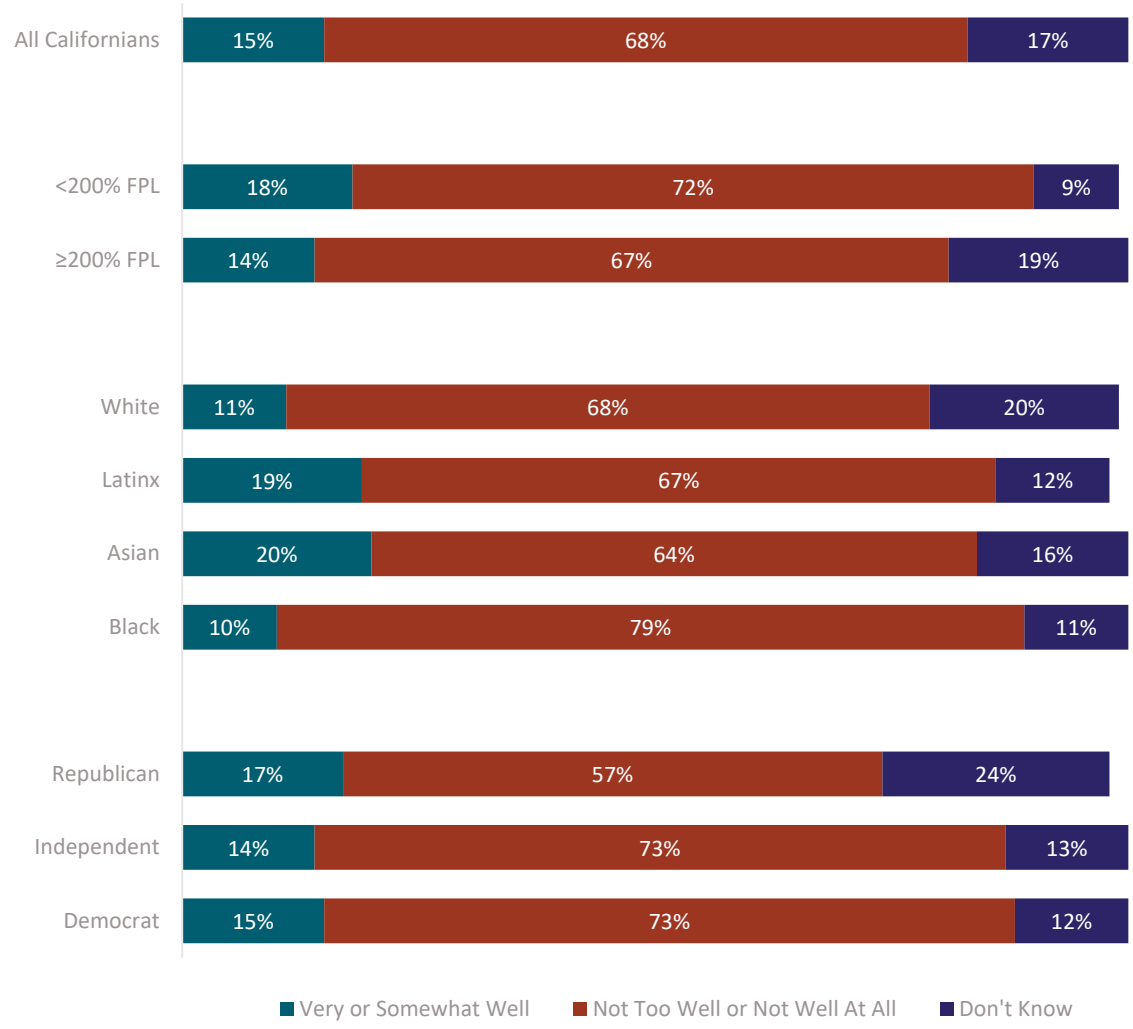
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Nearly 7 in 10 Californians (68%) think that the state is not doing well in terms of making housing affordable for people with low incomes. Large majorities of every racial and ethnic group hold this view, with Black Californians reporting the highest percentage (79%) followed by White (68%), Latinx (67%), and Asian Californians (64%). When examining differences by party affiliation, a higher proportion of Democrats (73%) and Independents (73%) think the state is not doing well in addressing housing affordability compared to Republican Californians (57%) (Figure 20).

Eight in 10 Californians (80%) believe that the lack of affordable housing impacts mental or physical health among people with low incomes "a lot" or "some." Democratic Californians are more likely to hold this belief compared to Republicans (88% compared to 69%) (Figure 21).

Figure 20. Californians Do Not Think the State Is Doing Well in Making Affordable Housing Available

Q: HOW WELL IS CALIFORNIA DOING IN MAKING AFFORDABLE HOUSING AVAILABLE FOR PEOPLE WITH LOW INCOMES?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding. *FPL* is federal poverty level.

Figure 21. Californians Think the Lack of Affordable Housing Has a Large Impact on the Physical or Mental Health of People with Low Incomes

Q: HOW MUCH DO YOU THINK LACK OF AFFORDABLE HOUSING IMPACTS MENTAL OR PHYSICAL HEALTH AMONG PEOPLE WITH LOW INCOMES?

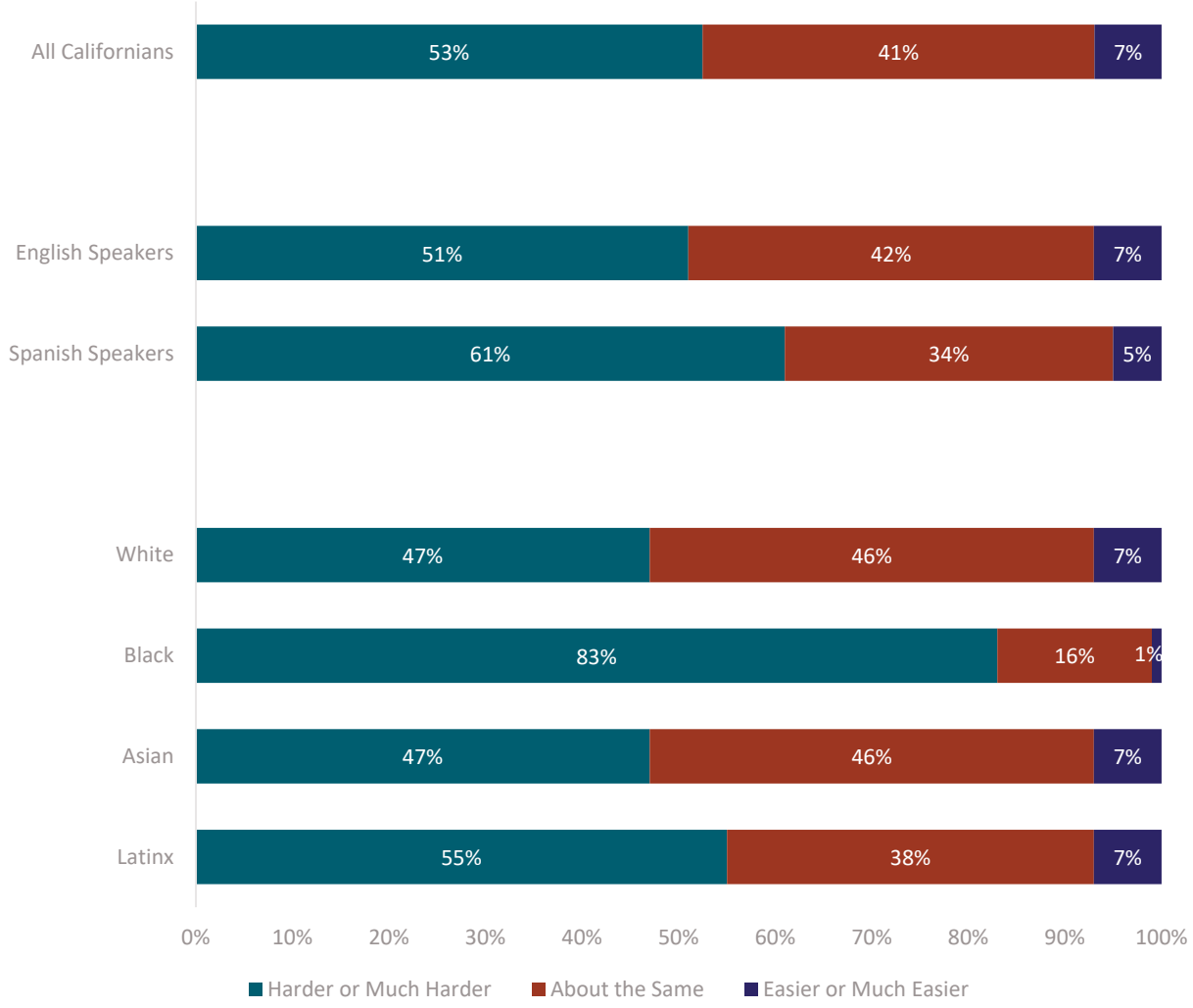
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding. *FPL* is federal poverty level.

Section 4. Equity

Similar to last year's poll, the majority of Californians (53%) say that it is "harder" or "much harder" for Black people to get the care they needed compared to White people. Eight in 10 Black Californians (83%) report it is more difficult, compared to the 55% of Latinx, 47% of Asian, and 47% of White Californians who say so. Black Californians are less likely to say that it was "about the same" for Black people to get the health care they need (16%) when they are sick compared to all other racial groups (46% of Asian, 46% of White, and 38% of Latinx Californians). Spanish speakers (61%) are more likely than English speakers (51%) to say it is "harder" or "much harder" for Black people (Figure 22).

Figure 22. The Majority of Californians Think It Is Harder for Black People to Get the Health Care They Need

Q: DO YOU THINK IT IS HARDER, ABOUT THE SAME, OR EASIER FOR BLACK OR AFRICAN AMERICAN PEOPLE TO GET THE HEALTH CARE THEY NEED WHEN THEY ARE SICK COMPARED TO WHITE PEOPLE?

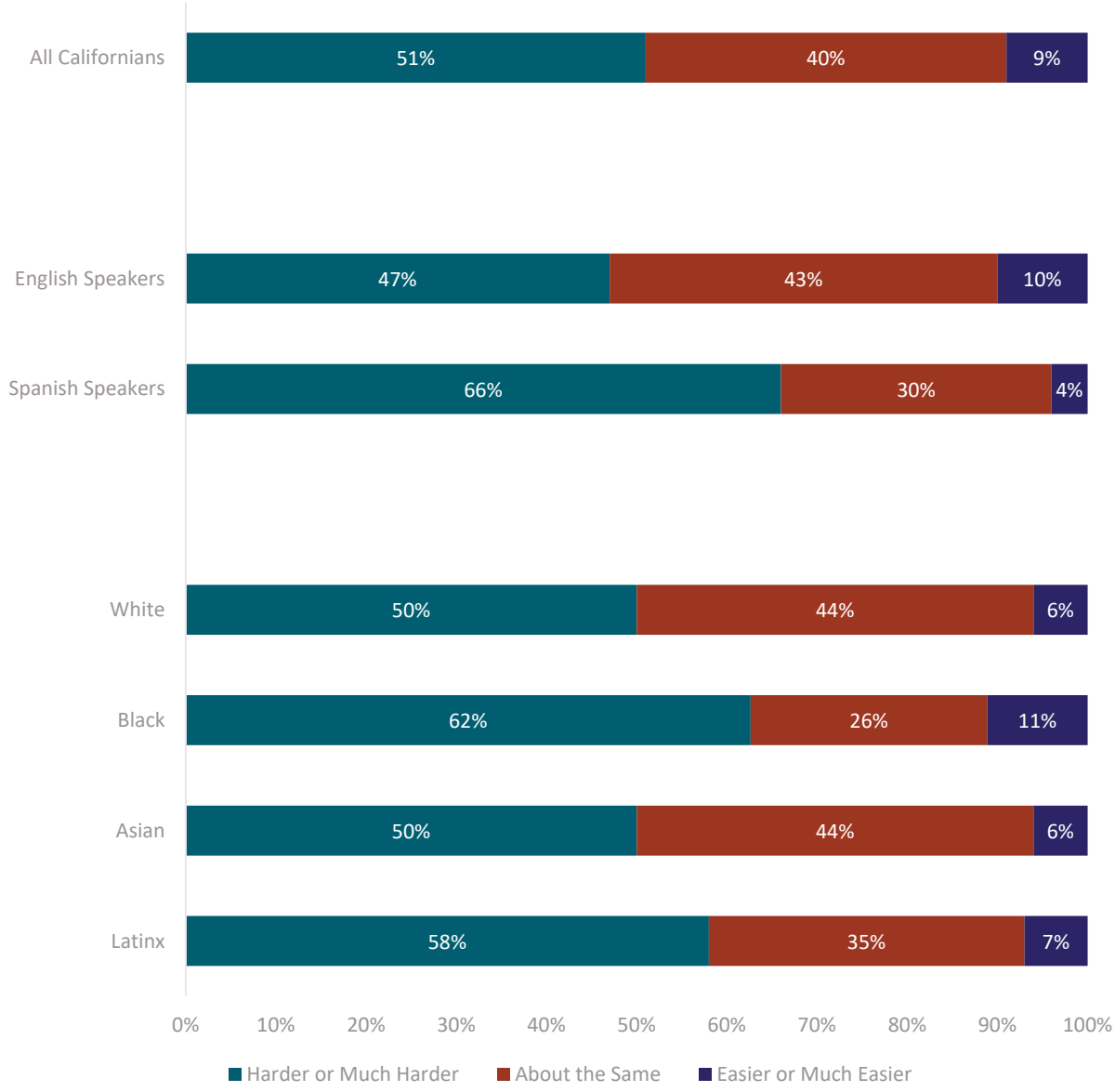


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Similarly, about half of Californians (51%) say that it is "harder" or "much harder" for Latinx people to get the care they needed compared to White people. This proportion did not change appreciably from last year's poll. Black Californians (62%) are the most likely to say it was "harder" or "much harder" followed by Latinx (58%), Asian (50%), and White Californians (50%). About two-thirds of Spanish speakers (66%) say it is "harder" or "much harder" for Latinx people to get care, compared to 47% of English speakers (Figure 23).

Figure 23. The Majority of Californians Think It Is Harder for Latinx People to Get the Health Care They Need

Q: DO YOU THINK IT IS HARDER, ABOUT THE SAME, OR EASIER FOR HISPANIC OR LATINX PEOPLE TO GET THE HEALTH CARE THEY NEED WHEN THEY ARE SICK COMPARED TO WHITE PEOPLE?

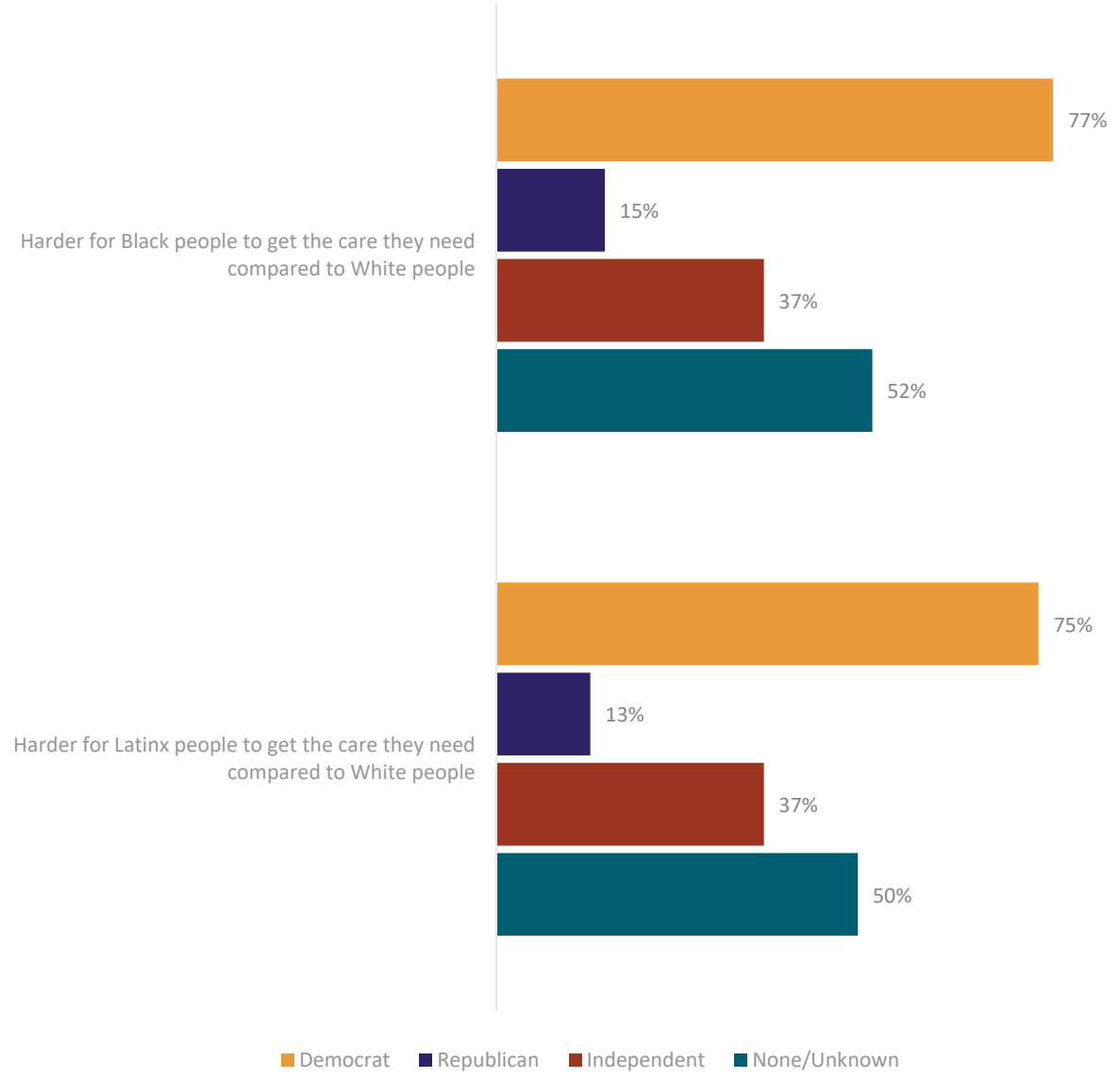


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

There were also differences in views on racial and ethnic health disparities by political party. Democrats (77%) are much more likely than Republicans (15%) and Independents (37%) to say it was "harder" or "much harder" for Black people to get the care they needed compared to White people. The political party alignment on this item is similar to last year's results. Three-quarters of Democrats (75%) say it is "harder" or "much harder" for Latinx people to get the care they need compared to White people, compared to only 13% of Republicans and 37% of Independents (see Figure 24).

Figure 24. Views on Racial and Ethnic Health Disparities Vary by Party

PERCENTAGE WHO SAY IT IS HARDER OR MUCH HARDER FOR BLACK/LATINX PEOPLE TO GET THE HEALTH CARE THEY NEED WHEN THEY ARE SICK COMPARED TO WHITE PEOPLE.



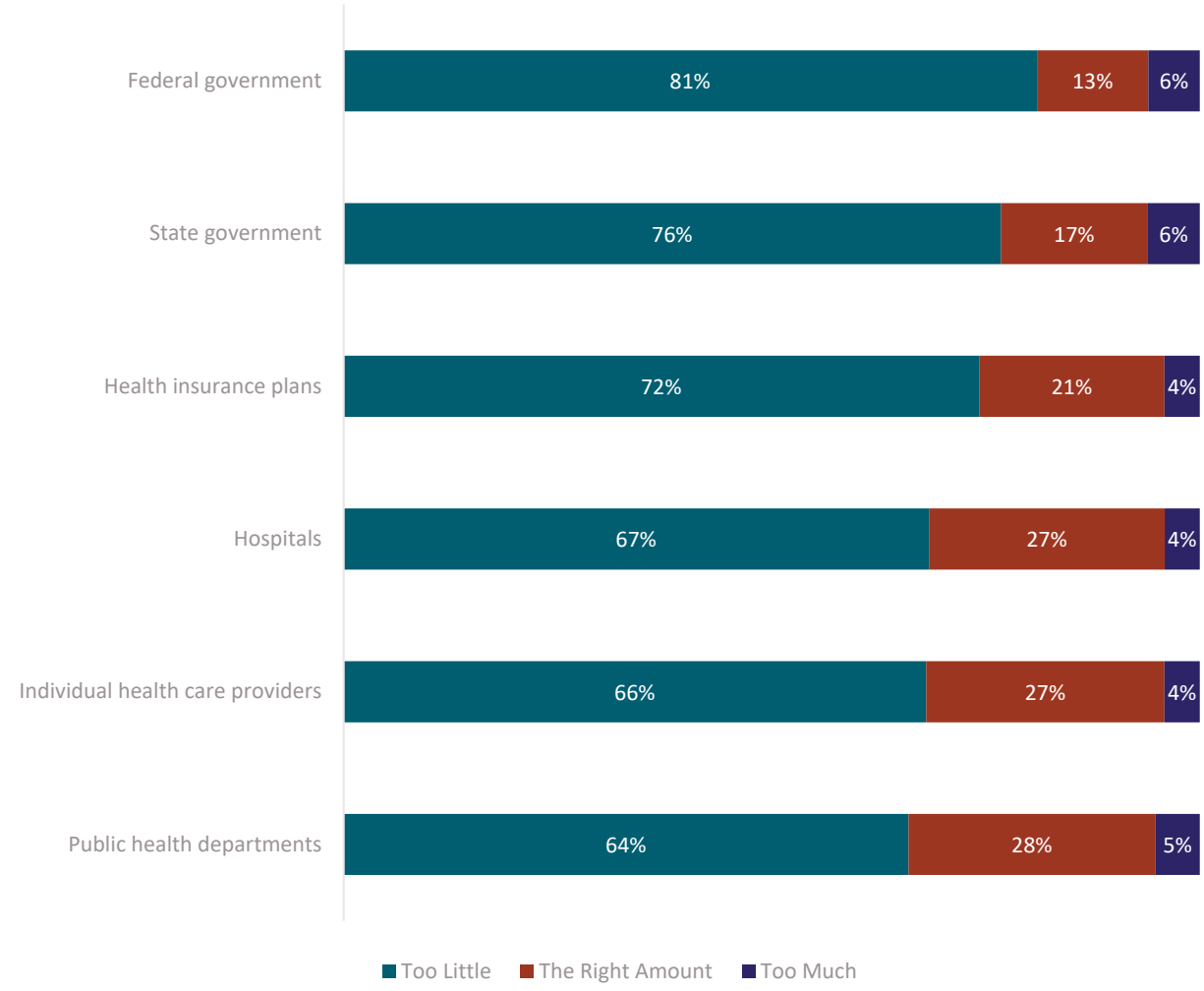
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Californians who say that they think it is “harder” or “much harder” for Black or Latinx people to get the health care they need when they are sick compared to White people were then asked whether different actors were doing enough to address racial and ethnic inequality in the health care system. Strong majorities believe that the federal government (81%), state government (76%), health insurance plans (72%), hospitals (67%), individual health care providers (66%), and public health departments (64%) are all doing “too little” (Figure 25).

Across four of the six actors asked about, Californians were less likely to report that they were doing too little to address racial and ethnic inequality in the health care system in this year’s poll compared to last year’s.

Figure 25. Californians Who Believe That Black and Latinx People Have a Harder Time Getting Health Care Than White People Also Say That the Government Is Doing “Too Little” to Address Racial and Ethnic Inequality in the Health Care System

Q: IS EACH OF THE FOLLOWING DOING TOO MUCH, TOO LITTLE, OR THE RIGHT AMOUNT TO ADDRESS RACIAL AND ETHNIC INEQUALITY IN THE HEALTH CARE SYSTEM?



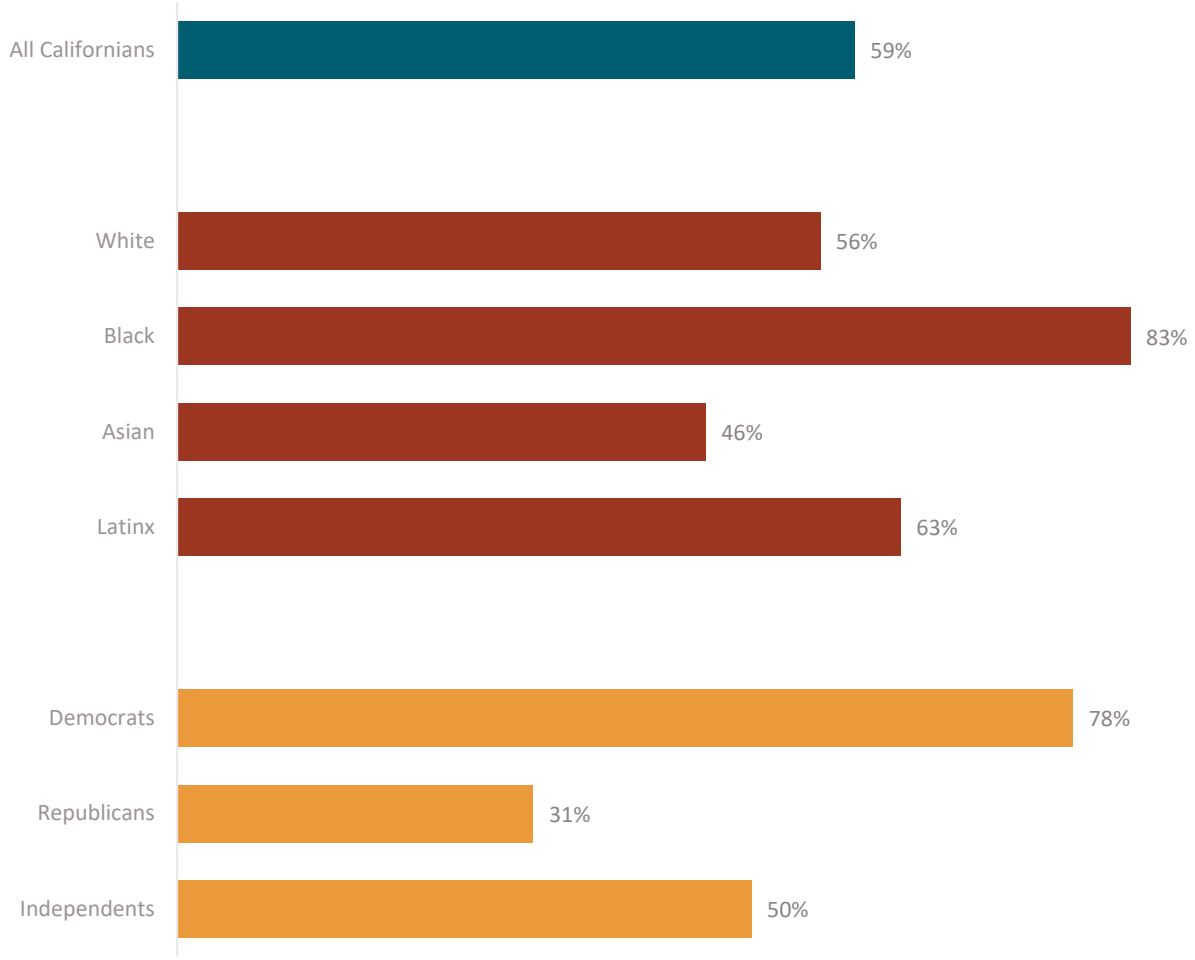
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Californians were also asked how often they thought the health care system treats people unfairly based on their racial or ethnic background. One-quarter (26%) say “regularly” and another third (33%) say “occasionally.” Another quarter (24%) say “rarely” and only 6% say “never.”

Views about how the health care system treats people varied by race of respondent, with 8 in 10 Black Californians (83%) saying that the system “regularly” or “occasionally” treats people unfairly based on their race, compared to 63% of Latinx, 56% of White, and 46% of Asian Californians. Californians are also divided on this topic by political party, with 78% of Democrats saying the system “regularly” or “occasionally” treats people unfairly based on race, compared to 50% of Independents and 31% of Republicans (Figure 26). Further, only 1% of Democrats say this “never” happens compared to 15% of Republicans.

Figure 26. One-Quarter of All Californians and the Majority of Black Californians Believe That the Health Care System Regularly or Occasionally Treats People Unfairly Based on Their Race or Ethnic Background

CALIFORNIANS WHO SAY THAT THE HEALTH CARE SYSTEM “REGULARLY” OR “OCCASIONALLY” TREATS PEOPLE UNFAIRLY BASED ON THEIR RACE OR ETHNIC BACKGROUND.



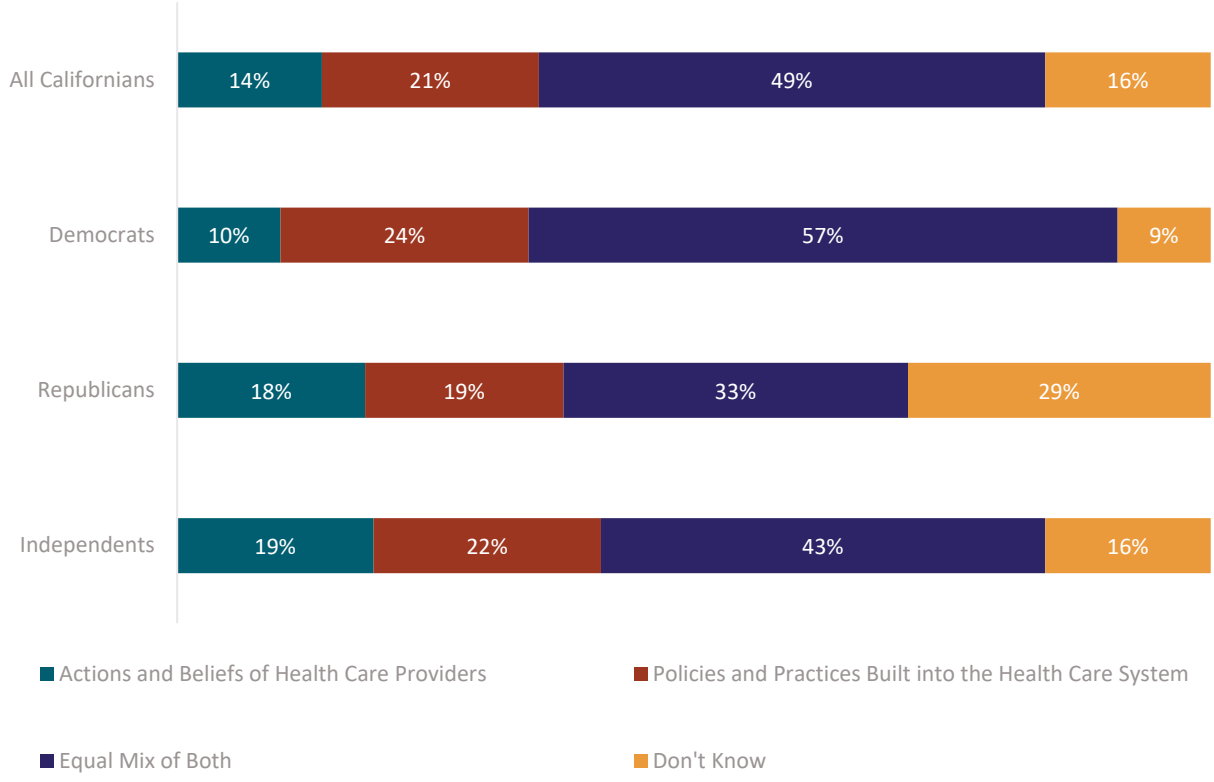
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Californians who say that the health care system "regularly," "occasionally," or "rarely" treats people unfairly based on their race or ethnic background were then asked if they think that this is more because of the actions and beliefs of health care providers, more because of policies and practices built into the health care system, or an equal mix of both. Half (49%) say it is an equal mix of both. About one in five (21%) say this was more because of "policies and practices built into the health care system," and 14% of Californians attributed unfair treatment to the "actions and beliefs of health care providers." Spanish speakers are more likely to attribute unfair treatment to an equal mix of both aspects (56%) than English speakers (47%).

Democrats are most likely (57%) to attribute unfair treatment to both the actions and beliefs of providers and to policies and practices, compared to Republicans (33%) and Independents (43%). Almost one-third of Republicans (29%) say that they "don't know" compared to 16% of Independents and 9% of Democrats (Figure 27).

Figure 27. Democrats Are Most Likely to Attribute Unfair Treatment by the Health Care System to an Equal Mix of Actions and Beliefs of Health Care Providers and of Policies and Practices Built into the Health Care System

Q: TO THE EXTENT THAT THE HEALTH CARE SYSTEM TREATS PEOPLE UNFAIRLY BASED ON THEIR RACE OR ETHNIC BACKGROUND, DO YOU THINK THIS IS MORE BECAUSE OF THE ACTIONS AND BELIEFS OF HEALTH CARE PROVIDERS, MORE BECAUSE OF POLICIES AND PRACTICES BUILT INTO THE HEALTH CARE SYSTEM, OR IS IT AN EQUAL MIX OF BOTH?

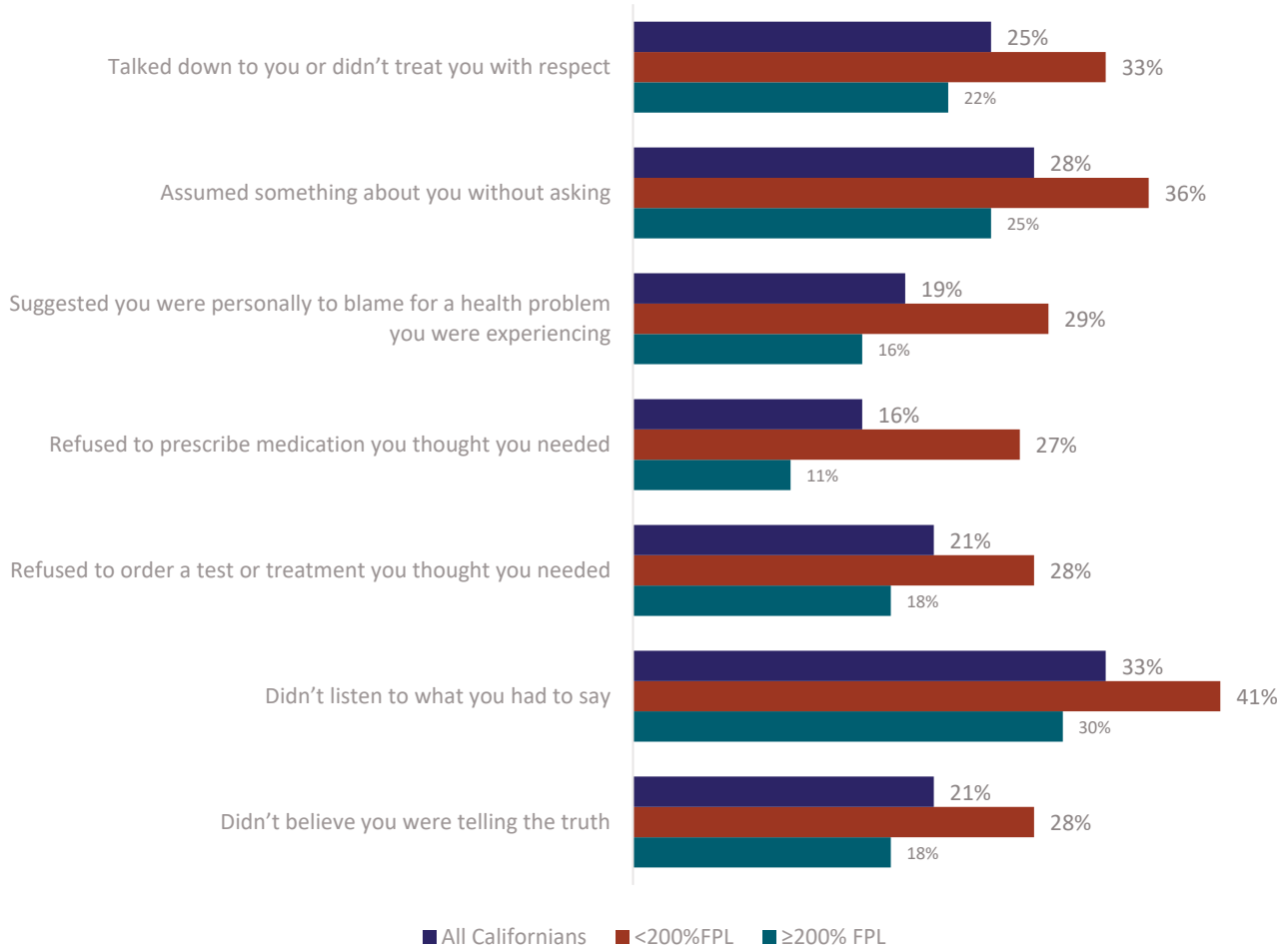


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Californians were also asked to think about their experiences with health care visits in the last few years and report whether or not they had been treated negatively. Specifically, they were asked if they ever felt that a doctor or other health care provider talked down to them or didn't treat them with respect, assumed something about them without asking, suggested they were personally to blame for a health problem they were experiencing, refused to prescribe medication they thought they needed, refused to order a test or treatment they thought they needed, didn't listen to what they had to say, or didn't believe they were telling the truth. Californians with low incomes are more likely to report experiencing each of these negative health care experiences (Figure 28). Additionally, Black and Latinx Californians were more likely than White or Asian Californians to report each of the negative health care experiences asked about (Figure 29).

Figure 28. Californians With Low Incomes are More Likely than Those with Higher Incomes to Report That They Felt a Doctor or Health Care Provider Treated Them Negatively in the Past Few Years.

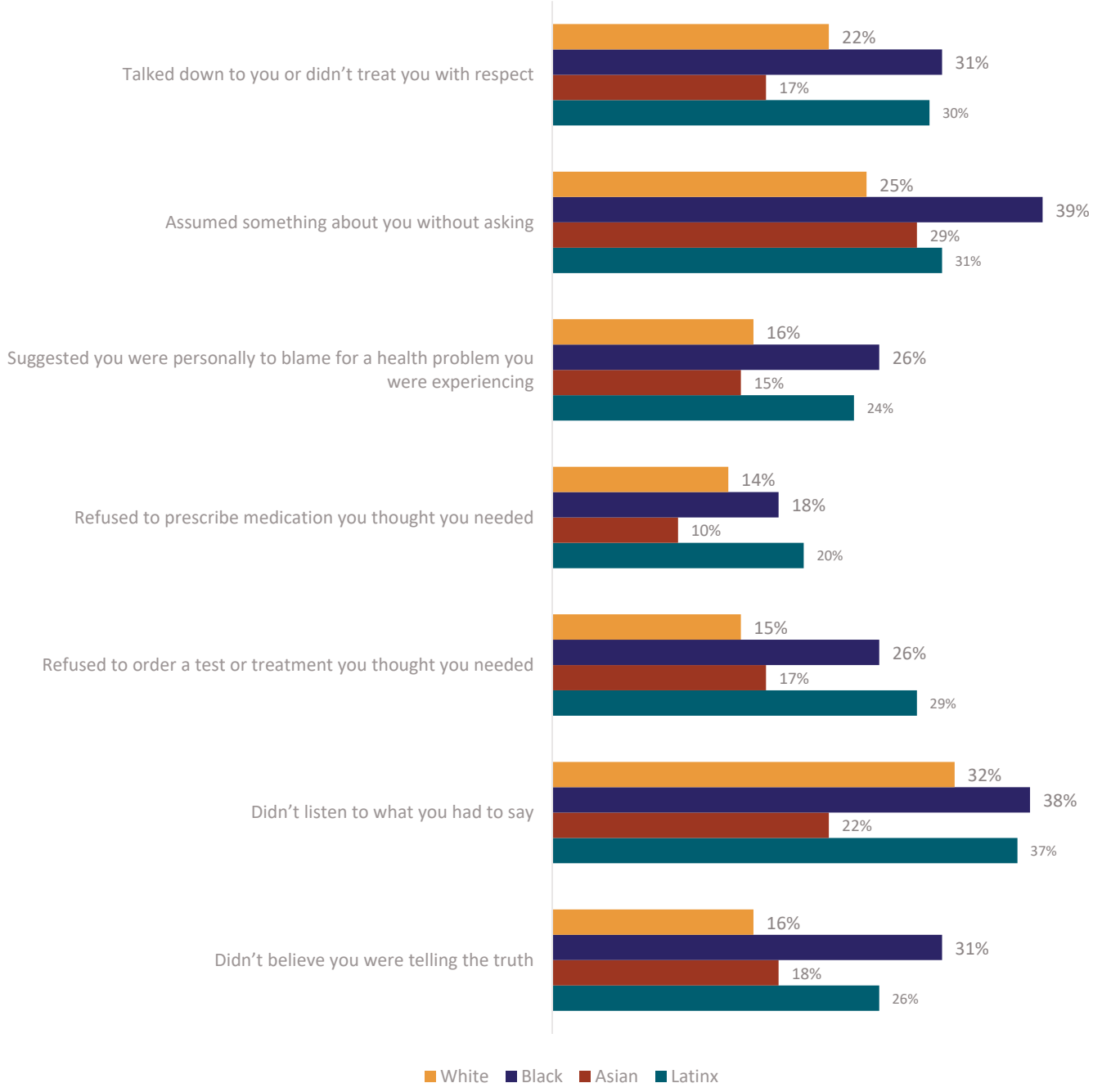
PERCENTAGE WHO SAY THEY HAD EVER FELT THAT A DOCTOR OR HEALTH CARE PROVIDER DID THE FOLLOWING WHEN THINKING ABOUT THEIR EXPERIENCES WITH HEALTH CARE VISITS IN THE LAST FEW YEARS.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Figure 29. Black and Latinx Californian Are More Likely Than Asian or White Californians to Report Negative Treatment in the Last Few Years

PERCENTAGE WHO SAY THEY HAD EVER FELT THAT A DOCTOR OR OTHER HEALTH CARE PROVIDER DID THE FOLLOWING WHEN THINKING ABOUT THEIR EXPERIENCES WITH HEALTH CARE VISITS IN THE LAST FEW YEARS.

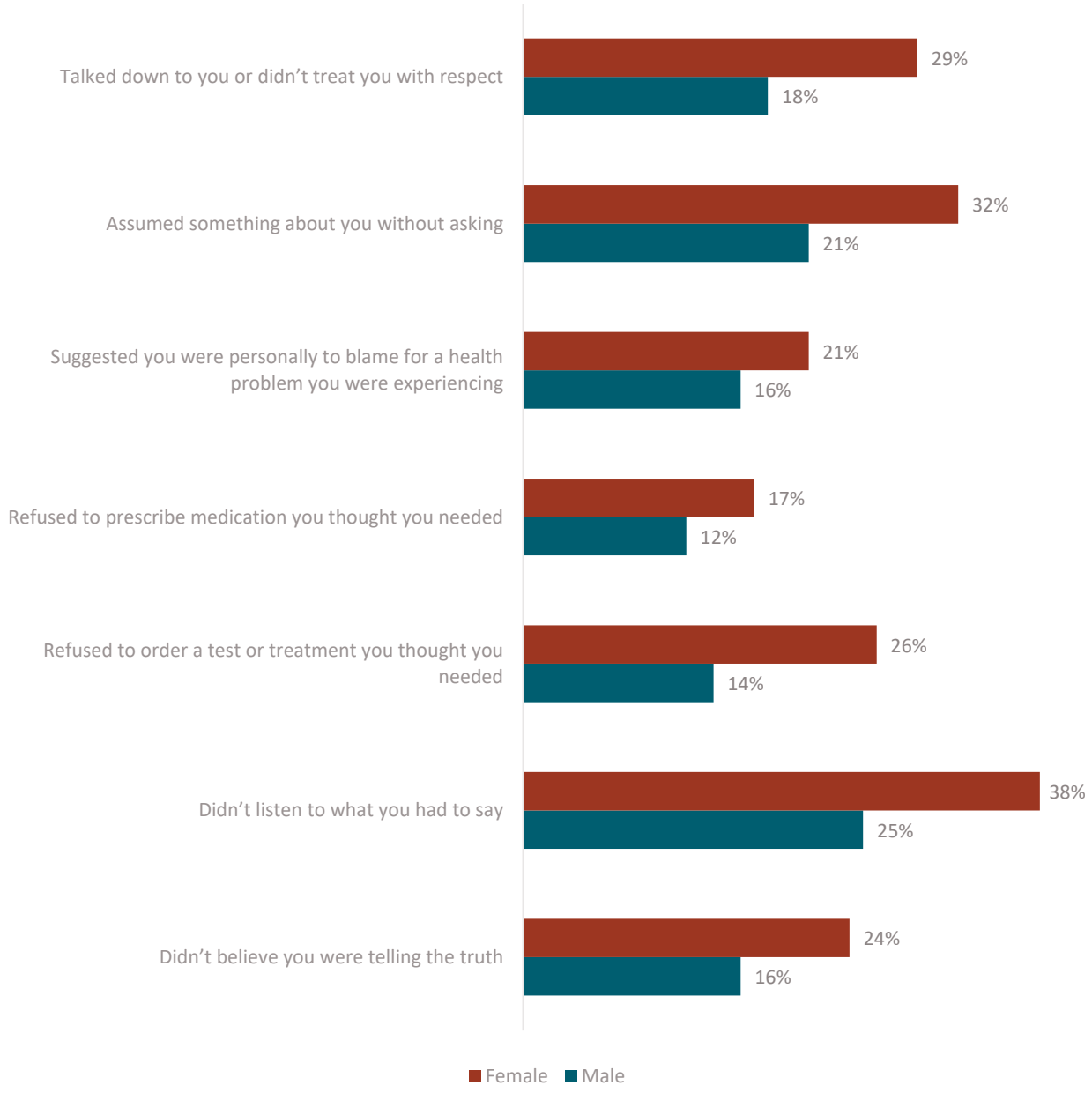


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Women are more likely than men to report negative experiences with a doctor or other health care provider, although the majority of Californians overall do not report such behaviors (Figure 30).

Figure 30. Female Californians Are More Likely to Report Negative Experiences with a Doctor or Other Health Care Provider Than Male Californians

CALIFORNIANS WHO REPORT THAT THEY HAD EVER FELT THAT A DOCTOR OR OTHER HEALTH CARE PROVIDER DID THE FOLLOWING WHEN THINKING ABOUT THEIR EXPERIENCES WITH HEALTH CARE VISITS IN THE LAST FEW YEARS.

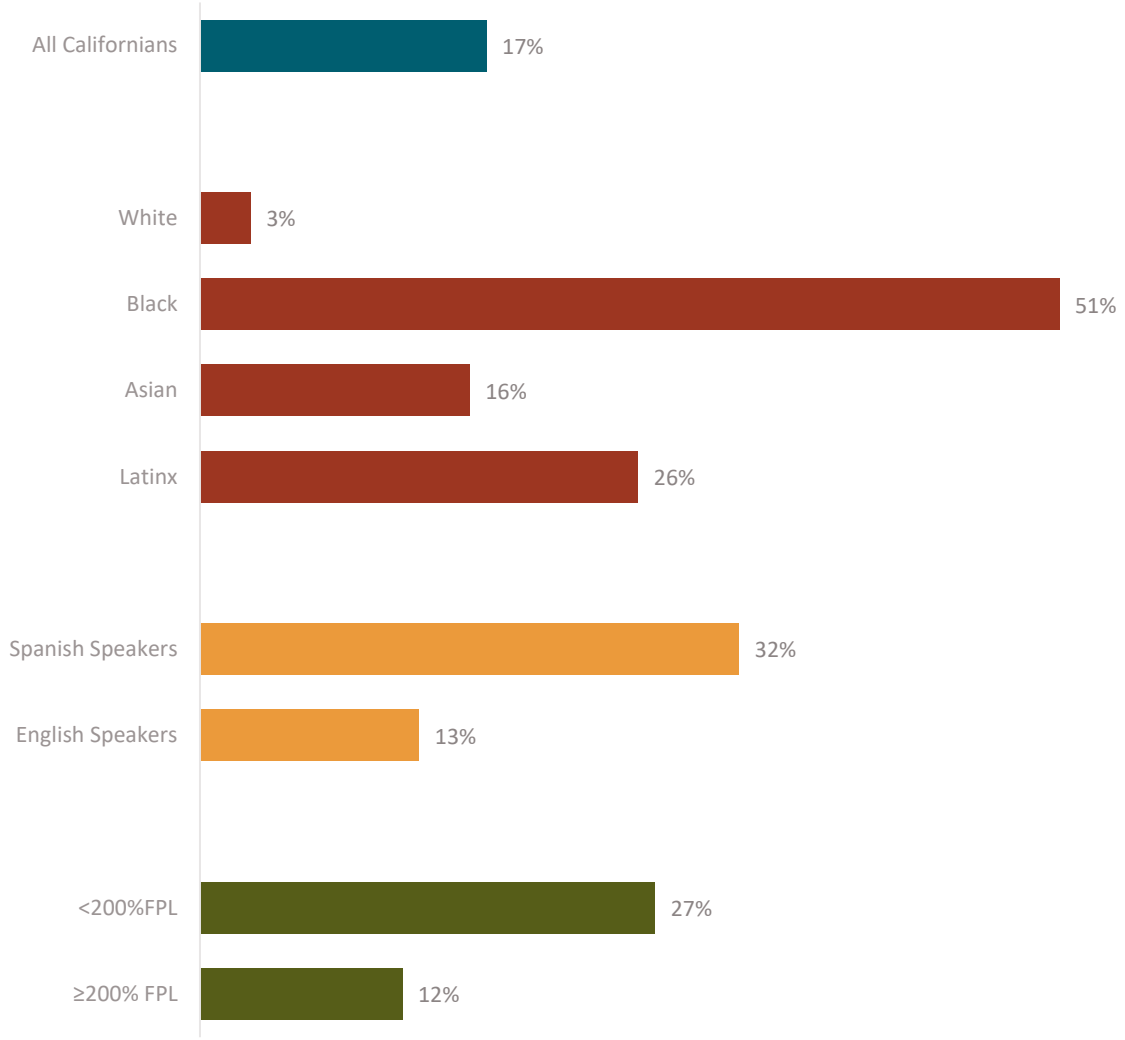


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Californians were asked if there was a time in the last few years when they thought they would have gotten better medical care if they had belonged to a different racial or ethnic group. Seventeen percent of Californians overall say they think they would have. Black Californians (51%) are most likely to think so, more than Latinx (26%), Asian (16%), and White Californians (3%). Spanish speakers are more than twice as likely as English speakers to think so (32% compared to 13%), and Californians with lower incomes are also more than twice as likely as people with higher incomes to say there was a time in the last few years when they think they would have gotten better care if they belonged to a different racial or ethnic group (27% compared to 12%) (Figure 31).

Figure 31. Black Californians Are Most Likely to Think They Would Get Better Medical Care If They Belonged to Another Racial Group

PERCENTAGE WHO SAY THERE WAS A TIME IN THE LAST FEW YEARS WHEN THEY THOUGHT THEY WOULD HAVE GOTTEN BETTER MEDICAL CARE IF THEY HAD BELONGED TO A DIFFERENT RACIAL OR ETHNIC GROUP.



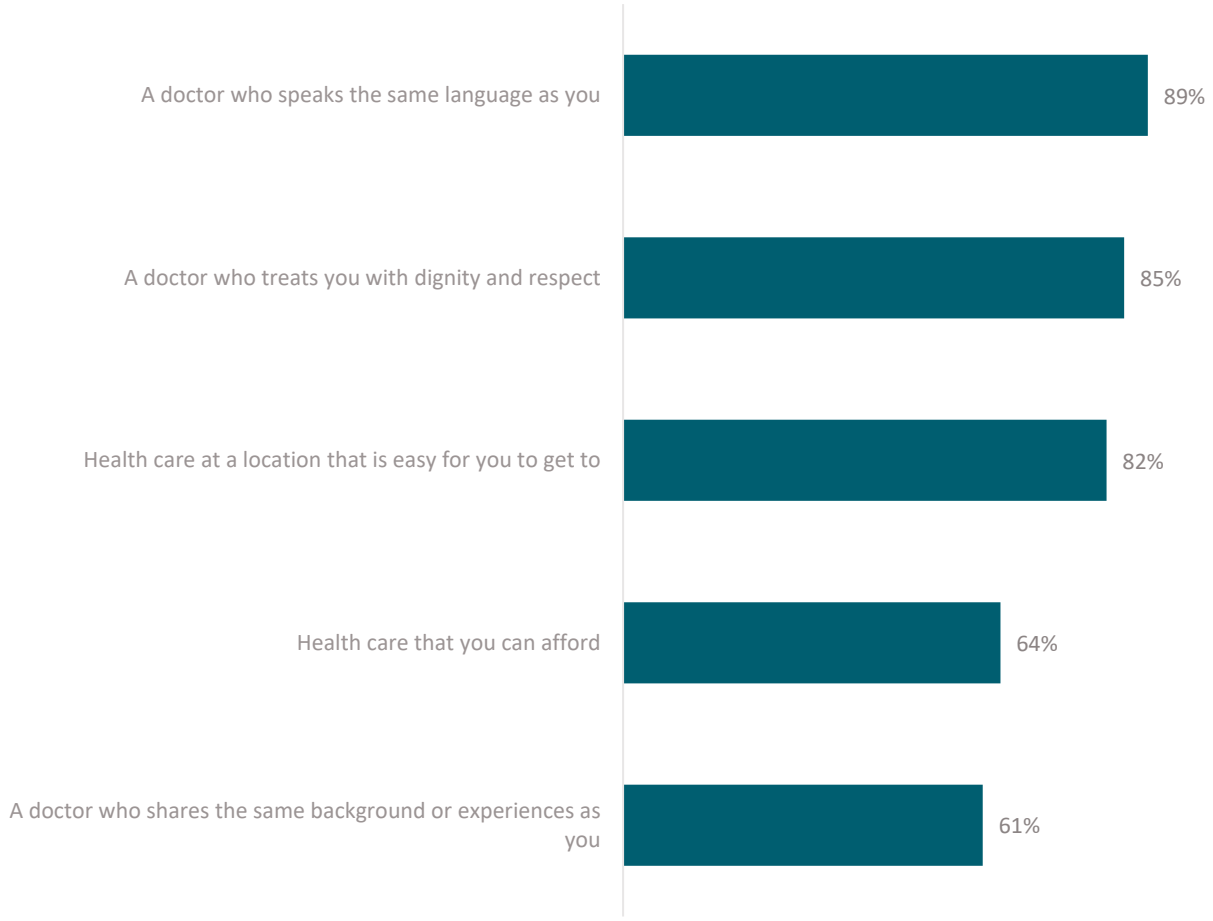
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Californians were also asked about how easy or difficult it is to find doctors and health care providers that meet their personal, cultural, linguistic, and budget needs. Overall, 85% of Californians say it was “easy” or “very easy” to find a doctor who treats them with dignity and respect, and 82% say it was “easy” or “very easy” to find health care at a location easy for them to get to. Nearly 9 in 10 Californians (89%) say it was “easy” or “very easy” to find a doctor who spoke the same language. Sixty-four percent say it was “easy” or “very easy” to find health care they can afford, and 61% say it was “easy” or “very easy” to find a doctor who shares the same background or experiences (Figure 32).

Californians who live in rural areas are much less likely to say it was “easy” or “very easy” for them to find health care at a location easy for them to get to (68%) compared to those living in urban areas (83%). Rural Californians are also less likely to say that it was “easy” or “very easy” for them to find health care they can afford (52%) compared to those in urban Californians (66%).

Figure 32. Most Californians Found It Easy to Find Providers That Met Their Personal, Linguistic, Cultural, and Budget Needs

PERCENTAGE WHO SAY IT WAS “EASY” OR “VERY EASY” TO FIND THE FOLLOWING ITEMS, THINKING ABOUT THEIR EXPERIENCE GETTING HEALTH CARE FOR THEMSELVES AND THEIR FAMILY IN THE LAST FEW YEARS.

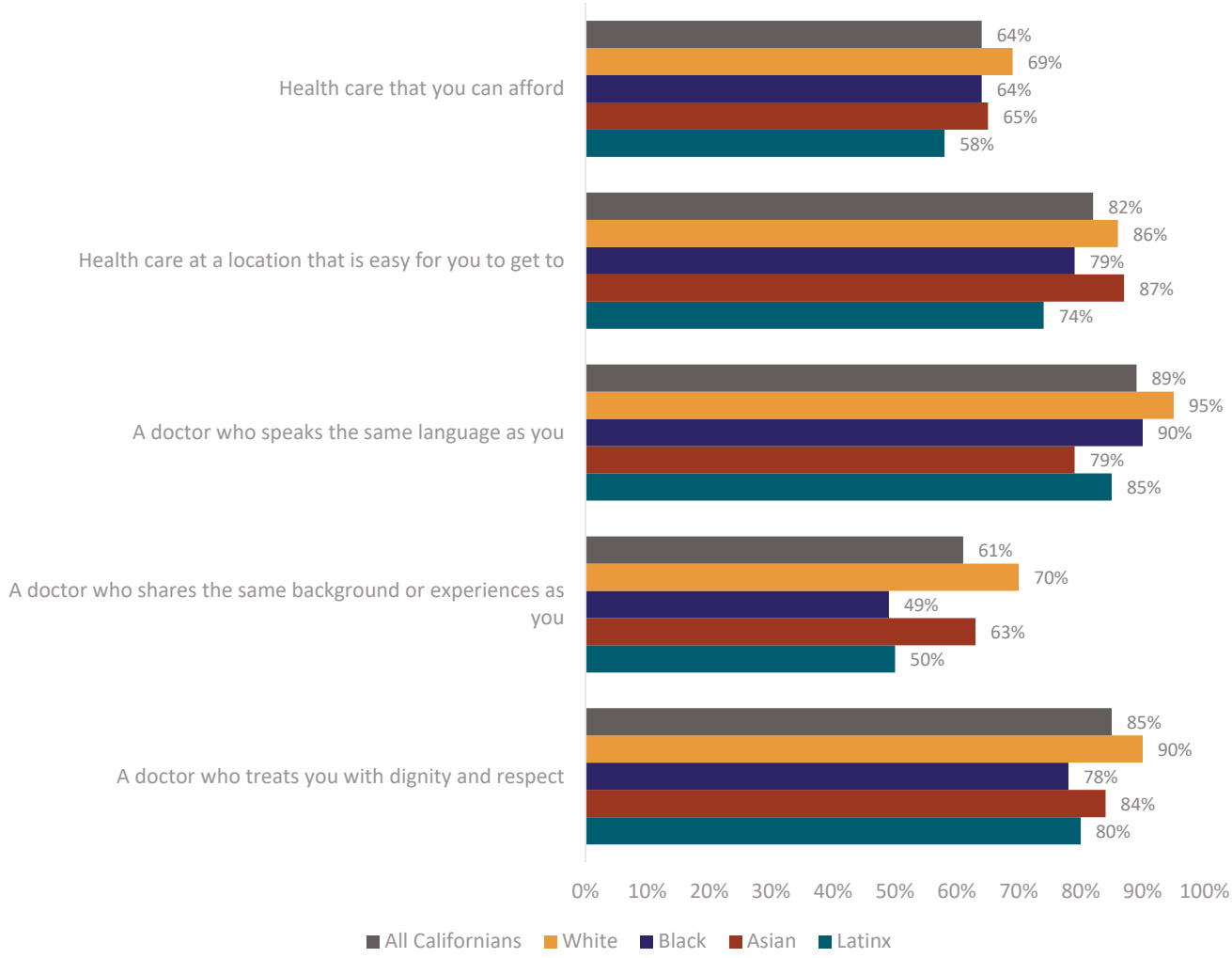


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

White Californians are more likely to report that it was “easy” or “very easy” for them to find a doctor that treats them with dignity and respect (90%) compared to Black (78%), Asian (84%) and Latinx Californians (80%). Black (49%) and Latinx Californians (50%) are much less likely than Asian (63%) and White Californians (70%) to say that it was “easy” or “very easy” for them to find a doctor who shares the same background or experiences. Asian Californians (79%) are less likely than White (95%), Black (90%) and Latinx Californians (85%) to say it was “easy” or “very easy” for them to find a doctor who speaks the same language. Latinx Californians (74%) are less likely to say that it was “easy” or “very easy” for them to find health care at a location easy for them to get to than White (86%) and Asian Californians (87%). White Californians are much more likely to say that it was “easy” or “very easy” for them to find health care that they can afford (69%) compared to Latinx Californians (58%) (Figure 33).

Figure 33. White Californians Find It Easier to Find Providers Who Meet Their Needs Than Californians of Color

PERCENTAGE WHO SAY IT WAS “EASY” OR “VERY EASY” TO FIND THE FOLLOWING ITEMS, THINKING ABOUT THEIR EXPERIENCE GETTING HEALTH CARE FOR THEMSELVES AND THEIR FAMILY IN THE LAST FEW YEARS.

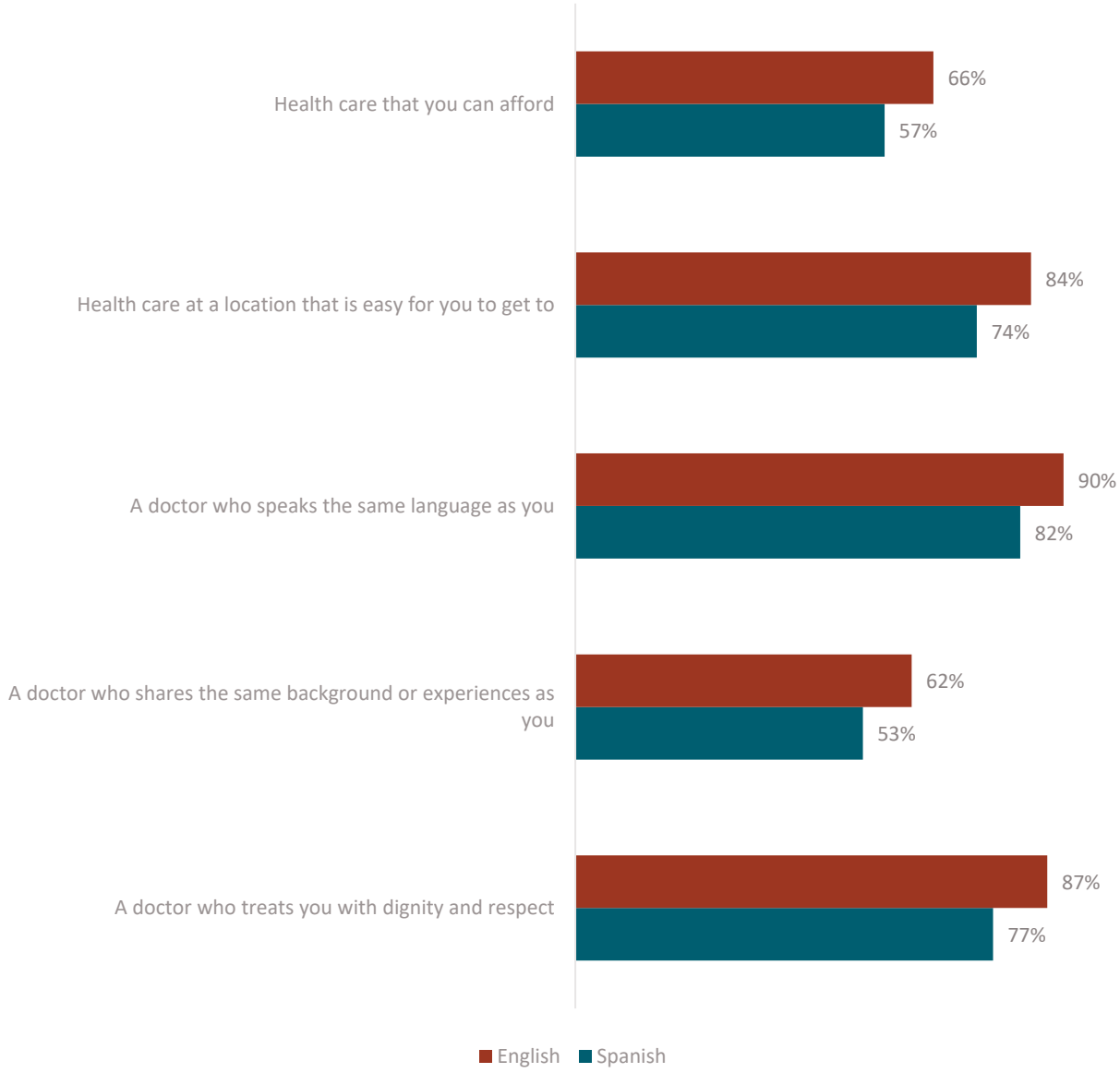


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Californians who speak English are more likely than those who speak Spanish to say that it was "easy" or "very easy" to find a doctor that treats them with dignity and respect (87% vs. 77%), a doctor who shares the same background and experiences (62% vs. 53%), a doctor that speaks the same language (90% vs. 82%), health care at a location "easy" or "very easy" to get to 84% vs. 74%), and health care they can afford (66% vs. 57%) (Figure 34).

Figure 34. English-Speaking Californians Report an Easier Time Finding Providers That Meet Their Needs Than Spanish Speakers

PERCENTAGE WHO SAY IT WAS “EASY” OR “VERY EASY” TO FIND THE FOLLOWING ITEMS, THINKING ABOUT THEIR EXPERIENCE GETTING HEALTH CARE FOR THEMSELVES AND THEIR FAMILY IN THE LAST FEW YEARS.

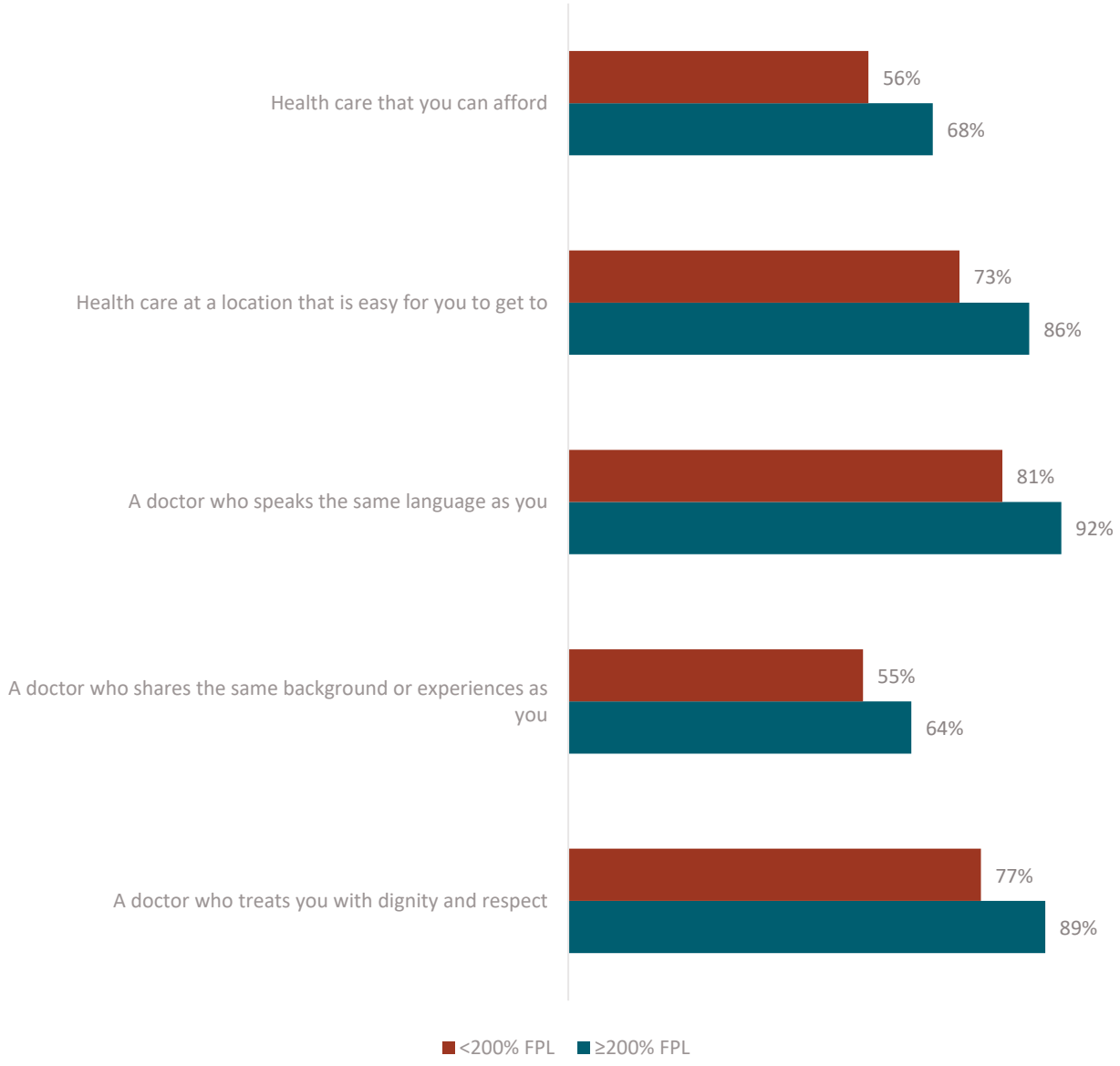


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Californians with lower incomes are less likely than those with higher incomes to say that it was "easy" or "very easy" for them to find a doctor who treats them with dignity and respect (77% vs. 89%), a doctor who shares the same background and experiences (55% vs. 64%), a doctor that speaks the same language (81% vs. 92%), health care at a location easy to get to (73% vs. 86%), and health care they can afford (56% vs. 68%) (Figure 35).

Figure 35. Californians with Higher Incomes Found It Easier to Find Care That Met Their Needs Than Those with Lower Incomes

PERCENTAGE WHO SAY IT WAS "EASY" OR "VERY EASY" TO FIND THE FOLLOWING ITEMS, THINKING ABOUT THEIR EXPERIENCE GETTING HEALTH CARE FOR THEMSELVES AND THEIR FAMILY IN THE LAST FEW YEARS.

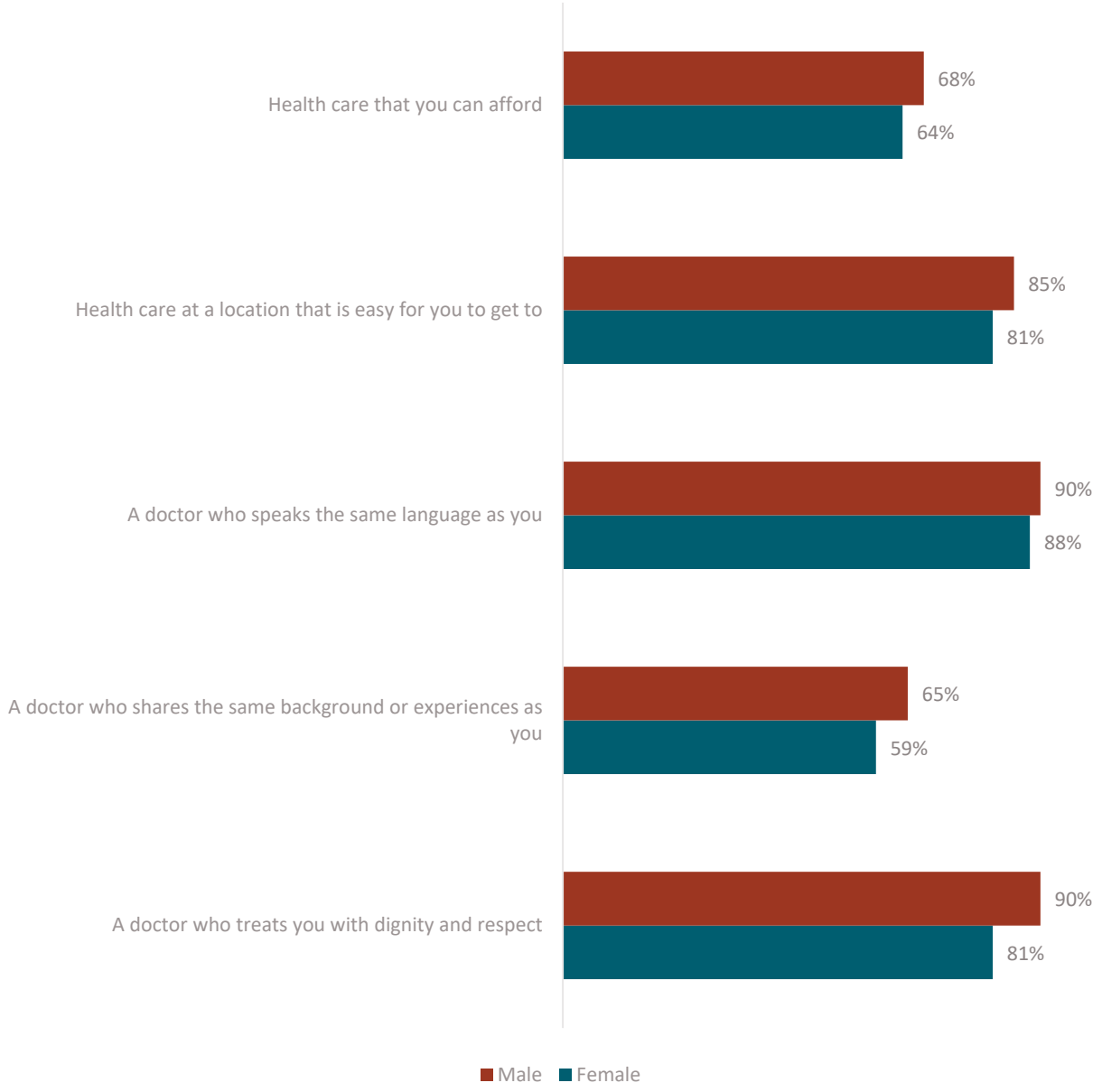


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Male Californians are more likely to say that it was “easy” or “very easy” to find health a doctor that treats them with dignity and respect (90%), a doctor who shares the same background and experience (65%), and health care at a location easy for them to get to (85%) compared to female Californians (81%, 59%, and 81%, respectively) (Figure 36).

Figure 36. Male Californians Report an Easier Time Finding Health Care and Doctors That Meet Their Needs Than Female Californians

PERCENTAGE WHO SAY IT WAS “EASY” OR “VERY EASY” TO FIND THE FOLLOWING ITEMS, THINKING ABOUT THEIR EXPERIENCE GETTING HEALTH CARE FOR THEMSELVES AND THEIR FAMILY IN THE LAST FEW YEARS.



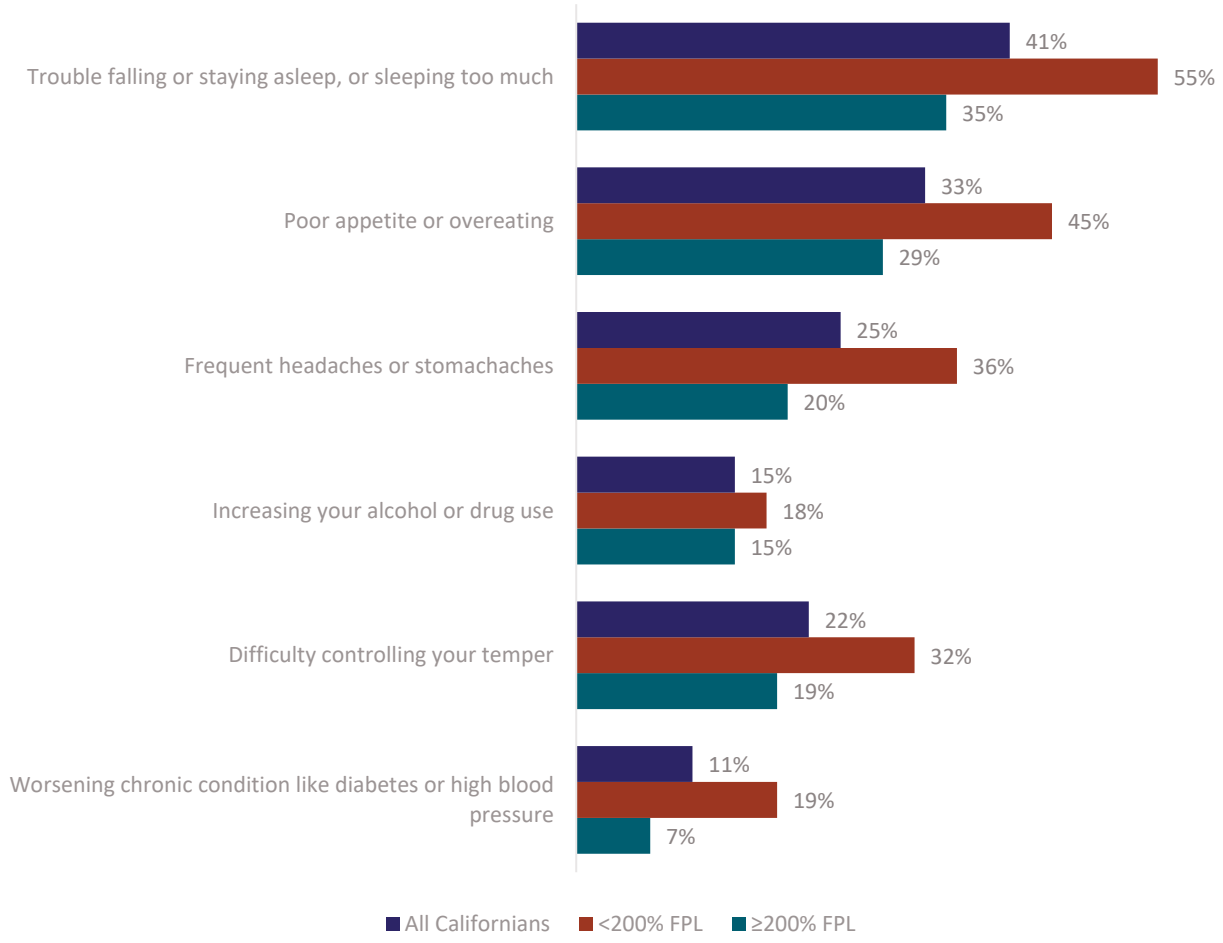
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Section 5. COVID-19

The stress from the COVID-19 pandemic continues to impact the health and well-being of Californians. Like last year's poll, more than half of Californians (56%) say that they have been negatively impacted by the worry or stress related to the COVID-19 public health emergency. The most commonly cited experiences include sleep interruptions (41%) and changes in eating habits (33%). One in 10 Californians says that the stress of the pandemic has worsened chronic conditions (Figure 37). Compared to those with higher incomes, Californians with lower incomes are more likely to experience negative impacts due to worry or stress from the pandemic. There are differences between income groups in terms of sleep interruptions (55% compared to 35%), changes in eating habits (45% compared to 29%), and frequency of headaches or stomachaches (36% compared to 20%). Black and Latinx Californians are also more likely to report experiencing stressors caused by COVID-19 than those who are White and Asian (Figure 38).

Figure 37. Stress from the COVID-19 Pandemic Has Worsened Chronic Conditions in 1 in 10 Californians

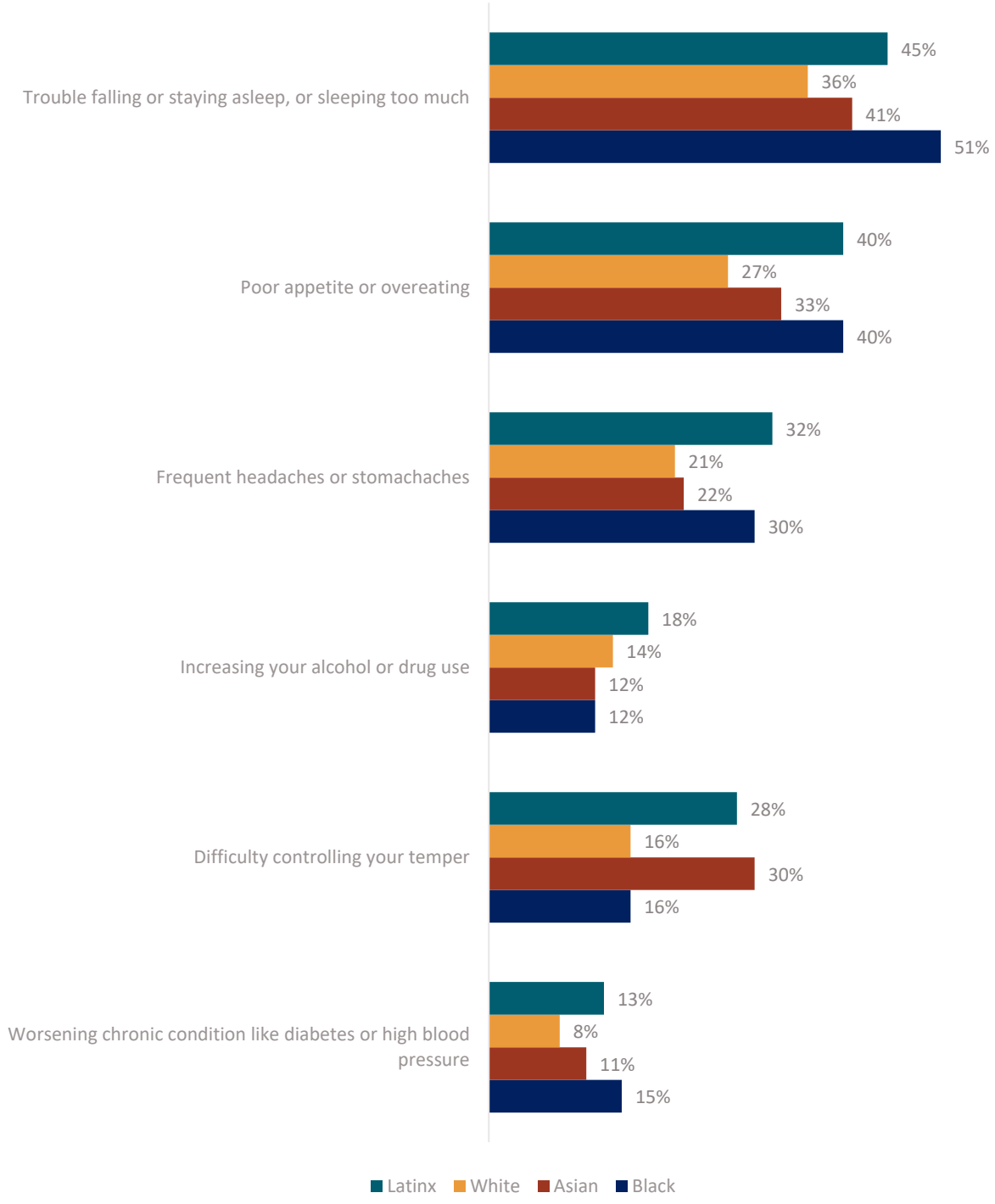
Q: HAS WORRY OR STRESS RELATED TO THE COVID-19 PANDEMIC CAUSED YOU TO EXPERIENCE THE FOLLOWING IN THE PAST 12 MONTHS?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Figure 38. Symptoms of Stress Due to COVID-19 Vary by Racial and Ethnic Group

Q: HAS WORRY OR STRESS RELATED TO THE COVID-19 PANDEMIC CAUSED YOU TO EXPERIENCE THE FOLLOWING IN THE PAST 12 MONTHS?

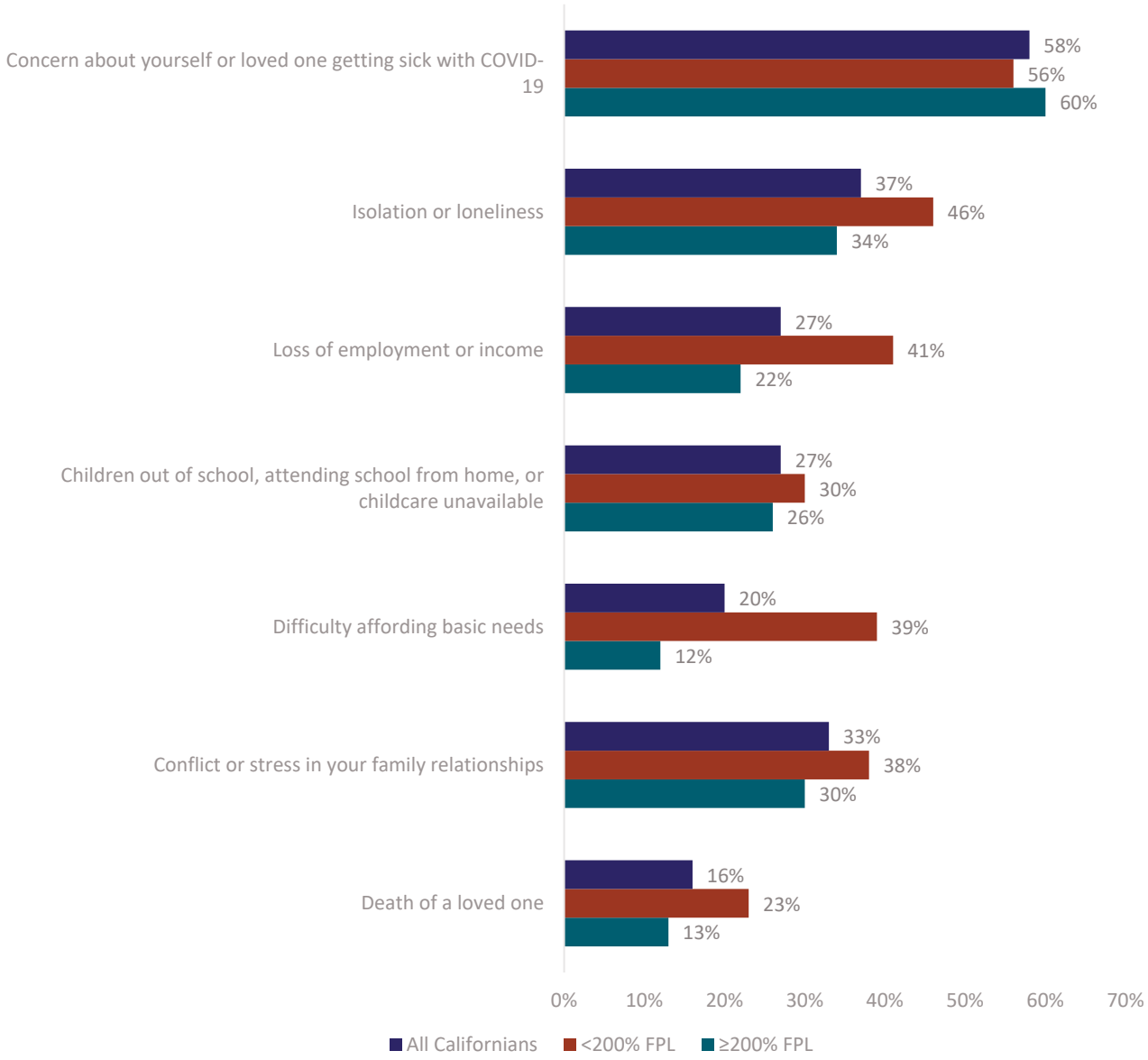


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Common stressors from the COVID-19 pandemic include concerns about becoming infected with COVID-19 (58%), isolation or loneliness (37%), and conflict in family relationships (33%). Californians with lower incomes are much more likely to be stressed from loss of employment or income (41% compared to 22%) and challenges affording basic needs (39% vs. 12%) compared to those with higher incomes (Figure 39). When looking at differences by race and ethnicity, Black and Latinx Californians are more likely to stress about affording basic needs and death of a loved one (Figure 40).

Figure 39. Most Californians Are Concerned About Themselves or a Loved One Getting Sick from COVID-19

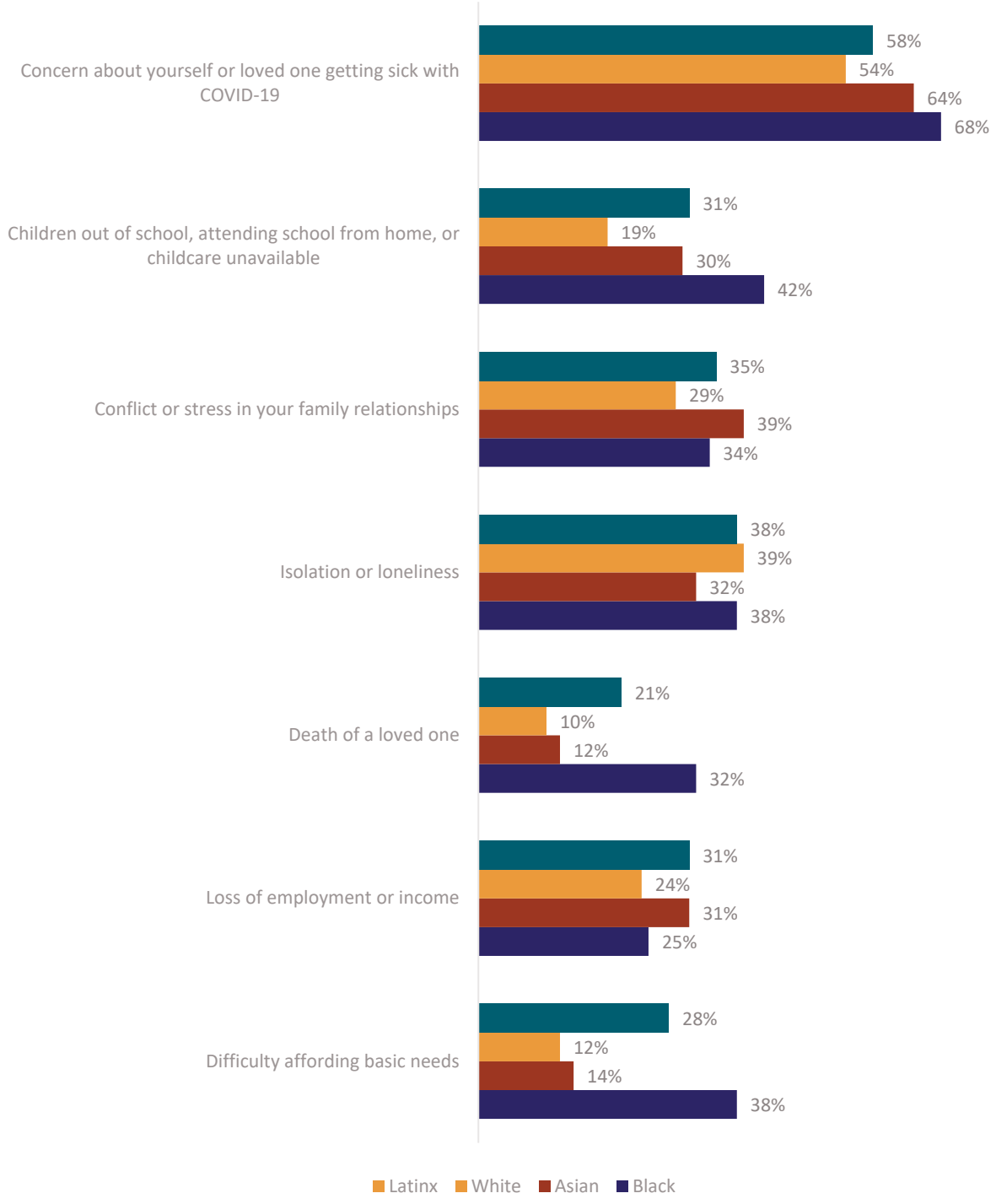
PERCENTAGE WHO EXPERIENCED STRESS BECAUSE OF ANY OF THE FOLLOWING DURING THE COVID-19 PANDEMIC.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Figure 40. COVID-19 Related Stressors Vary by Race and Ethnicity

PERCENTAGE WHO EXPERIENCED STRESS BECAUSE OF ANY OF THE FOLLOWING DURING THE COVID-19 PANDEMIC.

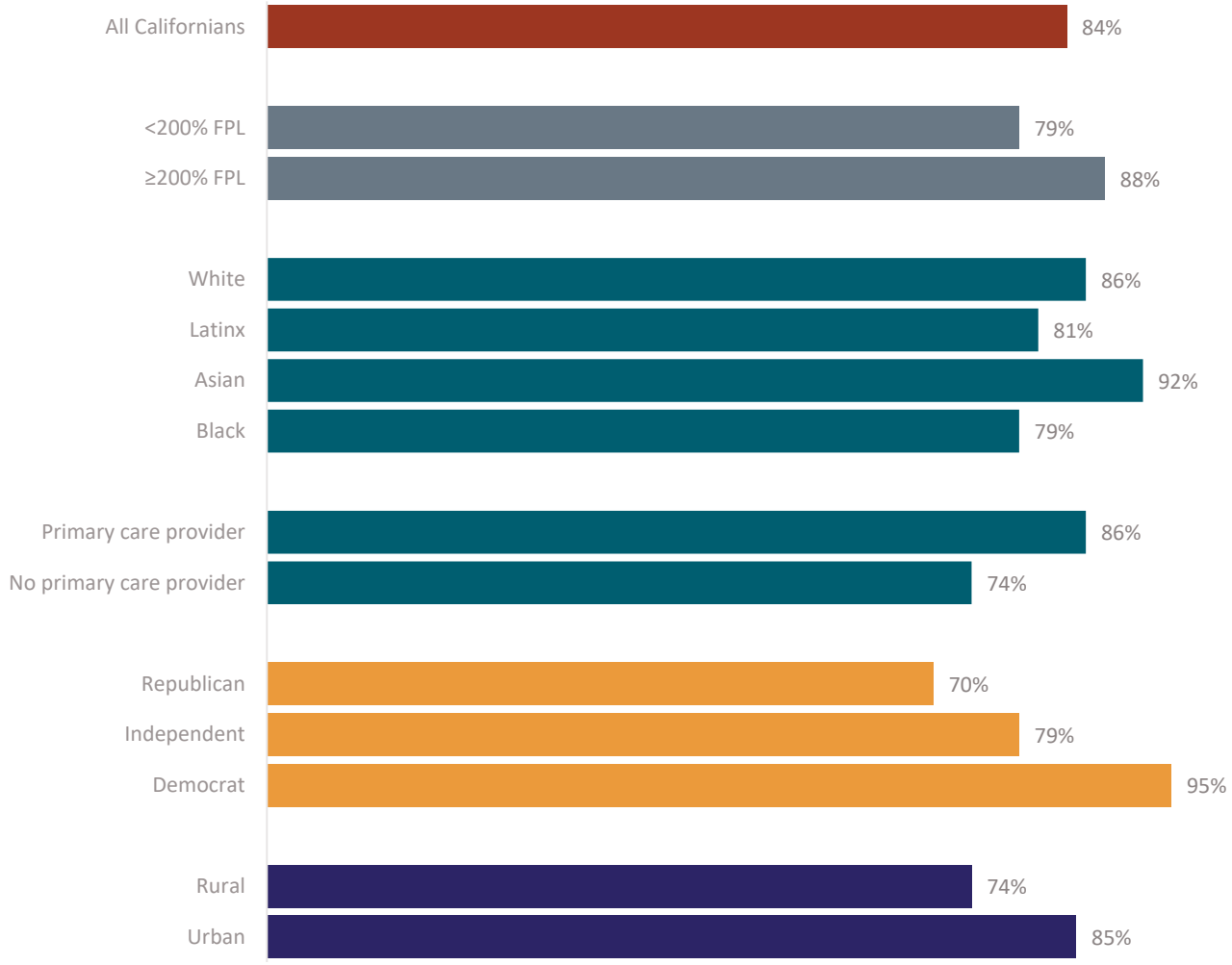


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

More than 8 in 10 Californians (84%) report being vaccinated against COVID-19. This poll did not define vaccination by number of doses or ask details about vaccine type. This is higher than the percentage of vaccinated Californians (77%) who received one dose as of the last day of the survey field period, November 17, 2021, as reported by the State of California. Californians with higher incomes (88%) are more likely than those with lower incomes (79%) to report being vaccinated. When looking across racial and ethnic groups, Asian Californians (92%) are the most likely to report being vaccinated followed by White (86%), Latinx (81%), and Black Californians (79%). The largest differences across subgroups are in party affiliation and rurality. More than 9 in 10 Democratic Californians (95%) say they are vaccinated against COVID-19 compared to 70% of Republican Californians. Similarly, 85% of Californians living in urban areas are vaccinated compared to 74% of Californians residing in rural areas (Figure 41).

Figure 41. Californians Living in Urban Areas and Democrats Most Likely to Report Being Vaccinated for COVID-19.

Q: HAVE YOU BEEN VACCINATED FOR COVID-19?



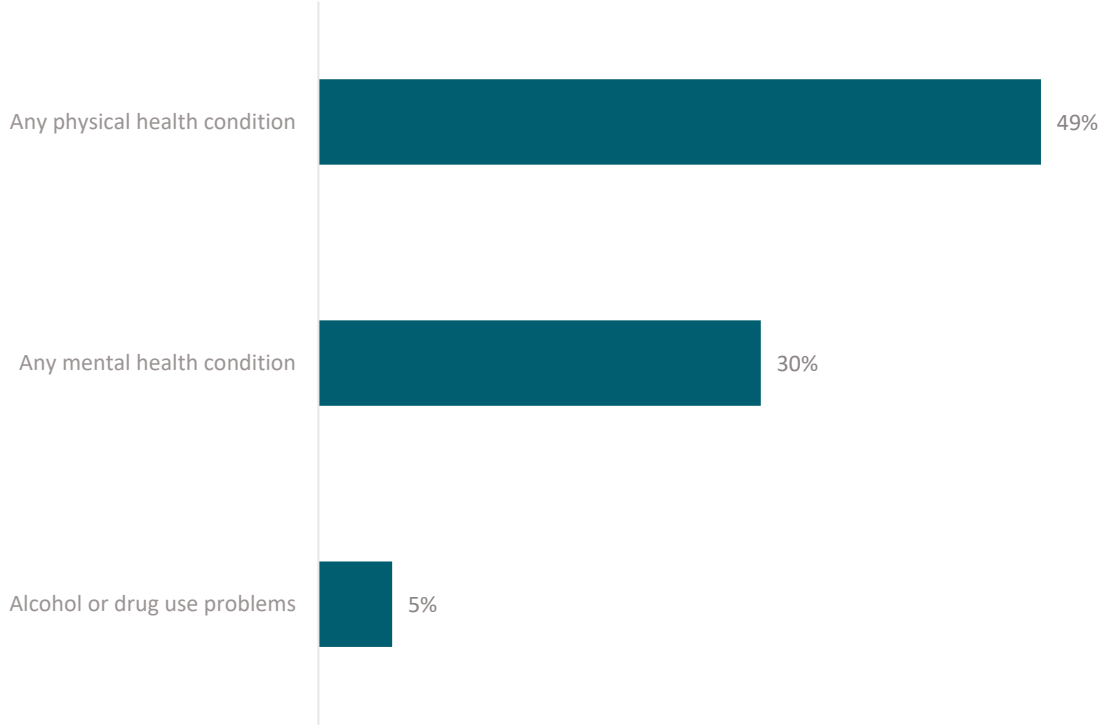
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Section 6. Access and Experiences with Health Care

Half of Californians (49%) report that they or a family member received treatment for a physical health condition in the past 12 months, similar to last year's findings (52%). Three in 10 Californians (30%) report that they or a family member received treatment for a mental health condition, an increase from the last three years, when 25% of Californians reported receiving treatment for a mental health condition. Much of the increase was due to a rise in Californians with lower incomes reporting receiving treatment for a mental health condition. The rate of Californians who say that they or a family member received treatment for an alcohol or drug use problem was 5%, similar to last year's finding (4%) (Figure 42).

Figure 42. Half of Californians Received Treatment for Physical Health

PERCENTAGE WHO SAY THAT THEY OR A FAMILY MEMBER RECEIVED TREATMENT OR COUNSELING FOR ANY OF THE FOLLOWING IN THE PAST 12 MONTHS.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Proportions of Californians receiving treatment for a physical or substance use issue did not differ across income groups; however, Californians with lower incomes (37%) are more likely to report that they or a family member received treatment for a mental health condition than those with higher incomes (28%). Black Californians (62%) are more likely than Californians of all other racial and ethnic groups to report receiving physical health care, followed by White (52%), Latinx (50%), and Asian Californians (37%).

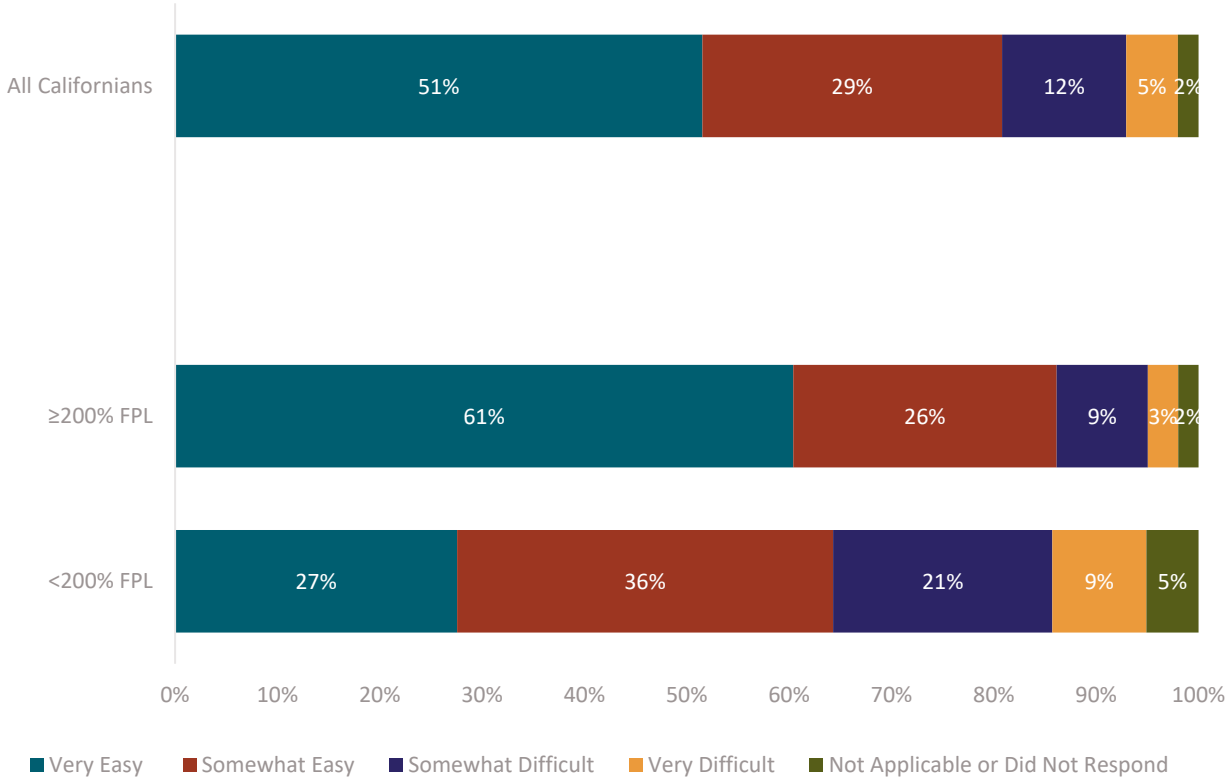
Experiences with Physical Health Care

Four in 10 Californians (42%) report trying to make an appointment for physical health care in the past 12 months, significantly less than the proportion reporting doing so in the prior year's survey (68%). Half of Black Californians (51%) report trying to make an appointment for physical health care, followed by White (45%), Latinx (40%), and Asian Californians (31%). Of those Californians who report trying to make an appointment for physical health care, 4 in 10 (44%) report waiting longer than they though was reasonable, the same proportion reporting this in last year's survey.

Similar to last year's findings, nearly one in five Californians (17%) who report trying to make an appointment for physical health care say it was "very" or "somewhat" difficult to find a provider who took their insurance. Latinx Californians (21%) are twice as likely as White Californians (11%) to report difficulty, and those with lower incomes (30%) are more likely than those with higher incomes (12%) to report that it was difficult to find a physical health care provider who took their insurance (Figure 43).

Figure 43. More Than 4 in 10 Californians with Low Incomes Report Difficulty Finding a Provider Who Takes Their Insurance

Q: HOW EASY OR DIFFICULT WAS IT TO FIND A PHYSICAL HEALTH CARE PROVIDER WHO TOOK YOUR INSURANCE?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding. *FPL* is federal poverty level. Five percent of Californians with incomes <200% FPL did not respond.

Experiences with Mental Health Care

Nearly 1 in 5 Californians (18%) report trying to make an appointment for mental health care in the last 12 months, similar to the proportion who reported this in last year's survey. There were no differences across income groups, with roughly 2 in 10 Californians with lower and higher incomes (21% compared to 17%) reporting trying to make an appointment for mental health care. Of those who tried to make an appointment, half (49%) report waiting longer than they thought reasonable to get one. In addition, 45% say it was difficult for them to find a mental health care provider who accepted their insurance (22% "very" difficult). Proportions of Californians who report waiting longer than they thought reasonable to get an appointment with — or difficulty finding — a mental health care provider who took their insurance remained stable relative to last year.

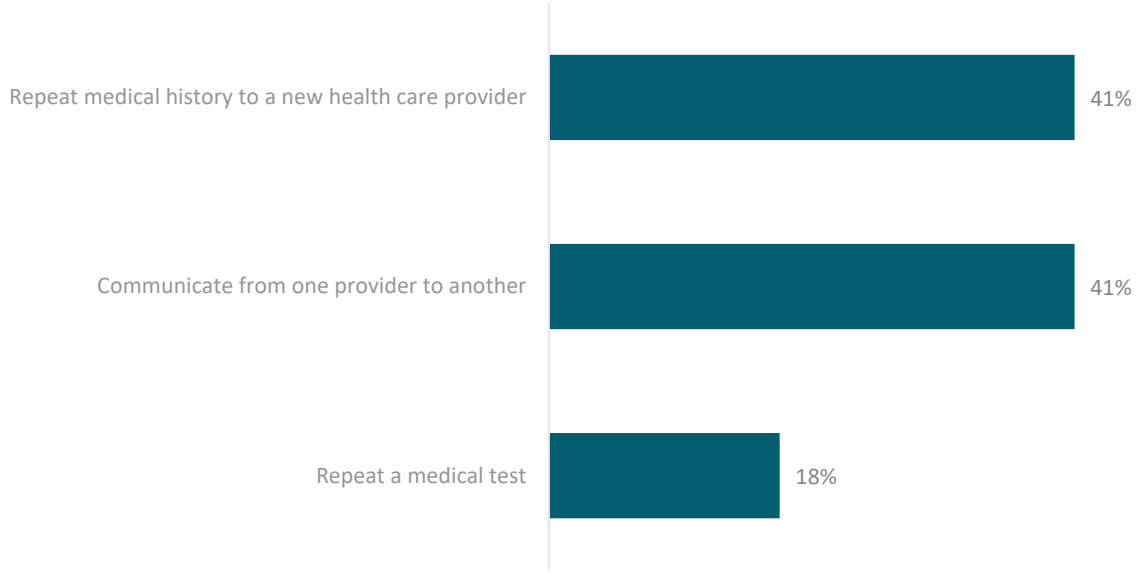
Care Experience

Four in 10 Californians (41%) report having needed to repeat their medical history to a new health care provider in the last five years. This was the case for half of White Californians (48%), followed by Latinx (41%), Black (36%), and Asian Californians (27%). Four in 10 Californians (41%) also report communicating information about their condition or treatment from one provider to another provider in the last five years.

Two in 10 Californians (18%) report needing to repeat a medical test because prior results are not available to a new provider (Figure 44). Californians with lower incomes are more likely than those with higher incomes to say they repeated a test in this circumstance (26% compared to 14%).

Figure 44. Four in 10 Californians Report Needing to Repeat Their Medical History or Communicate Health Information Between Providers

PERCENTAGE WHO HAD TO DO THE FOLLOWING IN THE LAST FIVE YEARS.

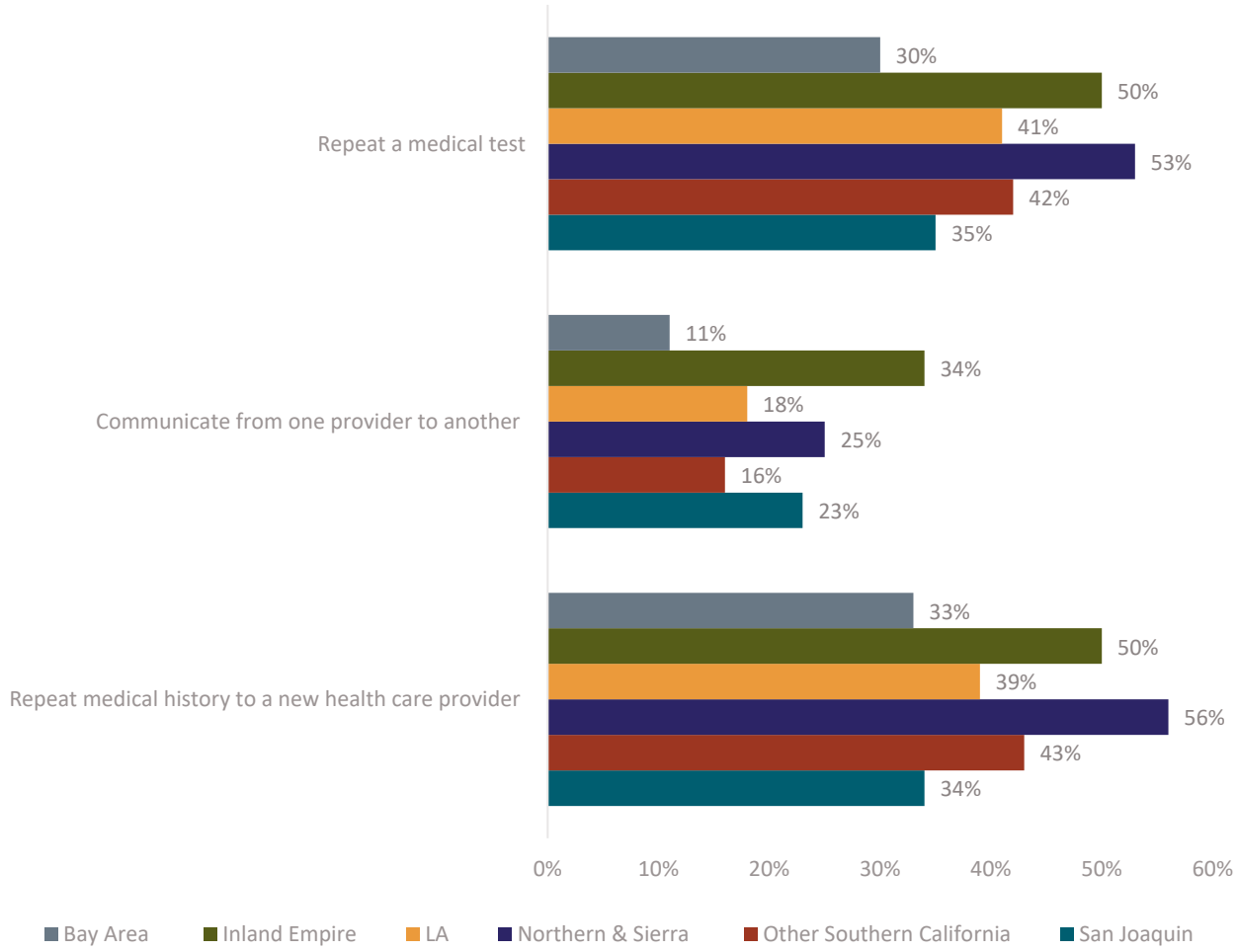


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Regional differences exist for care experience. Californians who live in the Inland Empire and the Northern & Sierra regions are more likely to report repeating medical history to a new health care provider (50% and 56%, respectively) and communicating other information about their condition or treatment from one provider to another (50% and 53%, respectively) (Figure 45).

Figure 45. Some Care Experiences Differ by Region

PERCENTAGE WHO HAD TO DO THE FOLLOWING IN THE LAST FIVE YEARS.



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Telehealth

Telehealth refers to care delivered in a variety of electronic platforms — including a live video connection (where the patient and health care provider can see each other) or by telephone. Seventy-five percent of Californians report receiving care via telehealth (by either “talking on the telephone” or “live video”) in the past 12 months, up from 68% in last year’s survey.

Phone

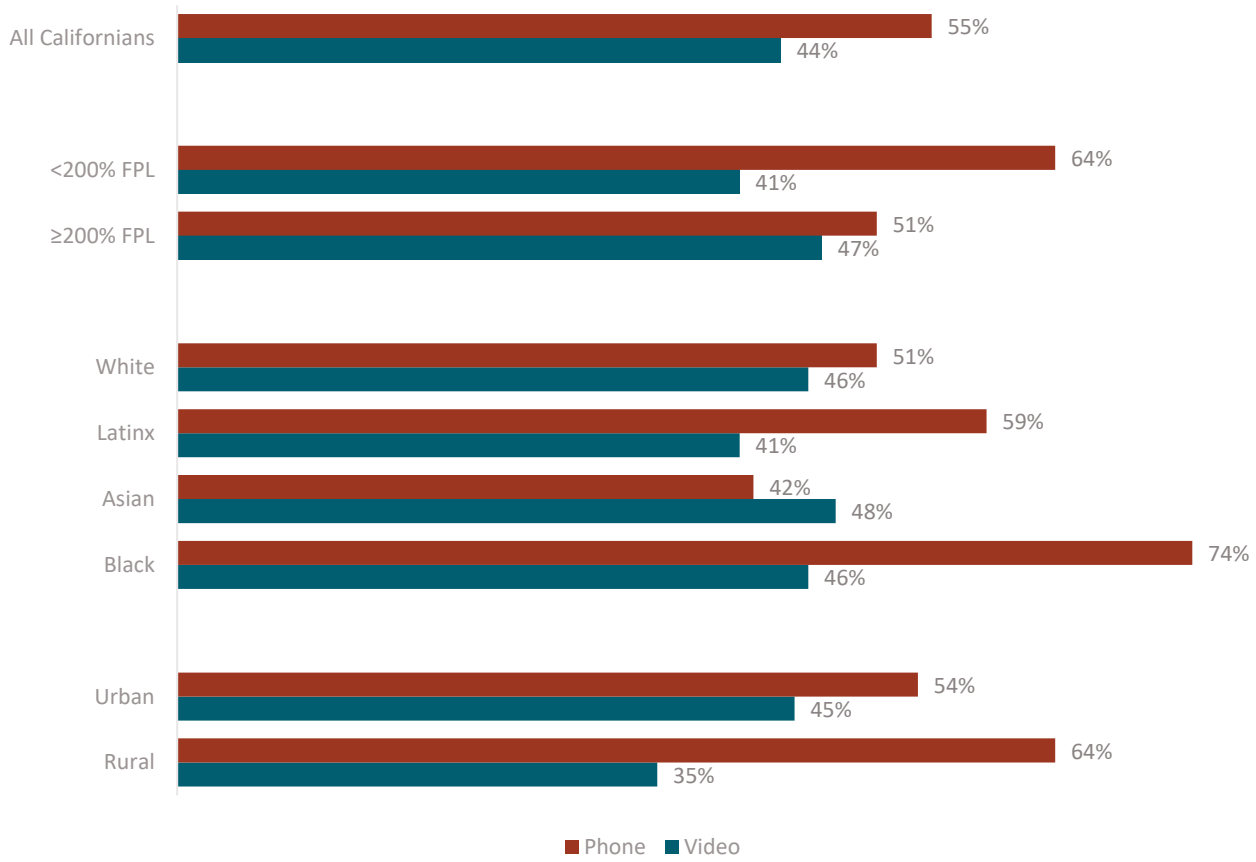
More than half of Californians (55%) report receiving care by "talking on the telephone" in the past 12 months, an increase from the 45% who reported using phone telehealth in last year's poll. There are differences among subgroups. Californians with lower incomes (64%) are more likely than those with higher incomes (51%) to receive care via telephone. Black Californians (74%) are more likely to report receiving care via telephone than Latinx (59%), White (51%), and Asian Californians (42%). Spanish-speaking Californians (61%) are more likely than those who speak English (53%) (not shown) and likewise, those who live in rural areas (64%) are more likely than Californians who live in urban settings (54%) to receive care via telephone.

Video

More than 4 in 10 Californians (44%) report receiving care "by live video" in the past 12 months, an increase from the 35% who reported this in last year's poll. There are no differences in reports of experiencing care by video between Californians with lower and higher incomes, racial and ethnic groups, or between English- and Spanish-speaking Californians (Figure 46).

Figure 46. More Than Half of Californians Experienced a Phone Telehealth Visit, 4 in 10 a Video Visit

PERCENTAGE WHO RECEIVED CARE USING ANY OF THE FOLLOWING IN THE PAST 12 MONTHS.

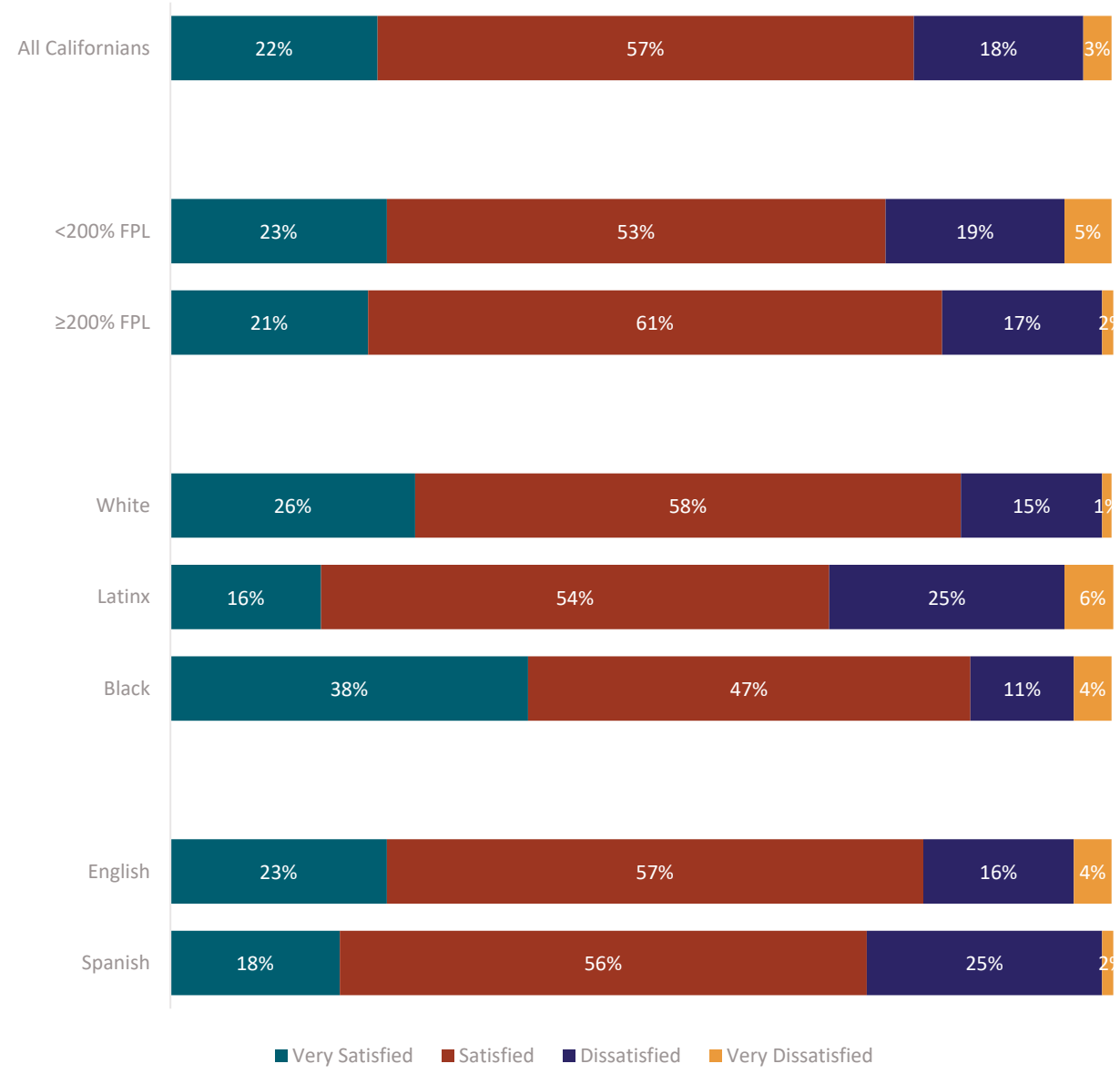


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Eight in 10 Californians (79%) say they are satisfied with the quality of the health care they received via phone (22% "very" satisfied). Californians with higher incomes are more satisfied with the quality of the health care they received via phone (82% "very satisfied" or "satisfied") compared with Californians with lower incomes (76% "very satisfied" or "satisfied"). Black (85%) and White Californians (84%) are more satisfied with the quality of care they received via phone than Latinx Californians (70%), and English-speaking Californians (80%) are more satisfied than those who speak Spanish (74%) (Figure 47).

Figure 47. Eight in 10 Californians Are Satisfied with the Quality of Care They Receive via Phone

Q: HOW SATISIFED OR DISSATISFIED ARE YOU WITH THE QUALITY OF CARE YOU RECEIVED VIA PHONE?

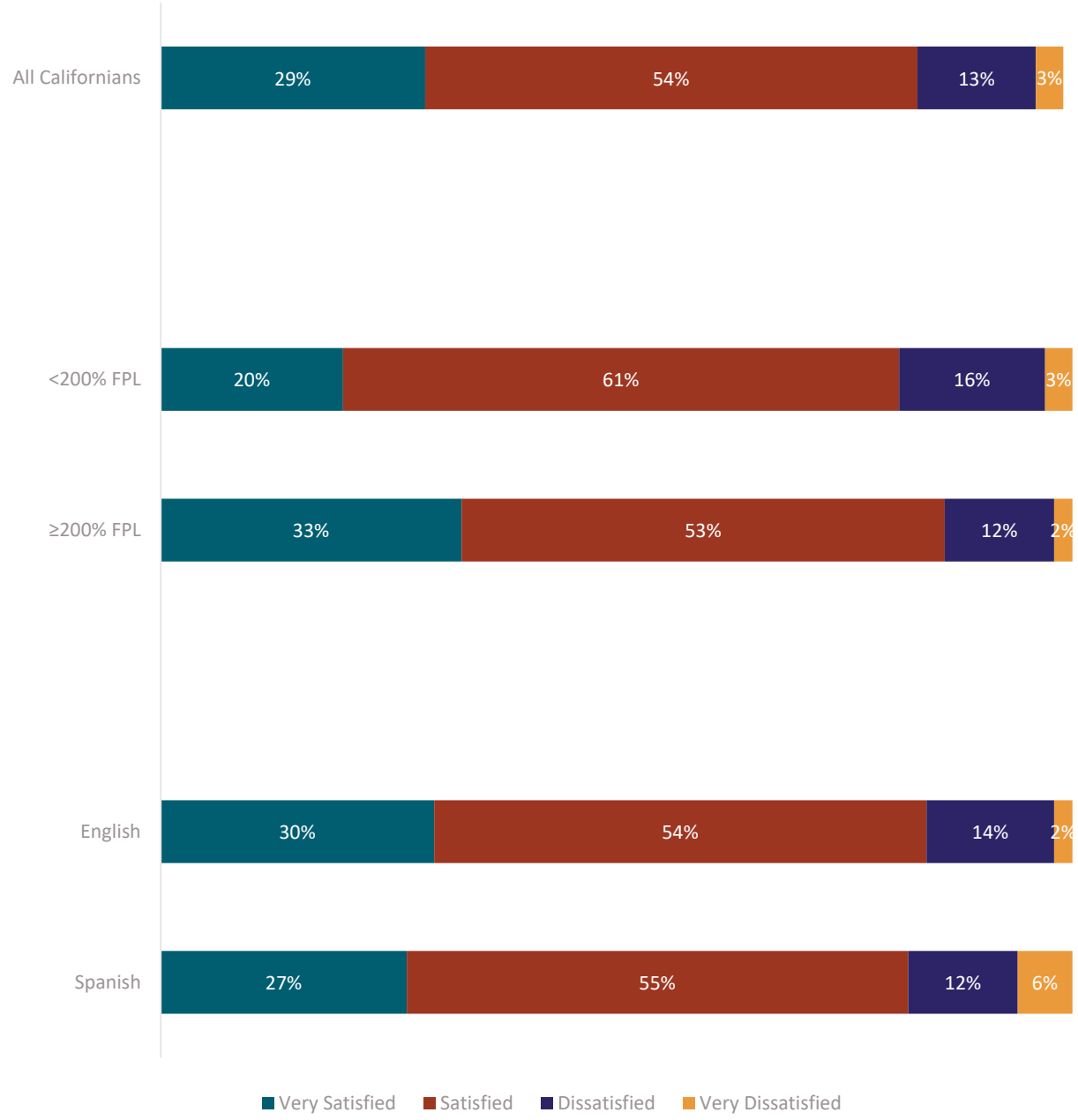


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding. FPL is federal poverty level. The number of Asian respondents for this question (n = 71) is too small to report meaningful results.

More than 8 in 10 Californians (83%) who received care via video express satisfaction with the quality of the health care they received, with 29% reporting they are "very" satisfied and half (54%) reporting they are "satisfied." Of the 16% of Californians dissatisfied with the quality of care they received via video, 1 in 10 (13%) say they are "dissatisfied" and 3% report feeling "very dissatisfied" (Figure 48).

Figure 48. More Than 8 in 10 Californians Are Satisfied with the Quality of Care They Receive via Video

Q: HOW SATISIFED OR DISSATISFIED ARE YOU WITH THE QUALITY OF CARE YOU RECEIVED VIA VIDEO?

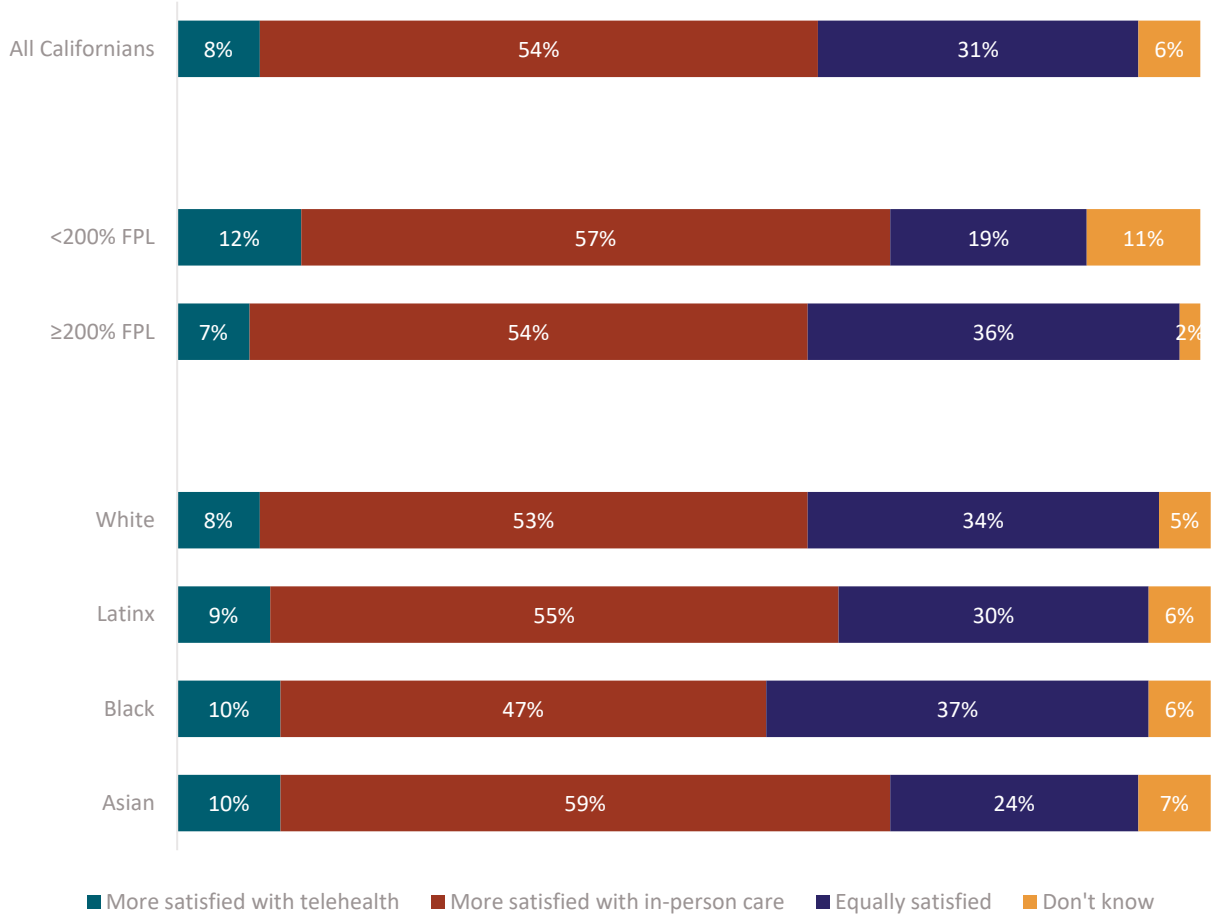


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding. *FPL* is federal poverty level.

Californians who received care either by phone or video in the last 12 months were asked how it compared to in-person care. Three in 10 (31%) say they are equally satisfied with in-person and telehealth care. Half (54%) are more satisfied with care in person, and 8% are more satisfied with telehealth. Californians with higher incomes are almost twice as likely (36% compared to 19%) to be equally satisfied with in-person and telehealth care. There were no statistically significant differences across racial and ethnic groups (Figure 49).

Figure 49. Three in 10 Californians Are Equally Satisfied with the Care They Receive via Telehealth and In Person

Q: THINKING ABOUT THE LAST TIME YOU RECEIVED IN-PERSON CARE, ARE YOU MORE SATISFIED WITH THE CARE YOU RECEIVED VIA TELEHEALTH OR IN PERSON?



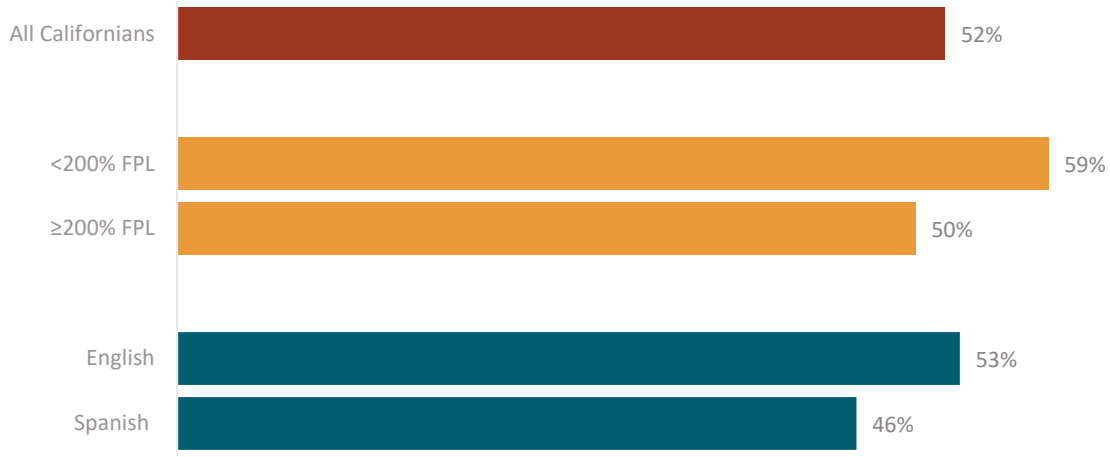
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Deferred Care

Half of Californians (52%) say they or a member of their household has skipped or postponed some type of medical or dental care in the last 12 months. This proportion is similar to last year's poll, when 51% of Californians reported skipping or postponing care. Californians with lower incomes (59%) are more likely than those with higher incomes (50%) to say they skipped or postponed care, and those who speak English (53%) are more likely to report skipping or delaying care compared to those who speak Spanish (46%) (Figure 50).

Figure 50. Half of Californians Report Skipping or Postponing Care in the Last 12 Months

PERCENTAGE WHO SAY THEY OR A FAMILY MEMBER IN THEIR HOUSEHOLD SKIPPED OR POSTPONED ANY TYPE OF MEDICAL OR DENTAL CARE FOR ANY REASON IN THE PAST 12 MONTHS.

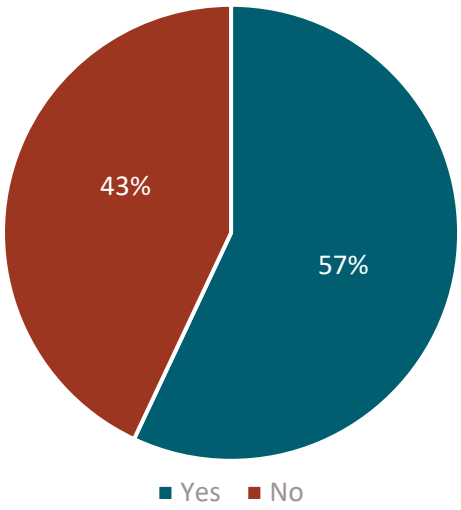


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

For those Californians who report skipping or postponing care in the last 12 months, more than half (57%) cite the conditions caused by the COVID-19 pandemic as the reason they skipped or postponed care (Figure 51). There are no differences between population subgroups (Figure 51).

Figure 51. More Than Half of the Californians Who Skipped or Deferred Care Did So Because of the COVID-19 Pandemic

Q: WAS THE REASON YOU OR YOUR FAMILY MEMBER POSTPONED CARE DUE TO THE CONDITIONS CAUSED BY THE COVID-19 PANDEMIC?



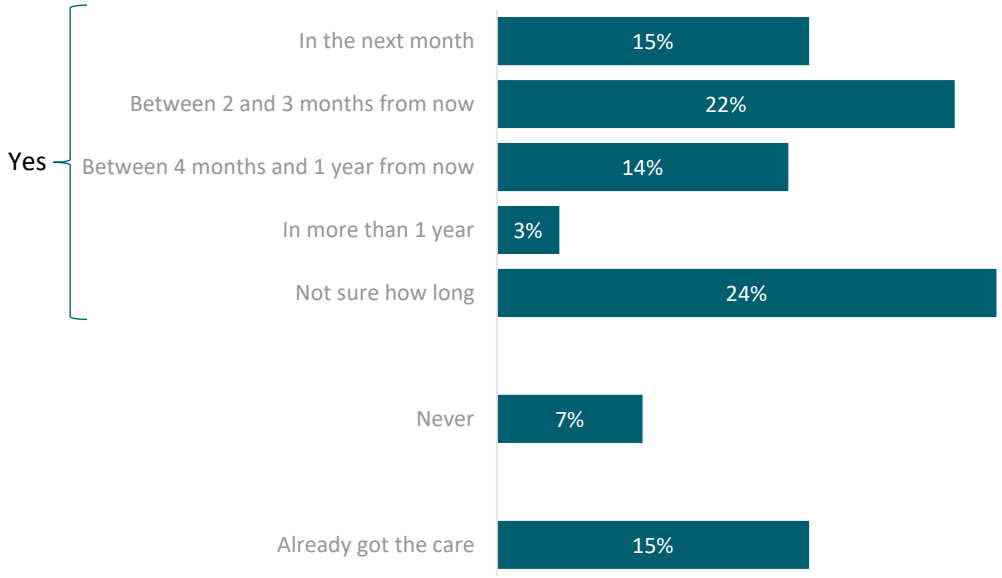
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Three in 10 Californians (29%) who report they or a family member skipped or postponed care say that their or their family member's condition got worse as a result, similar to the third (33%) of Californians who reported this last year. Californians with lower incomes (37%) and Latinx Californians (39%) are more likely than those with higher incomes (25%) and White Californians (25%), respectively, to report their condition got worse.

Of those Californians who skipped or postponed care, 15% "have already gotten the care they needed." More than half (51%) say they will get this care in the next year: 15% "in the next month," 22% "between 2 and 3 months from now," and 14% "between 4 months and 1 year from now." Three percent of Californians say they will get this care "in more than 1 year," and a quarter (24%) say they are "not sure how long" it will take for them to get this care. Seven percent of Californians say they will never get this care (Figure 52).

Figure 52. A Quarter of Californians Who Skipped or Postponed Care Are Not Sure When They Will Get the Care They Skipped or Postponed — More Than 1 in 20 Say They Will Never Get It

Q: THINKING ABOUT THE CARE YOU OR YOUR FAMILY MEMBER SKIPPED OR POSTPONED, DO YOU THINK YOU OR THEY WILL EVENTUALLY GET THIS CARE, OR NOT?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Healthy Behaviors

Preventive Health Behaviors

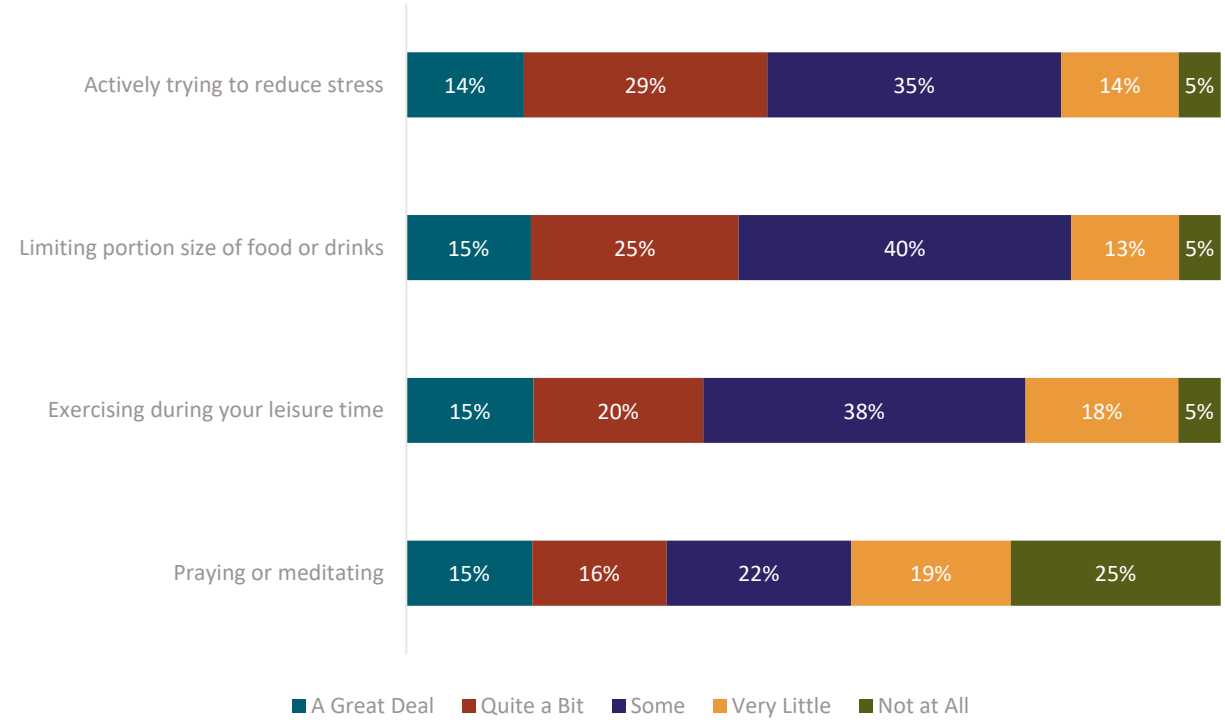
When asked about the extent to which Californians put effort into some preventive health behaviors, more than 4 in 10 (43%) say that they put "a great deal" or "quite a bit" of effort into actively trying to reduce stress. This is followed by those who say they put "a great deal" or "quite a bit" of effort into limiting portion size of food or drinks (40%), exercising during leisure time (35%), and praying or meditating (31%) (Figure 53).

Black Californians (57%) are more likely to report that they put “quite a bit” or “a great deal” of effort into actively trying to reduce stress than White (42%) and Asian Californians (39%). Half of Latinx Californians (46%) say that they put “quite a bit” or “a great deal” of effort into actively trying to reduce stress. Black Californians (51%) are more likely than Californians in other racial and ethnic groups to say that they put “quite a bit” or “a great deal” of effort into praying or meditating followed by Latinx (36%), White (31%), and Asian Californians (18%). There are also differences between Asian and both Latinx and White reports of putting effort into praying or meditating. White Californians (46%) are the most likely to say they put “quite a bit” or “a great deal” of effort into limiting portion size, followed by Asian (37%), Latinx (36%), and Black Californians (34%). There were no statistically significant differences between racial and ethnic groups in terms of the amount of effort put into exercising during leisure time (Figure 54).

Though there are no differences among income groups in trying to reduce stress and limiting portion size, though there are differences in exercising and praying. Californians with lower incomes are more likely to describe the effort they put into exercise during their leisure time as “not at all” or “very little” (31%), which is more than those with higher incomes (22%). Conversely, Californians with higher incomes (39%) are more likely to say that they put “a great deal” or “quite a bit” of effort into exercise than those with lower incomes (29%).

Figure 53. Eight in 10 Californians Say They Put at Least Some Effort into Actively Trying to Reduce Stress or Limit Portion Sizes

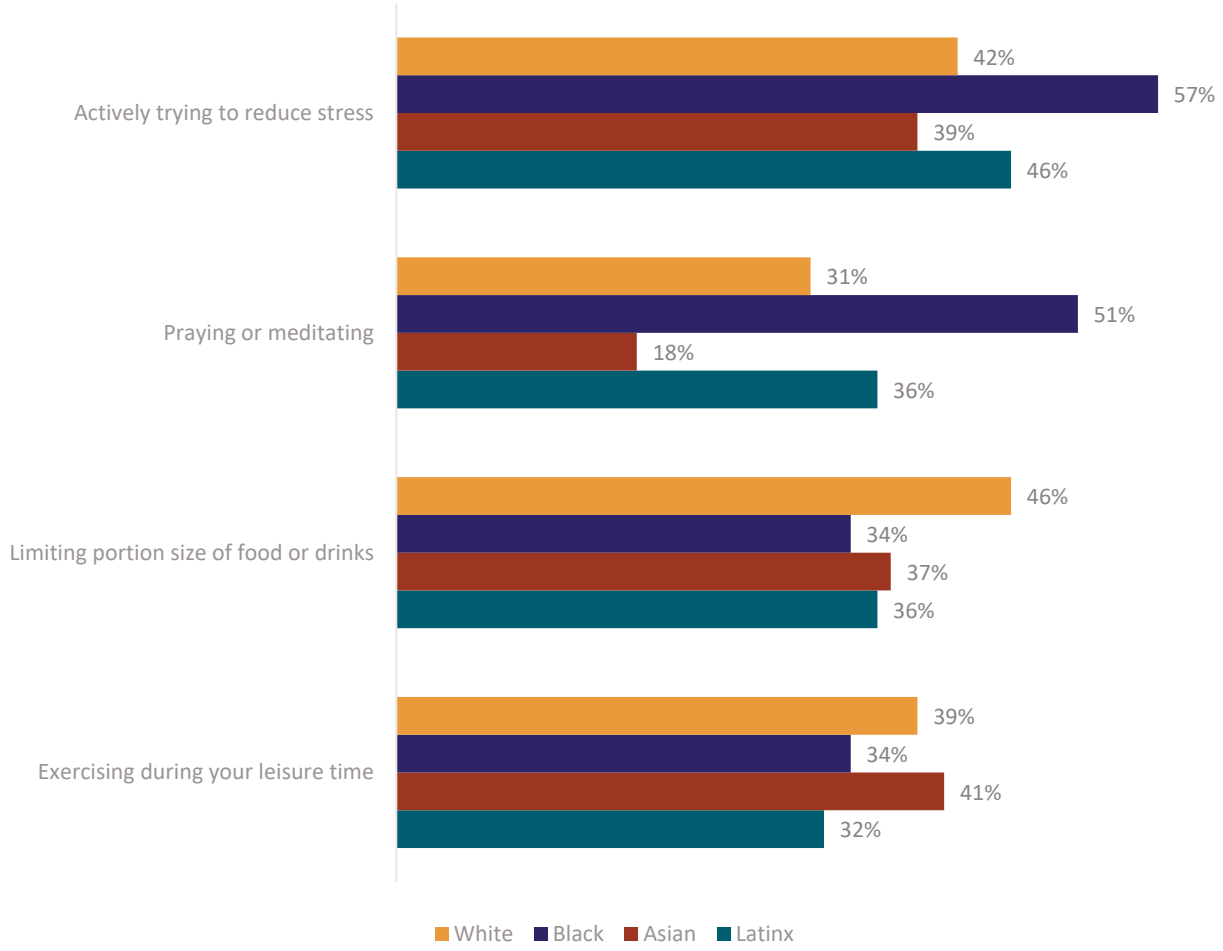
Q: HOW MUCH EFFORT DO YOU PUT INTO EACH OF THE FOLLOWING?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Figure 54. Black Californians Are More Likely Than Those in Other Racial or Ethnic Groups to Report Putting Quite a Bit or a Great Deal of Effort into Actively Trying to Reduce Stress and Praying or Meditating

PERCENTAGE WHO SAY THEY PUT "QUITE A BIT" OR "A GREAT DEAL" OF EFFORT INTO THE FOLLOWING . . .



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

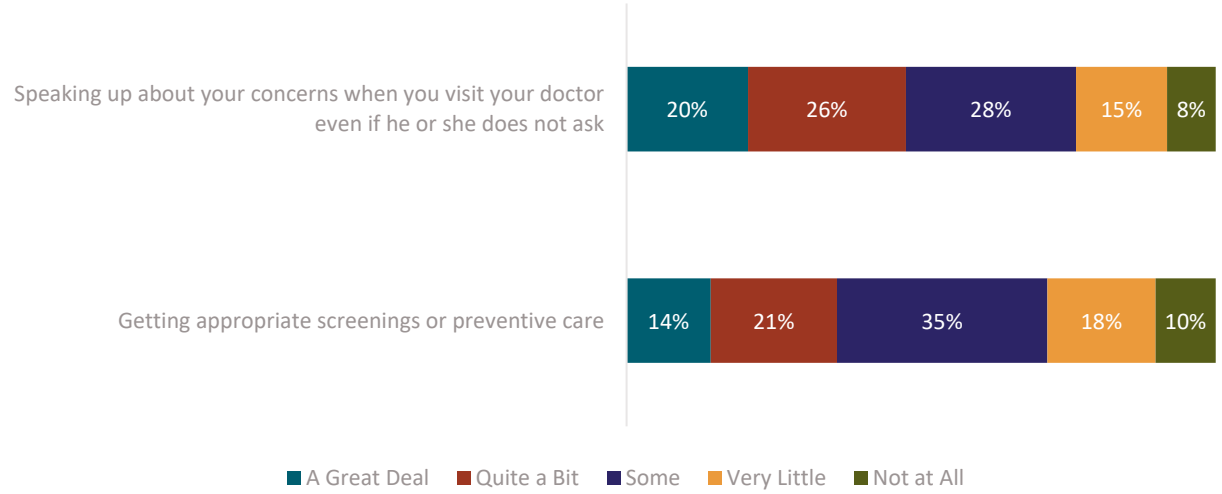
Appropriate Care Seeking

More than 4 in 10 Californians (46%) report putting "a great deal" or "quite a bit" of effort into speaking up about their concerns when they visit their doctor "even if he or she does not ask," with an additional quarter (28%) reporting "some" effort. Close to 3 in 10 Californians say they put "very little" or no effort into getting appropriate screenings or preventive care (Figure 55). Californians with lower incomes (37%) are more likely to report "very little" or no effort into getting appropriate screeners compared to those with higher incomes (26%).

Black Californians (66%) are more likely than other racial or ethnic subgroups to say they put "a great deal" or "quite a bit" of effort into speaking up about their concerns when they visit their doctor followed by White (59%), Latinx (45%), and Asian Californians (38%) (Figure 56). Additionally, Californians who speak English (49%) are more likely than those who speak Spanish (40%) to put "a great deal" or "quite a bit" of effort into speaking up about their concerns at the doctor.

Figure 55. Most Californians Say They Put Some Effort into Speaking Up About Concerns with Their Doctors; 3 in 10 Say They Put Very Little or No Effort into Getting Screening or Preventive Care

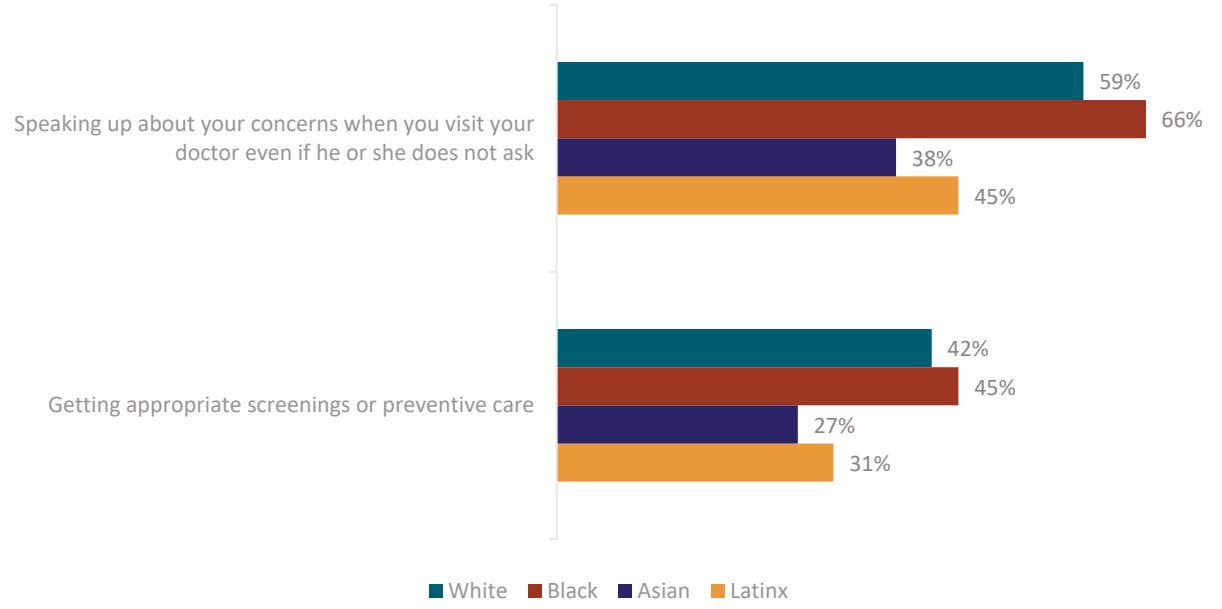
Q: HOW MUCH EFFORT DO YOU PUT INTO EACH OF THE FOLLOWING?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. Figures may not sum due to rounding.

Figure 56. Black Californians Are More Likely Than Those in Other Racial or Ethnic Groups to Report Putting Quite a Bit or a Great Deal of Effort into Speaking Up About Concerns When Visiting the Doctor

PERCENTAGE WHO SAY THEY PUT "QUITE A BIT" OR "A GREAT DEAL" OF EFFORT INTO THE FOLLOWING . . .

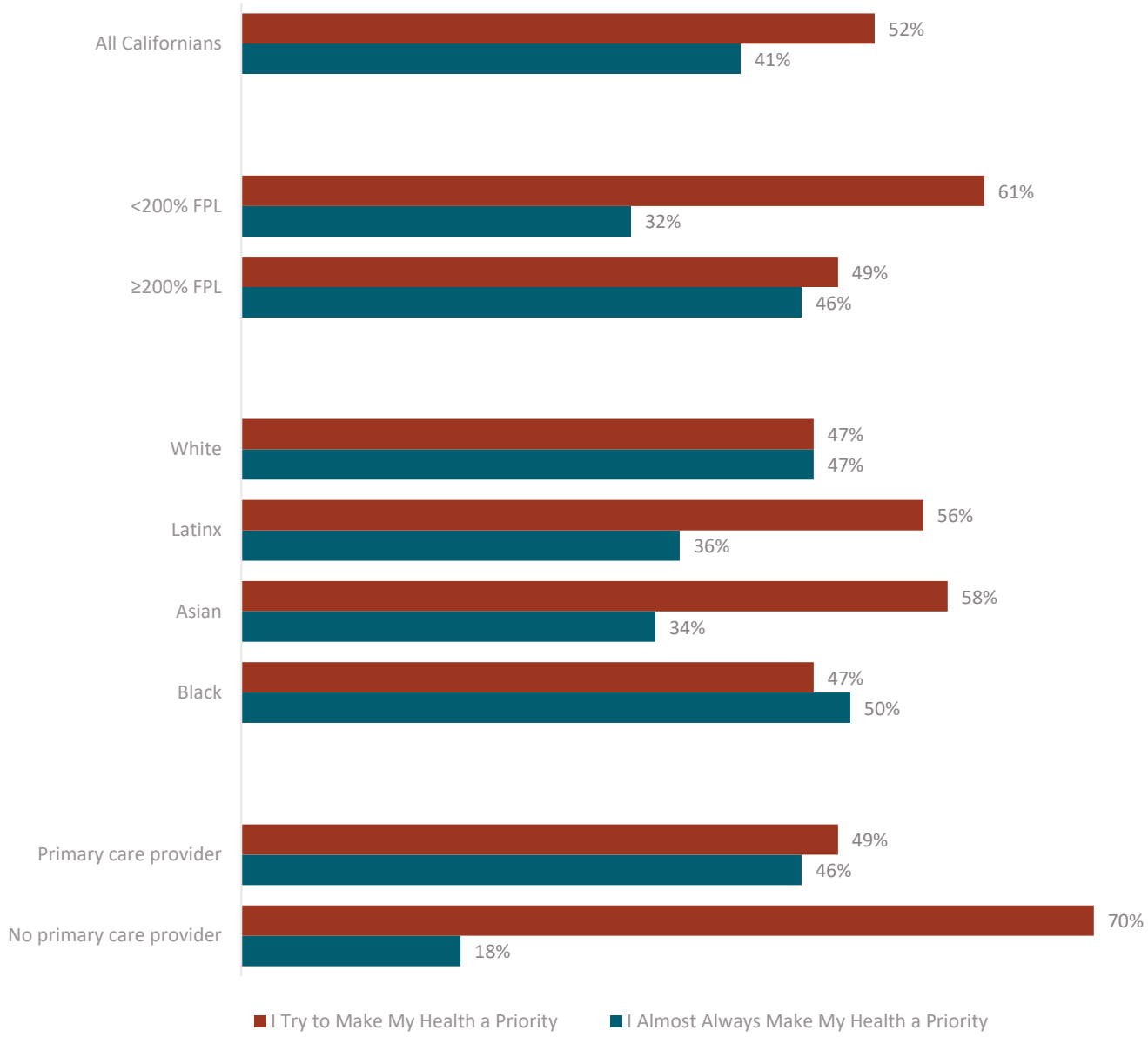


Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Half of Californians (52%) report that they try to make their health a priority but often have to put other things ahead of it. Four in 10 Californians (41%) say they almost always make their health a priority. Californians with lower incomes (61%) are more likely than those with higher incomes (49%) to say that they try to make their health a priority but often have to put other things ahead of it. Asian (58%) and Latinx Californians (56%) are more likely than White (47%) and Black Californians (47%) to say that they try to make their health a priority but often have to put other things ahead of it (Figure 57).

Figure 57. More Say They Try to Make Their Health a Priority but Often Have to Put Other Things Ahead of Their Health Than Those That Say They Almost Always Make Their Health a Priority

Q: WHICH OF THE FOLLOWING STATEMENTS BEST DESCRIBES YOU, EVEN IF NEITHER IS EXACTLY RIGHT?



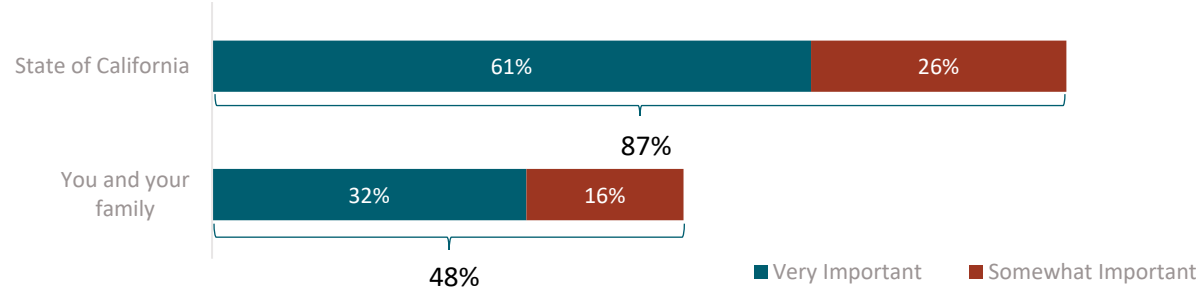
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Section 7. Views on Medi-Cal

For the third year in a row, Californians overwhelmingly support the Medi-Cal program, with 87% saying it is "very" or "somewhat" important to the state (61% "very"). Half (48%) say Medi-Cal is "very" or "somewhat" important to themselves and their family (32% "very") (Figure 58). There is strong support for the program across racial and ethnic groups, income levels, and political party affiliations (Figure 59).

Figure 58. Nine in 10 Californians Say Medi-Cal Is Important to the State — Half Say It Is Important to Them and Their Family

Q: HOW IMPORTANT IS MEDI-CAL FOR . . . ?



Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options.

Figure 59. Across Racial and Ethnic, Income, and Party Lines, Californians Think Medi-Cal Is Important to the State

PERCENTAGE WHO SAY THAT MEDI-CAL IS "VERY" OR "SOMEWHAT" IMPORTANT TO CALIFORNIA

Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). See topline for full question wording and response options. *FPL* is federal poverty level.

Appendix A: Survey Methodology

The California Health Care Foundation California Health Policy Survey was conducted September 27, 2021, through November 17, 2021, via a mixed AmeriSpeak Panel (*n* = 1,399) and address-based sample (ABS) (*n* = 282) design among a random representative sample of 1,681 adults age 18 and older living in California. Interviews were administered in English (*n* = 1,647) and Spanish (*n* = 34). Sampling, data collection, weighting, and tabulation were managed by NORC at the University of Chicago in close collaboration with California Health Care Foundation (CHCF) researchers. CHCF paid for all costs associated with the survey, and both NORC and CHCF worked together to design the survey and to analyze the results.

The sample was designed to achieve a sufficient number of interviews with respondents age 18 and older that would support accurate representation of the California resident adult population in the overall sample and for sociodemographic subgroups such as by age, race, Latinx ethnicity, and region. AmeriSpeak was selected as the foundational sample for this study for its probability-based survey platform, and its unique in-person recruitment that attains response rates, on average, 5 to 10 times higher than other probability panels. The AmeriSpeak Panel is a nationally representative panel sample recruited using NORC's National Frame based on both area probability sampling and address-based sampling methods to achieve coverage of around 97% of the US population.

To qualify for the study, all AmeriSpeak California respondents 18 and older invited to take the survey needed to confirm that they were currently residing in California. Most of the AmeriSpeak sampled panelists completed the survey via the web, with a small proportion completing the survey by phone with NORC telephone interviewers.

The address-based sample was randomly drawn from a sampling frame defined by the United States Postal Service's Computerized Delivery Sequence File, which is licensed by NORC. This database covers nearly all households in the US. To augment Asian and Black populations in the survey, the ABS frame was stratified into four mutually exclusive categories to allow accurate representation of the California adult population. This was accomplished by appending auxiliary data from commercial address databases to the ABS frame to construct four sampling strata: (1) addresses with a high proportion identifying as Asian, (2) addresses with a high proportion identifying as Black, (3) addresses with a high proportion identifying as Asian and Black, and (4) all other addresses. Only addresses identified in sampling strata 1–3 were selected and fielded in order to achieve an augment ABS sample of Asian and Black Californians for this survey. New this year, an independent ABS sample of rural addresses in California was also selected and fielded to augment the number of rural completes.

All ABS sample were sent an invitation letter including a web link to complete the survey online and a toll-free number for which respondents could call to complete the survey with a telephone interviewer. A $2 pre-incentive was included for the mailed invitations (*n* = 8,269). Respondents were offered a $10 post-incentive if they completed the survey before October 25, 2021. NORC sent one reminder letter, which included a survey web link and a unique participant code, around one week after the initial mailing and then followed up with a final postcard reminder and telephone calls about two weeks after the initial mailing to households whose address could be matched to a listed cellphone or landline telephone directory.

To qualify for the study, all ABS respondents needed to confirm that they were adults, age 18 or older, and currently residing in California.

A series of data quality checks were run on the final data, which resulted in 19 completes being removed. A multistage weighting design was applied to ensure accurate representation of the California adult population. The first stage of weighting included adjustments to the AmeriSpeak and ABS samples for their unique sample designs. Subsequent weighting steps included an adjustment to account for ABS undeliverable mailings, construction of weights for the combined AmeriSpeak and ABS samples, and an adjustment for nonresponse to the screener qualification questions on age and California residency. Finally, the combined AmeriSpeak and ABS sample weights underwent demographic adjustment via poststratification raking to balance the sample to match known adult population totals based on the US Census Bureau's 2021 Current Population Survey March Supplement. Demographic benchmark distributions utilized in the raking included age, race/Latinx ethnicity, region, in California, and household income relative to 200% of the federal poverty level. Next, to reduce the possibility that single cases could affect the data too excessively and to keep variance relatively low, the weights were truncated at the 5th and 90th percentile points of their distribution.

The margin of sampling error including the design effect for the full sample for an estimated percentage of 50% is plus or minus 3.5 percentage points. For results based on percentages other than 50%, the margins of sampling error are typically lower. For results based on specific subgroups, the margins of sampling error may be higher. Note that sampling error is only one of the many potential sources of error in this and any other public opinion poll.

Appendix B: California Regions

For this report, regions were defined as follows:

- **Bay Area:** Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma Counties
- **Inland Empire:** Riverside and San Bernardino Counties
- **Los Angeles:** Los Angeles County
- **Northern & Sierra:** Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba Counties
- **South Coast:** Imperial, Orange, and San Diego Counties

Key Facts on Health and Health Care by Race and Ethnicity

Latoya Hill (https://www.kff.org/person/latoya-hill/) (https://twitter.com/hill_latoya) ,

Samantha Artiga (https://www.kff.org/person/samantha-artiga/) (https://twitter.com/SArtiga2) ,

and **Sweta Haldar** (https://www.kff.org/person/sweta-haldar/)

Published: Jan 26, 2022

SUMMARY

The COVID-19 pandemic has brought the issue of disparities in health and health care into sharp focus. The pandemic's impacts have been uneven, with people of color bearing the heaviest burden in terms of negative impacts on health and well-being as well as economic impacts. However, health and health care disparities are not new. They have been documented for decades and reflect longstanding structural and systemic inequities rooted in racism and discrimination. While inequities in access to and use of health care contribute to disparities in health, inequities across broader social and economic factors that drive health, often referred to as social determinants of health (https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), also play a major role.

Using data to identify disparities and the factors that drive them is important for directing resources and efforts to address them and assessing progress toward achieving greater equity over time. To provide insight into the status of racial disparities in health and health care, this analysis examines how people of color fare compared to White people across measures of health coverage, access, and use; health status, outcomes, and behaviors; and social determinants of health. Where possible, we present data for six racial/ethnic groups: White, Asian, Hispanic, Black, American Indian and Alaska Native (AIAN), and Native Hawaiian and Other Pacific Islander (NHOPI). People of Hispanic origin may be of any race, but we classify them as Hispanic for this analysis. We limit other groups to people who identify as non-Hispanic. All differences described in the text are statistically significant. We use the most recent data available from a broad range of federal survey and administrative datasets, which largely represent experiences prior to the COVID-19 pandemic (see Data Sources). This analysis finds:

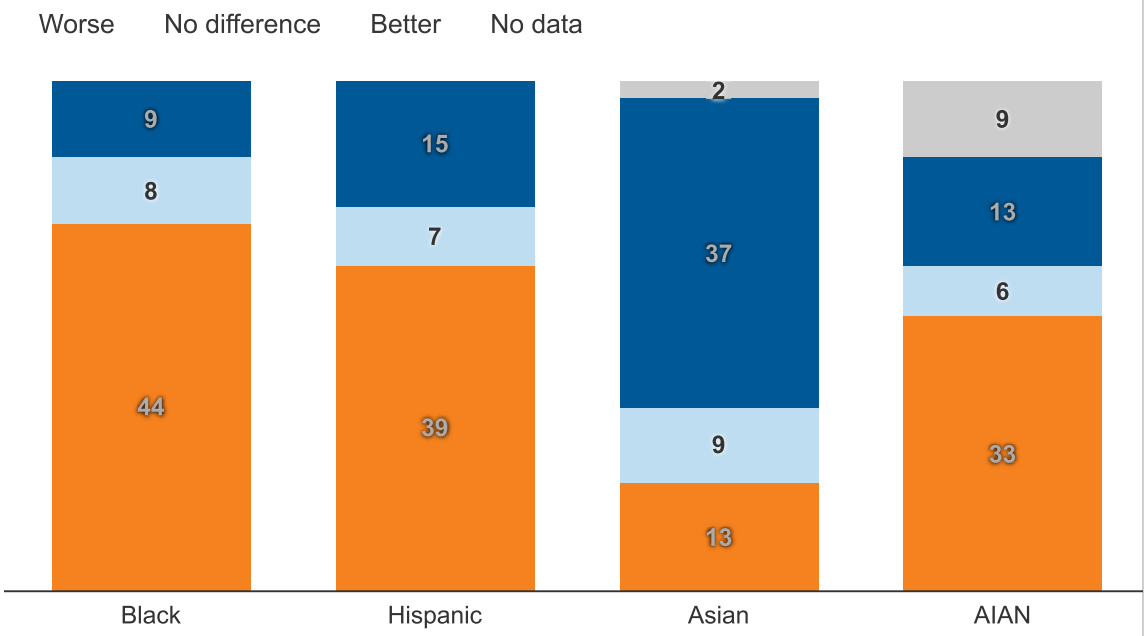
- **Black, Hispanic, and AIAN people fare worse than White people across the majority of examined measures (Figure 1).** This pattern is consistent across measures related to health coverage, access, and use; health status, outcomes, and behaviors; and social determinants of health. Notably, these groups do not fare

better than their White counterparts for any examined measures of social determinants of health. Black people do have better experiences than White people for some cancer screening and cancer incidence measures, although they have higher rates of cancer mortality. Hispanic people fare better than White people across some health outcome measures, including life expectancy, some chronic diseases, and most measures of cancer incidence and mortality. These findings may, in part, reflect variation in outcomes among subgroups of Hispanic people (https://www.sciencedirect.com/science/article/pii/S2352827316000203#bib6), with better outcomes for some groups, particularly recent immigrants to the U.S. AIAN people similarly fare better than White people for selected health measures, particularly related to cancer, and are less likely to be noncitizens or to not speak English well, reducing the likelihood of facing barriers accessing health coverage and care due to immigration status or language.

Figure 1

Health and Health Care among People of Color Compared to White People

NUMBER OF MEASURES FOR WHICH GROUP FARED BETTER, THE SAME, OR WORSE COMPARED TO WHITE PEOPLE:



NOTE: Measures are for the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from White people at the p<0.05 level. No difference indicates no statistically significant difference. "Data limitation" indicates no separate data for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. AIAN refers to American Indian or Alaska Native. NHOPI refers to Native Hawaiian or Other Pacific Islander. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

KFF

- **Asian people in the aggregate do not fare worse than White people across most examined measures.** They fare the same or better compared to White people for most examined measures**,** while they fare worse along some measures, including receipt of some routine care and screening and some social determinants of health, including home ownership, crowded housing, and childhood experiences with racism. They also have higher shares of people who are noncitizens and do not

speak English well, which can contribute to barriers accessing health coverage and care. Moreover, the data may mask underlying disparities among subgroups (https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=63) of the Asian population. The rise in anti-Asian hate crimes and increased discrimination (https://www.kff.org/coronavirus-covid-19/issue-brief/asian-immigrant-experiences-with-racism-immigration-related-fears-and-the-covid-19-pandemic/) resulting from the COVID-19 pandemic may have also negatively affected Asian people's experiences with health and health care.

- **Data gaps largely prevent the ability to identify and understand health disparities for NHOPI people.** For over half of the examined measures, data were insufficient or not disaggregated for NHOPI people. Where data are available, NHOPI people fare worse than White people for at least half of measures. No difference is identified for the remaining measures where data are available, but this is largely due to the smaller sample size for NHOPI people in many datasets which limits the power to detect statistically significant differences.

Together these data show that, prior to the pandemic, people of color fared worse compared to White people across a broad range of measures related to health and health care, particularly Black, Hispanic, and AIAN people. However, patterns vary across measures and there are variations in experiences within the broad racial and ethnic classifications used for this analysis. Many of these underlying disparities placed people of color at increased risk (https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/) for negative health and economic impacts from the COVID-19 pandemic. Moreover, the pandemic has exacerbated many of these disparities and may contribute to widening disparities in the future. Data show that people of color are at higher risk (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html) for COVID-19 infection, hospitalization, and death compared to their White counterparts and have suffered more significant negative social and economic (https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-november-2021/) impacts. Despite being disproportionately affected by the pandemic, Black and Hispanic people have been less likely than White people to receive COVID-19 vaccines (https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-by-race-ethnicity/), although these differences have narrowed over time, and this gap has closed for Hispanic people.

The data highlight the importance of efforts to address disparities in health and health care and show that it will be key for such efforts to address factors both within and beyond the health care system. Addressing these inequities is not only important for mitigating the disparate impacts of the COVID-19 pandemic but also for preventing further widening of disparities going forward. While these data provide insight into the status of disparities, ongoing data gaps and limitations (https://www.kff.org/policy-watch/advancing-health-equity-requires-more-better-data/) hamper the ability to get a complete picture of disparities, particularly for smaller population groups. Further, data reported by these broad racial and ethnic

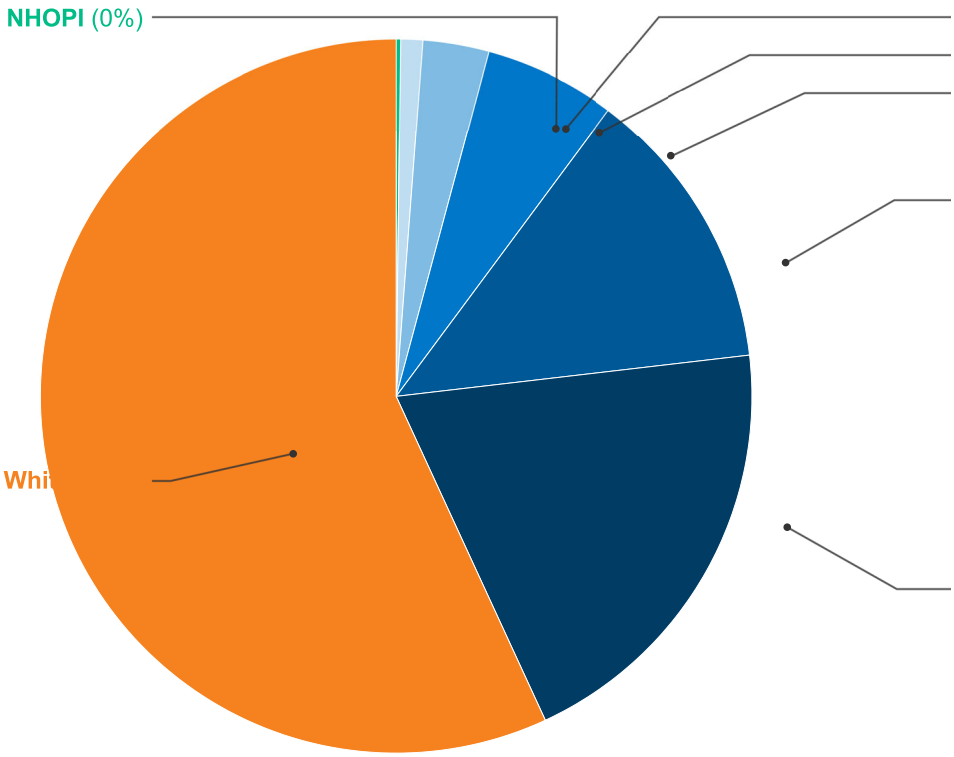
categories often masks disparities among subgroups of the populations. As the share of people who identify as multiracial grows, it also will be important to develop improved methods for classifying and understanding their experiences. Going forward, reassessment of how data are collected and reported by race/ethnicity will be important for providing more nuanced understanding of disparities and, in turn, improved efforts to address them.

Background: Racial Diversity within the U.S. Today

As of 2019, 43% of the total population in the United States were people of color (Figure 2). This group included 20% who were Hispanic, 13% who were Black, 6% who were Asian, 1% who were American Indian or Alaska Native (AIAN), less than 1% who were Native Hawaiian or Other Pacific Islander (NHOPI), and 3% who identified as another racial category, including individuals who identified as more than one race. The remaining 57% of the population were White. The share of the population who are people of color has been growing over time, with the largest growth occurring among those who identify as Hispanic or Asian.

Figure 2

Total United States Population by Race/Ethnicity, 2019

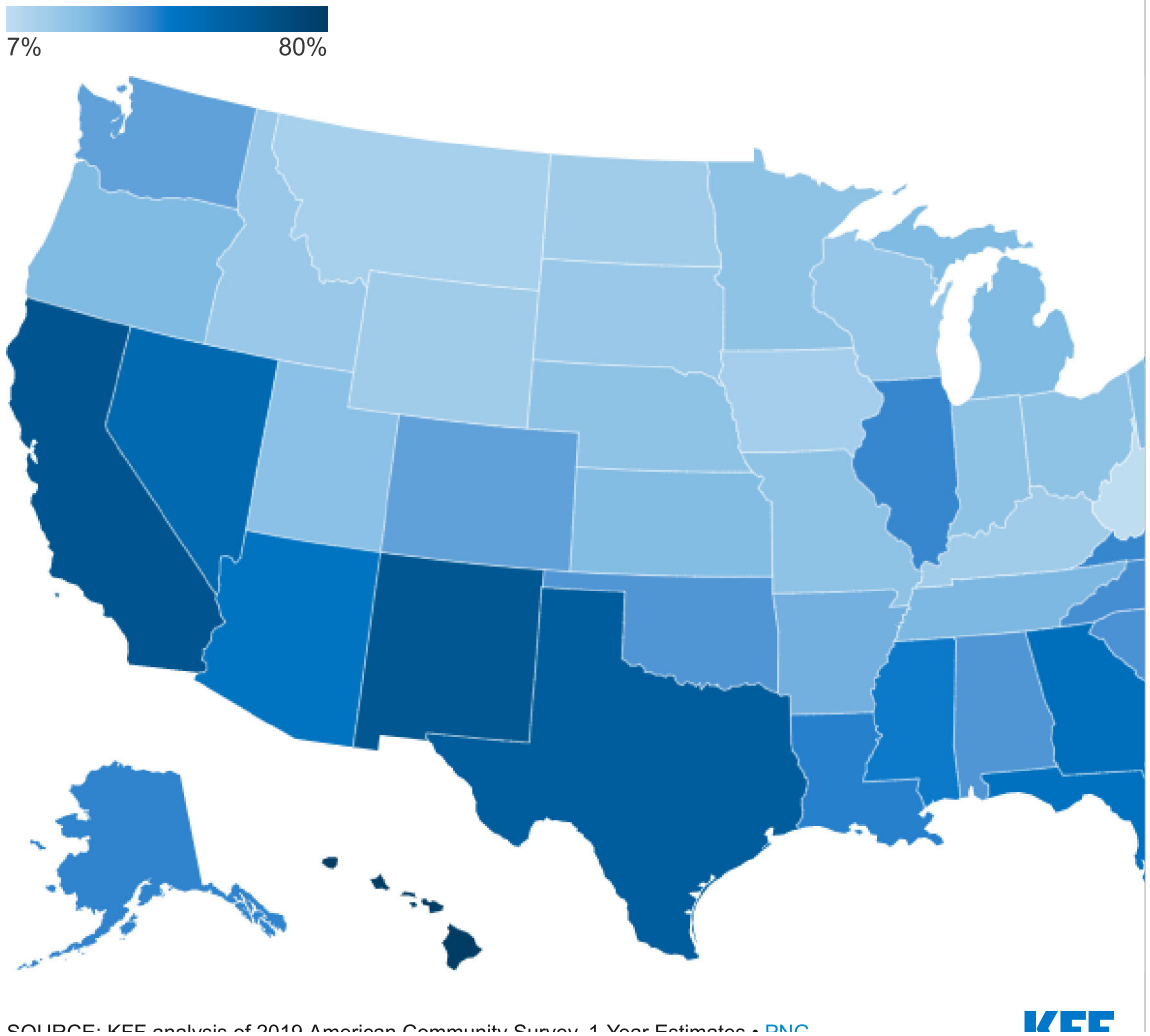


NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian and Alaska Native. NHOPI refers to Native Hawaiian and Other Pacific Islander. Other includes people with more than one race. Total may not sum to 100% due to rounding.
SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates. • PNG

Certain areas of the country, particularly the South, are more racially diverse than others (Figure 3). Overall, the share of the population who are people of color ranges from below 10% in Maine, Vermont and West Virginia to over half of the population in California, District of Columbia, Hawaii, Maryland, Nevada, New Mexico, and Texas. Most people of color live in the South and West, with more than half (59%) of the Black population residing in the South while, overall, nearly eight in ten Hispanic people live in the West (39%) and in the South (38%). Over three quarters of the NHOPI population (77%), almost half (47%) of the AIAN population, and 44% of the Asian population live in the Western region of the country.

Figure 3

Share of Total Population that is a Person of Color by State, 2019

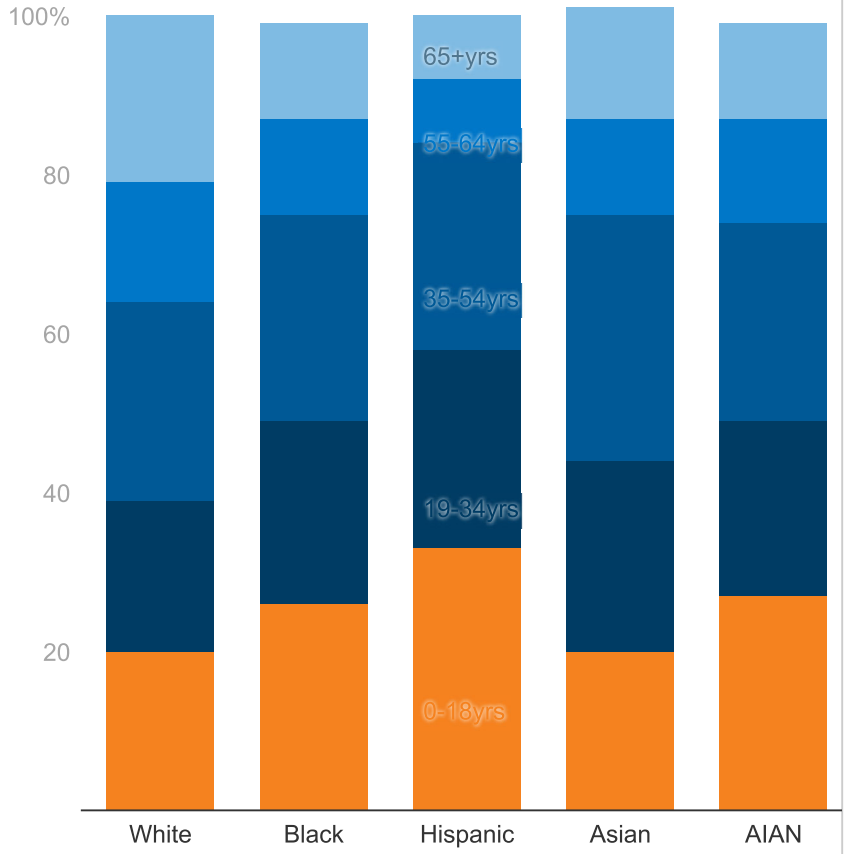


SOURCE: KFF analysis of 2019 American Community Survey 1-Year Estimates • PNG

People of color are younger compared to White people. Hispanic people are the youngest population, with 33% below age 18, and 57% below age 34 (Figure 4). Roughly half of Black (49%), AIAN (49%), and NHOPI (51%) people are below age 34, compared to 44% of Asian people and 39% of White people.

Figure 4

Age Distribution of Population by Race/Ethnicity, 2019



NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian and Alaska Native. NHOPI refers to Native Hawaiian

HEALTH COVERAGE AND ACCESS TO AND USE OF CARE (HTTPS://WWW.KFF.ORG/REPORT-SECTION/KEY-FACTS-ON-HEALTH-AND-HEALTH-CARE-BY-RACE-AND-ETHNICITY-HEALTH-COVERAGE-AND-ACCESS-TO-AND-USE-OF-CARE/)

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Resource
2022 Estimates, Deductibles in State-Regulated Health Insurance

December 2021

Prepared by
California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: 2022 Estimates, Deductibles in State-Regulated Health Insurance. Berkeley, CA*

OVERVIEW

At the request of the California State Legislature, the California Health Benefits Review Program (CHBRP) provides prompt, independent, and rigorous evidence-based analyses of proposed health insurance benefit laws that would impact Californians enrolled in health plans regulated by the California Department of Managed Care (DMHC) and health policies regulated by the California Department of Insurance (CDI). These are enrollees whose benefits are subject to state regulation and can be influenced by the proposed state-level legislation. CHBRP estimates the presence of various kinds of deductibles, a form of cost sharing, among these enrollees because the bills CHBRP analyzes sometimes directly address application of a deductible.[1]

This resource discusses deductibles and their interaction with other forms of cost sharing, as well as estimates regarding their presence among state-regulated health insurance, potential impacts of new prohibitions on their application, and related state and federal law.

Approximately 41% of commercial and CalPERS[2] associated enrollees in plans and policies regulated by DMHC or CDI have a medical deductible and approximately 28% of enrollees have a pharmacy benefit regulated by DMHC or CDI that includes a deductible. Deductible amounts vary, as does their presence by market segment. No CalPERS associated enrollees have any deductible but in the individual market, 62% of enrollees have a high (≥ $1,400) medical deductible and 34% have a high pharmacy deductible.

When considering a bill that proposes state-level deductible prohibitions (which would be enforced by DMHC and/or CDI), it is important to consider how other forms of cost-sharing, as well as out-of-pocket maximums would impact enrollees' total cost sharing for a plan or policy year.

Deductibles – One Form of Cost Sharing

When present, a deductible is the amount an enrollee is generally required to pay out-of-pocket (OOP) before the health plan or policy begins to reimburse medically necessary use of covered benefits. However, there are some benefits for which application of a deductible may be prohibited.[3] When applicable, once this amount is paid, other forms of cost sharing (such as coinsurance[4] or copayments[5]) may still be applicable to the use of covered benefits. Premiums do not count towards a deductible. The presence of deductibles varies depending on the enrollee's plan or policy design and relevant laws and regulations.

For the majority of enrollees in plans and policies regulated by DMHC or CDI, there are no deductibles.[6] However, as previously noted, deductibles are present for a substantial minority. When deductibles are present, their amount typically varies from $500 per year to the Internal Revenue Service (IRS)-specified "high deductible threshold" of $1,400 per year, to perhaps as much as $8,550 per year, which is the current annual OOP spending threshold set by the federal government (HealthCare.gov Glossary, n.d.). Enrollees may have annual cost sharing limits that are lower than the OOP spending threshold. Lower income individuals and families may qualify for reduced OOP maximums through cost sharing reduction

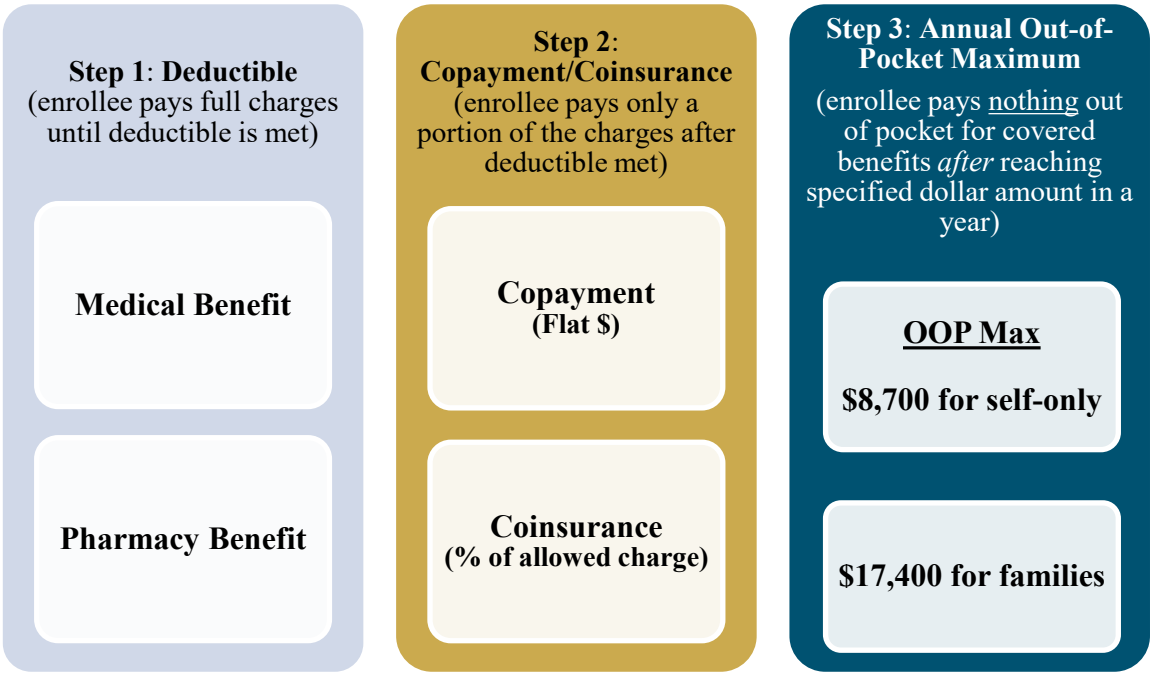
[1] Recent examples include CHBRP's analyses of SB 568 (2021) and AB 97 (2021), both available at: http://chbrp.com/completed_analyses/index.php.
[2] California Public Employees' Retirement System
[3] For example, federal and California state law states that non-grandfathered group and individual health insurance plans and policies must cover certain preventive services without cost-sharing (including deductibles) when delivered by in-network providers. For more information, see CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at: www.chbrp.org/other_publications/index.php.
[4] Coinsurance is a form of cost sharing in which an enrollee pays a percentage of covered health care costs, such as 20% of a hospital stay.
[5] Copayments are a form of cost sharing in which an enrollee pays a predetermined, flat dollar amount out-of-pocket at the time of receiving a health care service, such as a $20 copayment for a physician office visit.
[6] This includes all CalPERS enrollees and all Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

discounts (HealthCare.gov Cost-sharing Reductions, n.d.). OOP maximums limit deductibles as well as other forms of cost sharing.

The number of deductibles applicable for an enrollee also varies. Deductibles applicable to a medical benefit (which covers hospitalization and office visits) are somewhat more common than deductibles applicable to an outpatient pharmacy benefit (which generally covers self-administered medications accessed at a pharmacy). Among enrollees with a medical deductible, most also have a pharmacy deductible. Additionally, deductibles can be designed to be applicable to both the medical and pharmacy benefit, as is the case for most enrollees in Health Savings Account (HSA)-qualified High Deductible Health Plans (HDHPs).

To better understand how plans and policies with a deductible work on a yearly basis, it is useful to think of stages before and after the deductible is met (see Figure 1).

Figure 1. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2021; CMS, 2021.

Note: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2). The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS' Notice of Benefit and Payment Parameters (CMS, 2021).
Key: OOP Max = annual out-of-pocket maximum.

The beginning of Step 1 is marked by the first day of the plan or policy year. During Step 1, an enrollee pays the full price of most covered benefits until they meet their deductible. However, in some plans and policies,[7] certain services are exempted from the deductible and allow for "first dollar" coverage.[8] The beginning of Step 2 is marked by the date the enrollee meets their deductible. During Step 2, an enrollee pays any applicable coinsurance and/or copayments, and insurers reimburse the rest of the price of covered benefits. The beginning of Step 3 is marked by the date an enrollee meets their out-of-pocket

[7] Several such plans and policies are available through Covered California, the state's ACA marketplace. For example, see https://www.coveredca.com/support/getting-started/gold-most-services-covered/. Accessed on August 31, 2021.
[8] "First dollar" coverage is when plans or policies have no deductible and the insurer reimburses the price of covered benefits for the first dollar spent

(OOP) maximum.[9] During Step 3, the enrollee pays nothing OOP for covered benefits for the remainder of the plan or policy year. The duration of each step depends on an enrollee's use of covered benefits. For example, an enrollee could have an inpatient procedure early in the plan or policy year[10] and meet their deductible in the first month. Then, through copayments and coinsurance for additional covered benefits throughout the next two months, the enrollee meets their OOP maximum. This enrollee would spend one month in Step 1, the following two months in Step 2, and the rest of the plan or policy year in Step 3. Conversely, an enrollee could never meet their deductible in a plan or policy year because the enrollee used no covered benefits that were subject to a deductible for that plan or policy year. This enrollee spends the entire year in Step 1.

There are situations where the application of a deductible is not as straightforward as described above. For enrollees in Preferred Provider Organization (PPO) plans and policies, where out-of-network coverage is expected to be regularly used, only the cost sharing associated with a "reasonable" price can count towards any applicable deductible. The remainder of the price that might be "balance billed" is not subject to the deductible limits and does not accrue to the enrollee's ability to meet the deductible.

Estimates of Deductibles for Californians Enrolled in State-Regulated Health Insurance

Approximately 21.9 million (55.7% of all) Californians[11] are enrolled in plans or policies regulated by DMHC or CDI and so have health insurance that can be subject to the benefit bills CHBRP is asked to analyze. Tables 1 and 2 display CHBRP's estimates regarding the presence of deductibles for these Californians. These estimates do not differentiate between self-only and family deductibles and, for analytic purposes, treat combined deductibles (medical and pharmacy) as separate. See Appendix A for further detail on the approach used to generate these estimates.

Among this group, no deductibles are present for the Medi-Cal beneficiaries or for the CalPERS associated enrollees in DMHC-regulated plans. Among the remaining 13.0 million Californians, approximately 41% have a medical deductible and 28% of those with a pharmacy benefit regulated by DMHC or CDI[12] have a pharmacy deductible. Tables 1 and 2 note the variation in presence of deductibles for California's commercial market segments: the individual market, the small group market, and the large group market. Table 1 notes the presence of medical deductibles and Table 2 notes the presence of pharmacy deductibles among enrollees with state-regulated health insurance.

[9] Out-of-pocket (OOP) maximum is the most an enrollee could pay for cost-sharing (copayments, coinsurance, and deductibles) towards covered benefits in a 1-year period.
[10] Deductibles are applicable to each plan year. For example, if a plan year aligns with the calendar year, the deductible will be applicable from January through December and will reset in January of the following year.
[11] See CHBRP's *Estimates of Health Insurance in California*, available as a resource at http://chbrp.org/other_publications/index.php.
[12] See CHBRP's *Estimates of Pharmacy Benefit Coverage*, available as a resource at http://chbrp.org/other_publications/index.php.

Table 2. Medical Deductibles among Commercial and CalPERS Enrollees in State-Regulated Plans and Policies, 2022

Market Segment	Enrollment	Any Deductible Present	Low Deductible ($1 - $1,399)	High Deductible (a) (≥ $1,400)	HSA-Qualified HDHP
DMHC/CDI Individual	2,133,000	84%	22%	52%	10%
DMHC/CDI Small Group	2,129,000	72%	37%	27%	9%
DMHC/CDI Large Group	8,789,000	27%	20%	1%	6%
DMHC CalPERS (b)	889,000	0%	0%	0%	0%
Total	**13,940,000**	**41%**	**21%**	**13%**	**6%**

Source: California Health Benefits Review Program, 2021.
Notes: (a) Does not include enrollees in HSA-qualified plans or policies. (b) CalPERS enrollees in DMHC-regulated plans do not have deductibles.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

Table 3. Pharmacy Deductibles among Commercial and CalPERS Enrollees in State-Regulated Plans and Policies with a State-Regulated Pharmacy Benefit, 2022

Market Segment (a)	Enrollment	Any Deductible Present	Low Deductible ($1 - $1,399)	High Deductible (b) (≥ $1,400)	HSA-Qualified HDHP
DMHC/CDI Individual	2,093,000	61%	27%	24%	10%
DMHC/CDI Small Group	2,129,000	36%	23%	5%	9%
DMHC/CDI Large Group	8,097,000	19%	13%	0%	6%
DMHC CalPERS (c)	672,000	0%	0%	0%	0%
Total	**12,991,000**	**28%**	**16%**	**5%**	**7%**

Source: California Health Benefits Review Program, 2021.
Notes: (a) approximately 95.3% of enrollees in DMHC or CDI regulated plans and policy have a pharmacy benefit also regulated by DMHC or CDI.[13] (b) Does not include enrollees in HSA-qualified plans or policies. (c) CalPERS enrollees in DMHC-regulated plans do not have deductibles.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

[13] See CHBRP's *Estimates of Pharmacy Benefit Coverage*, available as a resource at http://chbrp.org/other_publications/index.php

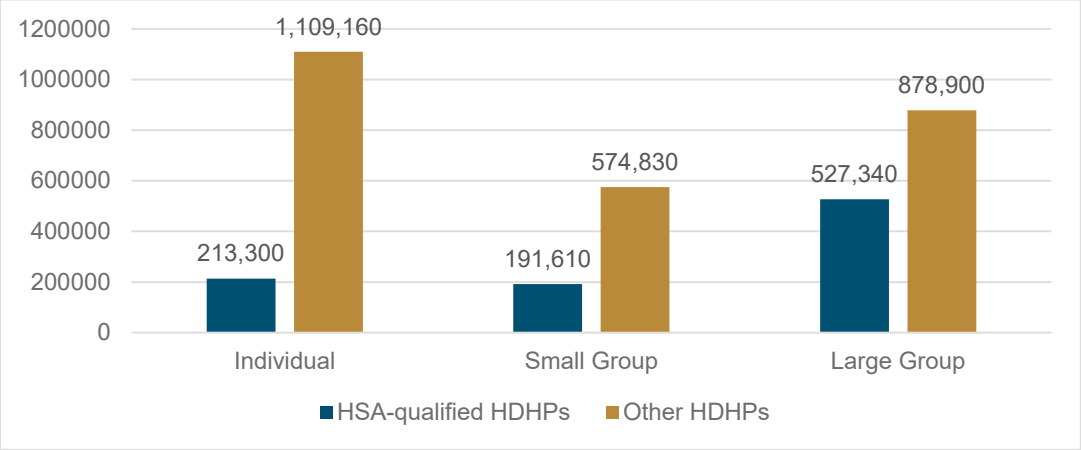
Health Savings Account-Qualified and Other High Deductible Health Plans and Policies

High deductible health plans and policies (HDHPs) have a higher deductible than a traditional health insurance plan and are subject to requirements set by federal regulation (HealthCare.gov Glossary, n.d.). For the 2021 plan year, the IRS defines a HDHP as any plan with a deductible of at least $1,400 for an individual and $2,800 for a family.

HDHPs can be paired with health savings accounts (HSAs), which are pre-tax instruments that allow enrollees (generally without the involvement of any employer (SHRM, 2018))[14] to put aside money for qualified healthcare expenses, including any healthcare services subject to a deductible (HealthCare.gov Glossary, n.d.). HSA-qualified HDHPs are not allowed to have separate medical and pharmacy deductibles.[15] To be eligible to establish an HSA for taxable years beginning after December 31, 2003, a person must be enrolled in an HSA-qualified HDHP. In order for a HDHP to be HSA-qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS.

Although the phrase “high deductible health plan” is frequently used to reference HSA-qualified plans and policies, in California there are many more commercial enrollees in non-HSA plans and policies that also have a “high” ($1,400 or greater) deductible (see Figure 2).[16] Approximately 2.6 million enrollees in state-regulated non-HSA health insurance plans and policies have a medical deductible that exceeds $1,400. As seen in Figure 2, HDHPs are most common among enrollees in the Individual Market.

Figure 2. Enrollment in State-Regulated High Deductible Health Plans and Policies, 2022*



Source: California Health Benefits Review Program, 2021.
Notes: *This figure uses enrollment in plans and policies with a medical deductible. All of the enrollees in HSA-qualified HDHPs would have a single deductible applicable to both their medical and pharmacy benefits. Most of the enrollees in other HDHPs would also have a deductible applicable to their pharmacy benefit.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

[14] HSAs may have employer involvement as employers can contribute to the HSA in addition to employees. For other pre-tax instruments, such as a health reimbursement arrangement (HRA), employers must be involved. HRAs, for example are funded solely by employers.
[15] HSA-qualified HDHPs have a combined medical and pharmacy deductible generally ranging from $1400 to $7000.
[16] Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) are other pre-tax strategies for covering health costs. HRAs are established and funded solely by employers. Enrollees in HDHPs that are not HSA-qualified may have HRAs, FSAs, or no account specific to paying medical expenses.

As is the case for most plans and polices, the Affordable Care Act (ACA) also requires HDHPs to cover select preventive services at no cost to enrollees on a pre-deductible basis.[17] For example, for an enrollee who is 12 to 16 weeks pregnant, a urine culture to test for bacteriuria is covered on a pre-deductible basis (and is not subject to other cost sharing). Federal guidance does allow, but does not require, HDHPs to cover select additional preventive care benefits without applying a deductible.[18] For example, for an enrollee who is pregnant or has a new child, routine prenatal and well-child care can be covered on a pre-deductible basis (but would still be subject to any other cost sharing). Federal guidance also allows, but does not require, HDHPs to cover certain additional medical services and purchased items, including prescription drugs, for certain chronic conditions that are classified as preventive care on a pre-deductible basis.[19] For example, for enrollees diagnosed with hypertension, a blood pressure monitor would be considered preventive care and could be covered on a pre-deductible basis (but would still be subject to any other cost sharing).

Potential Impacts of New Prohibitions on the Application of Deductibles

CHBRP has recently analyzed bills that would prohibit or limit application of a deductible. There are two primary ways a bill prohibits or limits a deductible. The first way is to prohibit all forms of cost sharing (copayments, coinsurance, and deductibles). For example, CHBRP analyzed Senate Bill 473 (2021), which proposed to limit all cost sharing for insulin. The second way is to prohibit only deductibles and still allow other forms of cost sharing such as copayments and coinsurance. For example, CHBRP analyzed Assembly Bill 97 (2021), which proposed to prohibit the application of a deductible for insulin, but permitted application of copayments and coinsurance.

There are many ways prohibition of a deductible can impact enrollees in plans or policies regulated by DMHC or CDI. Factors influencing this variation include cost of the service used, size of enrollee's deductible, application of OOP maximum, and an enrollee's use of services not subject to the prohibition. An enrollee who meets their deductible through the use of services not impacted by the prohibition will see no annual cost sharing impact, but may see a change in how quickly they meet their deductible, depending on when they use the other services. An enrollee who only uses services impacted by the prohibition, and does not meet their deductible, will see a decrease in total annual cost sharing. Enrollees in this group will still experience cost sharing in the form of copayments and coinsurance.

When prohibitions only apply to a deductible, but not other cost sharing, the other cost sharing amounts enrollees have to pay may still represent substantial costs. Among enrollees in HDHPs, high coinsurance and copayments are common. Therefore, while a bill may prohibit a deductible for some services, enrollees with a HDHP will still need to pay high coinsurance or copayments for those services. Some enrollees would have to pay high coinsurance and copayments on a monthly basis for some benefits, such as a medication that is prescribed for indefinite use. This is why prohibition of a deductible alone may not produce a substantial change in annual cost sharing (or in adherence to prescribed use) for some enrollees.

Examples

Example A illustrates annual cost sharing at baseline and postmandate for an enrollee who uses a single high-cost drug (and no other medical services). This enrollee would experience a decrease in total annual

[17] For more information, see CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at www.chbrp.org/other_publications/index.php.
[18] IRS Notice 2004-23 provides a safe harbor that lets HSA-qualified HDHPs waive the deductible for preventive care benefits. More information available at: https://www.irs.gov/pub/irs-drop/n-04-23.pdf.
[19] IRS Notice 2019-45 expands the list of preventive care benefits permitted to be provided by a HDHP under section 223(c)(2) of Internal Revenue Code without a deductible, or with a deductible below the applicable minimum deductible for an HDHP. More information available at: https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

cost sharing as a result of a deductible prohibition. Example B illustrates annual cost sharing at baseline and postmandate for an enrollee who would reach their deductible within a plan year, regardless of the prohibition, and would see no change in total annual cost sharing.

Example A: The enrollee example in Table 3 has a pharmacy deductible of $300 per year and a $1200 monthly drug cost. Coverage for the high-cost drug is subject to 30% coinsurance ($250 per prescription) once the deductible is met. At baseline, during month 1 of the plan or policy year, the enrollee pays $300 towards the total drug cost to meet their deductible, plus the $250 coinsurance since the deductible has been met. For the remainder of the months of the year, the enrollee pays $250 per month in coinsurance for the drug. The annual cost sharing at baseline is $3,300. Postmandate, the enrollee no longer has to meet the $300 deductible for this drug but still has to pay coinsurance. Therefore, the enrollee pays the $250 coinsurance all 12 months of the plan or policy year, starting at month 1, resulting in a total annual cost sharing postmandate of $3,000. Postmandate, annual cost sharing for the high-cost drug decreases by $300 (9%) as a result of the first month's filled prescription not being subject to the deductible.

Table 4. High-Cost Drug Example – Enrollee Cost Sharing Per Prescription By Month*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Baseline Enrollee Cost Sharing	$550	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$3,300
Postmandate Enrollee Cost Sharing	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$3,000

Source: California Health Benefits Review Program, 2021

Notes: *Example assumes the plan or policy year is on a calendar year basis.

Example B: The enrollee example in Table 4 has an HSA-qualified HDHP (and therefore a combined medical and pharmacy deductible) with a $1400 deductible and a $500 monthly insulin drug cost. Coverage for insulin is subject to a $25 copayment per prescription. The enrollee has additional medical costs for other medical care not subject to the deductible. At baseline, the enrollee meets the deductible through cost sharing for prescription insulin and other medical care. Postmandate, the enrollee meets the deductible through other medical care subject to the deductible. There is no change in annual cost sharing.

Table 4. Insulin Prescription Example – Enrollee Cost Sharing Per Prescription by Month*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Baseline Enrollee Cost Sharing	$25 $500 insulin $200 other	$25 $500 insulin $200 other	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$1,700
Postmandate Enrollee Cost Sharing	$25 $200 other	$25 $450 other	$25	$25	$25 $200 other	$25	$25	$25 $100 other	$25	$25	$25 $50 other	$25 $400 other	$1,700

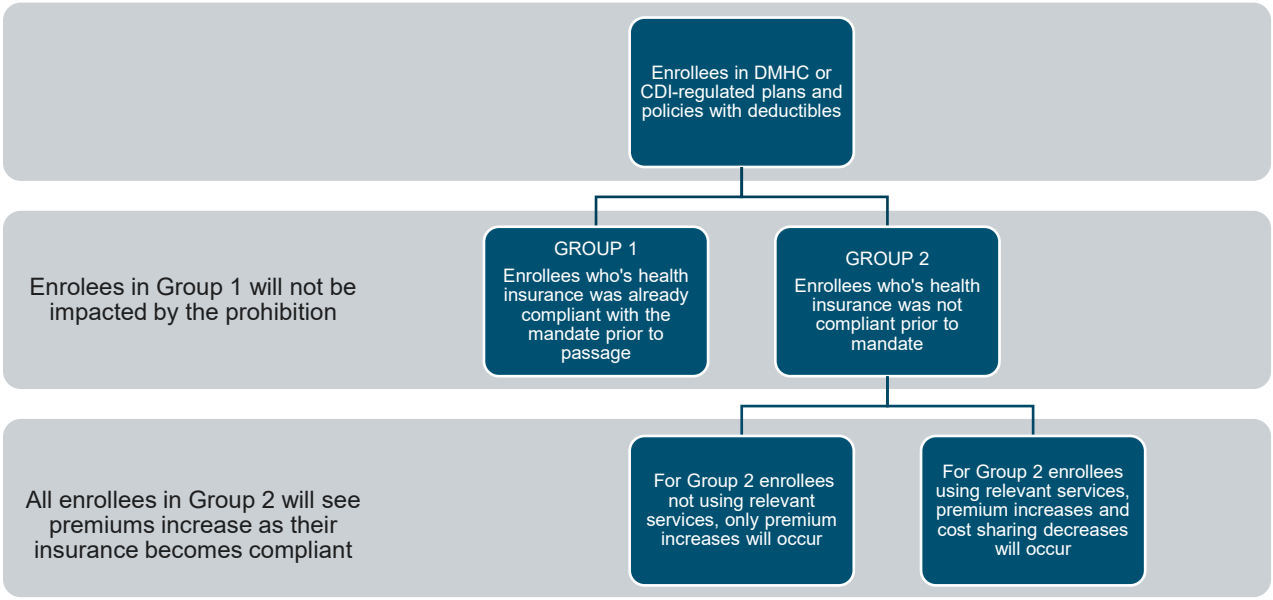
Source: California Health Benefits Review Program, 2021

Notes: *Example assumes the plan or policy year is on a calendar year basis.

Impact of Prohibition Depends on Plan or Policy Compliance Prior to Mandate

Enrollees in DMHC-regulated plans or CDI-regulated policies with deductibles may fall into two groups (see Figure 3). Enrollees in Group 1 will not see an immediate impact as a result of these types of mandates because the plans or policies are already compliant with the prohibition. Enrollees in Group 2 will be impacted as a result of the prohibition because the plans or policies are not already compliant. The impact to enrollees in Group 2 varies. All enrollees in Group 2 will see premiums increase. However, while some of these enrollees will additionally see changes in cost sharing, others will see no change because they will meet their deductible through the use of other medical care services, services still subject to the deductible.

Figure 3. Flow Chart of Impact to Enrollees when State-Regulated Plan or Policy is Subject to Deductible Prohibition



Source: California Health Benefit Review Program, 2021

State and Federal Laws Related to Deductibles

A number of state and federal health insurance laws place requirements regarding deductibles and all cost sharing (including deductibles) on plans and policies regulated by DMHC or CDI.

- **Federal Requirement of Presence of Deductible for HSA-Qualified Plans/Policies:** As previously discussed in the HDHP section, for HSA-qualified plans and policies, federal law requires the presence of a deductible but prohibits application of the deductible for selected preventive care – see IRS specifications,[20] which reference the Social Security Act[21] as well as IRS Notice 2019-45.[22]
- **Federally Selected Preventive Service Coverage Requirement:** The ACA requires that non-grandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing (including deductibles) when delivered by in-network

[20] Section 223(c)(2)(C) of Title 26 of the United States Code.
[21] Section 1861 of the Social Security Act.
[22] The IRS notice is available at: https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

providers and as soon as 12 months after a recommendation for such services appears in any of a number of federal lists (CCIIO, 2010).[23]

- **Federally Declared Public Health Emergency COVID-19 Testing and Vaccination Coverage Requirement:** For the duration of the federally declared public health emergency, FDA-approved COVID-19 testing and vaccinations must be covered without cost sharing (including deductibles)[24] when delivered by in-network or out-of-network providers.[25]
- **State of California Prescription Drug Coverage Requirement:** The annual deductible for outpatient prescription drugs, if any, shall not exceed $500.[26] However, this statute has different terms for enrollees in plans/policies with an actuarial value at or equivalent to bronze level.[27]

Conclusion

Approximately 5.7 million Californians are enrolled in plans and policies regulated by DMHC or CDI that include a deductible. Depending on a number of factors, including other forms of applicable cost-sharing and OOP maximums, the impact of a state-level deductible prohibition on enrollee's total cost-sharing for the plan or policy year would vary, and could have little or no impact for some enrollees.

[23] For more information: CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at: www.chbrp.org/other_publications/index.php.
[24] 2020 Families First Coronavirus Response Act (FFCRA).
[25] 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act
[26] H&SC 1342.73; IC 10123.1932. These laws have a scheduled expiration date of January 1, 2024. The cost sharing limit is relevant to non-grandfathered plans/policies issued, amended, or renewed on or after January 1, 2015.
[27] For plans and policies with an actuarial value at or equivalent to bronze level, the pharmacy benefit deductible shall not exceed $1000.

APPENDIX A

Below is a brief description of the approach and key assumptions used to estimate the presence of deductibles among enrollees in plans and policies regulated by DMHC and CDI.

Estimates were based on the results of surveys of California's largest (by enrollment) plans and insurers regulated by DMHC or CDI.

For both Tables 1 and 2, non-HSA plan/policy in-network medical deductible information was summarized by regulator, line of business, and deductible or metal tier levels.

For Table 1, assumptions include:

- For large group and grandfathered[28] plans/policies, ranges of deductibles exist. For plans in the $1 to $1,399 deductible range, a medical deductible of $750 was assumed. For plans with a deductible of $1,400 or greater, a $2,000 medical deductible was assumed.
- For small group plans/policies, the 2021 Covered California plan offerings (Covered CA, 2021) were reviewed. The average medical deductible for the Silver tier plans was assumed to be applicable to all plans in that tier. For all other tiers, the mode was assumed applicable to all.
- For individual plans/policies, the 2022 Covered California plan offerings (Covered CA, 2021) were reviewed. The non-HSA plan medical deductible at each tier was assumed to be applicable.

For Table 2, assumptions include:

- 14% of large group plans were assumed to have a pharmacy deductible based on the large group percentage of workers with a separate pharmacy deductible from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).
- Large group plans with a pharmacy deductible were assumed to have a pharmacy deductible of $190 based on the average large group pharmacy deductible from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).
- 10% of the small group and individual grandfathered plans was assumed to have a pharmacy deductible based on the small group percentage of workers with a separate pharmacy deductible from Kaiser Family Foundation's 2015 Employer Health Benefit Survey (KFF, 2015).
- The small group and individual grandfathered plans with a pharmacy deductible were assumed have a pharmacy deductible of $160 based on the average small group pharmacy deductible from Kaiser Family Foundation's 2015 Employer Health Benefit Survey (KFF, 2015). The 2015 report was used because grandfathered plans are allowed to offer benefits they had before the Affordable Care Act was signed in 2010 and are not allowed to significantly reduce coverage. The information needed was not available in more recent reports.
- For all nongrandfathered small group plans, the 2021 Covered California plan offerings were reviewed (Covered CA, 2021). Platinum and Gold plans were assumed to have no pharmacy deductible. Silver and Bronze plans were assumed to have $300 and $500, respectively.

[28] A grandfathered health plan is "a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." See http://www.healthcare.gov/glossary/grandfathered-health-plan. Accessed on December 7, 2021.

- For all nongrandfathered individual plans, the 2022 Covered California plan offerings were reviewed (Covered CA, 2021). The non-HSA plan pharmacy deductible was assumed for each tier.

For Tables 1 and 2, assumptions include:

- HSA-qualified plan/policy medical and pharmacy in-network deductibles were summarized using the 2021 individual and 2020 small group Covered California plans for individual and small group nongrandfathered plans (Covered CA, 2021). Large group and grandfathered plans were assumed to have a $2,500 deductible, based on the Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).

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ABOUT CHBRP

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

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report. Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at http://www.chbrp.org/.

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Adara Citron, MPH, Principal Policy Analyst
Sabrina Woll, Policy Associate
Karen Shore, PhD, Contractor*
An-Chi Tsou, PhD, Contractor*

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org
www.chbrp.org
(510) 664-5306

*Independent Contractor working with CHBRP to support analyses and other projects.

CHBRP is an independent program administered and housed by the University of California, Berkeley, in the Office of the Vice Chancellor for Research.

Acknowledgements

This issue brief was prepared by John Lewis, MPA, of CHBRP staff, and Katie Patrick, MPH candidate, a CHBRP Summer 2021 Intern. Drafts were reviewed by Garen Corbett, MS, and Adara Citron, MPH, both of CHBRP staff, and Dylan Roby, PhD of the University of California, Irvine.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

Resource:
Estimates of Sources of Health Insurance in California for 2022

February 4, 2021

Prepared by
California Health Benefits Review Program
University of California, Berkeley
MC 3116
Berkeley, CA 94720-3116

T: (510) 664-5306

www.chbrp.org

Additional copies of this and other CHBRP products may be obtained by visiting the CHBRP website at www.chbrp.org.

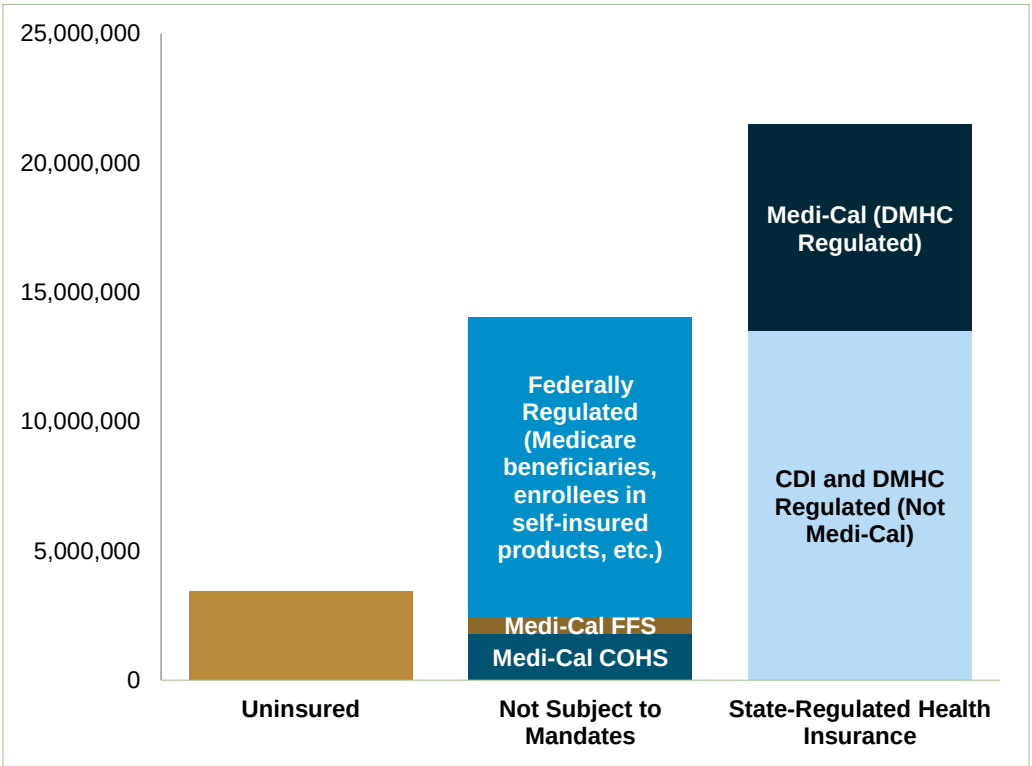
Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: Estimates of Sources of Health Insurance in California for 2022. Berkeley, CA*

OVERVIEW

The California Health Benefits Review Program (CHBRP) responds to requests from the California Legislature to analyze bills related to health insurance benefits.[1] As part of these analyses, CHBRP annually updates its Cost and Coverage Model, which includes estimates of sources of health insurance in California. This brief discusses CHBRP's 2022 estimates.

As shown in Figure 1, most Californians will be enrolled in health insurance regulated by either the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). Other Californians will have other types of health insurance or will remain uninsured.

Figure 1. Health Insurance by Regulator in California, 2022



Source: California Health Benefits Review Program, 2021.
Key: FFS = Fee for Service; COHS = County-Organized Health System; CDI = California Department of Insurance; DMHC = California Department of Managed Health Care

In 2022, CHBRP estimates that California's population will be 39.4 million. Figure 1 presents several key elements regarding the sources of health insurance in California:

- 55.7% will be enrolled in DMHC-regulated health care service plans or CDI-regulated health insurance policies. This figure includes beneficiaries of Medi-Cal (California's Medicaid program) who are enrolled in DMHC-regulated plans (about 76.4% of all Medi-Cal beneficiaries).
- 35.6% will have health insurance associated with some other regulator. These are primarily Californians who are Medicare beneficiaries or who are enrolled in self-insured products. This figure includes Medi-Cal beneficiaries associated with the Medi-Cal Fee-For-Service (FFS) program or enrolled in County-Organized Health System (COHS) managed care plans. These Californians will have health insurance that is not subject to state-level health insurance laws.

[1] Established in 2002, CHBRP's authorizing statute is available at: http://www.chbrp.org/faqs.php.

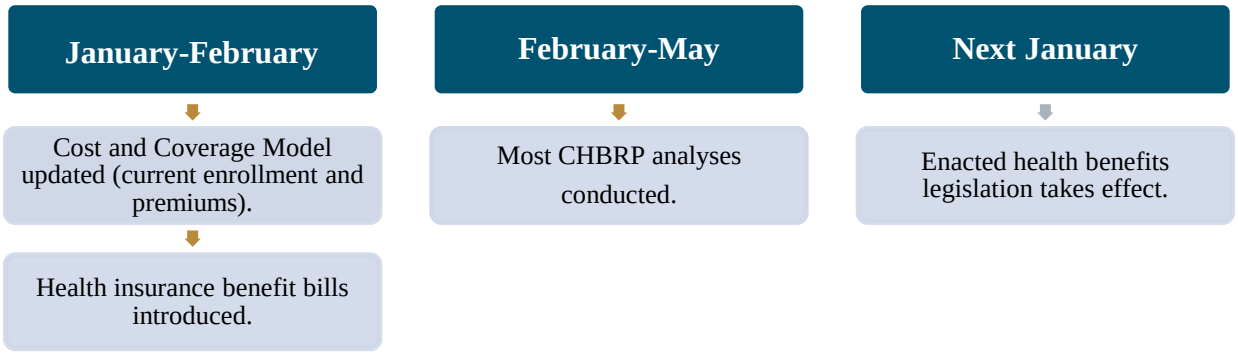
Only DMHC-regulated plans or CDI-regulated policies may be subject to state-level health insurance laws.

ESTIMATES OF SOURCES

Annually, CHBRP updates its Cost and Coverage Model (CCM) to estimate baseline health insurance enrollment and to project marginal, incremental impacts on benefit coverage, utilization, and cost of proposed health insurance benefit legislation.[2] The California Legislature generally proposes laws that would take effect in the following calendar year or later (if enacted, bills proposed in 2021 would generally take effect in 2022). For this reason, CHBRP annually projects the state's future distribution of health insurance by market segment.

Figure 2 describes: the analytic timeline for bill introduction preparation for and completion of bill analyses; and effective period of legislation if the bill is enacted.

Figure 2. Analytic Timeline



Enrollment Estimates and the Affordable Care Act

Although CHBRP is monitoring federal developments relevant to the Affordable Care Act (ACA), until any proposed changes are implemented, CHBRP will continue to anticipate impacts of the ACA on health insurance in California, including the following:

- Continued expansion of Medi-Cal eligibility.
- Continued presence of Covered California (the state's health insurance marketplace, through which subsidized health insurance may be available).
- Continued presence of some "grandfathered" plans and policies (privately funded plans and policies in existence before the ACA was signed). Grandfathered plans and policies are substantially unchanged and are exempt from some of the ACA's requirements.[3]

The continued presence of grandfathered plans and policies is relevant to CHBRP's analyses of health insurance bills because these plans and policies are not subject to the same requirements as are others (and so could be differently affected by a new health insurance law). For example, grandfathered plans

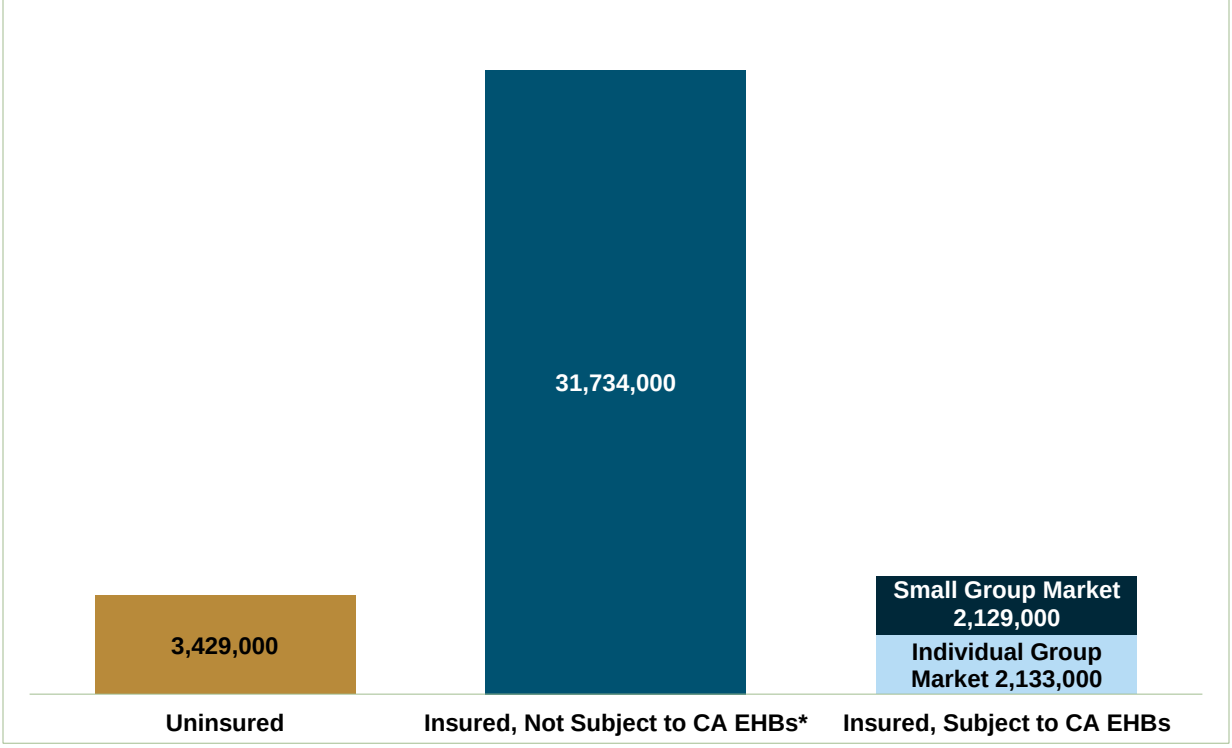
[2] Information on the CCM is available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
[3] A grandfathered health plan is "a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Accessed at: http://www.healthcare.gov/glossary/grandfathered-health-plan.

and policies are not required by the ACA to: (1) cover specific preventive services without cost sharing; (2) restrict cost sharing for emergency services; or (3) cover essential health benefits (EHBs).[4,5]

Essential Health Benefits

The Affordable Care Act requires each state to create a set of essential health benefits (EHBs) that some state-regulated health insurance must cover.[6] In California, individual and small-group health insurance regulated by DMHC or CDI is generally required to cover EHBs. Grandfathered health insurance[7] in either market is exempt from the requirement as is large group market health insurance. As noted in Figure 3 below, approximately 10.8% of California's population has health insurance required to cover EHBs.

Figure 3. California Health Insurance in Subject to Essential Health Benefits, 2022



Source: California Health Benefit Review Program, 2021.
Notes: "Insured, Not Subject to CA EHBs" includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies,

[4] As indicated in federal and California state law, non-grandfathered group and individual health insurance plans and policies must cover certain preventive services. See CHBRP's brief Federal Preventive Services Mandate and California Benefit Mandates, available at: http://chbrp.org/other_publications/index.php.
[5] The essential health benefits categories are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, including behavioral health treatment, prescription drugs, rehabilitation and habilitation services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care. See CHBRP's brief California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits," available at: http://chbrp.org/other_publications/index.php.
[6] Essential Health Benefits requirements and parameters are discussed in Section 1302 of the Affordable Care Act. More information is available online at https://www.healthcare.gov/glossary/essential-health-benefits/.
[7] A grandfathered health plan is "a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Accessed at: http://www.healthcare.gov/glossary/grandfathered-health-plan.

and enrollees in grandfathered individual and small group plans/policies
Key: CA = California; EHBs = Essential Health Benefits

CONCLUSION

To estimate potential impacts of health insurance benefits legislation, CHBRP develops forward-looking estimates of health insurance enrollment in California. Annual updates to CHBRP's Cost and Coverage Model are necessary to project insurance enrollments by market segment and associated with certain purchasers.

The resulting projections of sources of health insurance in California may be of use to the Legislature and to others interested in California health policy, as well as key to CHBRP's analytic work.

APPENDIX A

Table 1. Sources of Health Insurance in California, 2022

Publicly Funded Health Insurance

	Age	DMHC-regulated	Not regulated by DMHC or CDI	Total
Medi-Cal	0-17	2,736,000	273,000	3,009,000
	18-64	3,785,000	378,000	4,163,000
	65+	48,000	11,000	59,000
Medi-Cal COHS	All	-	1,803,000	1,803,000
Other public	All	-	-	567,000
Dually eligible Medicare & Medi-Cal	All	1,436,000	281,000	1,717,000
Medicare (non Medi-Cal)	All	-	-	5,032,000
CalPERS	All	889,000	317,000	1,206,000

Privately Funded Health Insurance

		DMHC-regulated		CDI-regulated		
	Age	Grand-fathered	Non-Grand-fathered	Grand-fathered	Non-Grand-fathered	Total
Self-insured	All	-	-	-	-	5,389,000
Individually purchased, Subsidized CovCA	0-17	-	104,000	-	4,000	108,000
	18-64	-	1,105,000	-	42,000	1,147,000
	65+	-	-	-	-	-
Individually purchased, Non-Subsidized CovCA and Outside CovCA	0-17	16,000	179,000	17,000	8,000	220,000
	18-64	48,000	520,000	50,000	20,000	638,000
	65+	1,000	16,000	2,000	1,000	20,000
Small group	0-17	41,000	441,000	*	10,000	492,000
	18-64	134,000	1,446,000	*	32,000	1,612,000
	65+	2,000	22,000	*	1,000	25,000
Large group	0-17	293,000	2,028,000	1,000	105,000	2,427,000
	18-64	755,000	5,231,000	4,000	270,000	6,260,000
	65+	12,000	86,000	*	4,000	102,000

Uninsured

Age	Total
0-17	237,000
18-64	3,140,000
65+	52,000

California's Total Population **39,425,000**

Source: California Health Benefits Review Program, 2021.

Notes: *Less than 500 individuals

Key: CDI = California Department of Insurance; CalPERS = California Public Employees' Retirement System; COHS = County-Organized Health System; CovCA = Covered California (the state's health insurance marketplace); DMHC = California Department of Managed Health Care

Enrollment by Market Segment and Purchaser

As noted, health insurance available through DMHC-regulated plans and CDI-regulated policies may be subject to state-level benefit-related legislation written into one or two sets of laws: the Health and Safety Code (enforced by DMHC) and/or the Insurance Code (enforced by CDI). However, such legislation may be written to exempt some health insurance market segments or to exempt health insurance associated with certain purchasers. To correctly determine the impact of proposed legislation, CHBRP determines estimates, as displayed in Table 1, of Californians' sources of health insurance.[8] The table is organized by column (regulation) and row (market segment) and divided in two (public and privately funded health insurance).

Although some Californians have more than one type of health insurance, for analytic purposes the table lists (excepting those dually eligible for Medi-Cal and Medicare) enrollment in the person's primary form of health insurance.

Table 1 indicates: (1) the number of Californians enrolled in health insurance market segments and (2) the number Californians associated with a purchaser that might be of interest to the California Legislature - including, enrollees associated with Medi-Cal, California Public Employees' Retirement System (CalPERS), and Covered California.

Similar to Figure 1, Table 1 indicates enrollment in DMHC-regulated plans and CDI-regulated policies. However, Table 1 provides further information, such as age of enrollees and details of market segments and purchasers. Age is relevant to many CHBRP analyses because many of the diseases and conditions addressed by a bill are more likely to be present in either older or younger enrollees. Market segment details are relevant because they indicate which enrollees do and do not have health insurance that can be subject to a state-level mandate as well as which do and do not have health insurance that would be subject to the mandate proposed by a particular bill.

Key elements of information from Table 1 include:

- 12.7 million Californians will be enrolled in privately funded DMHC-regulated plans or CDI-regulated policies.
    - 68.4% of these enrollees will be associated with the large group market (101+ enrollees). A majority of these enrollees will be in DMHC-regulated plans.
- 10.8 million Californians will be Medi-Cal beneficiaries.
    - 76.4% of Medi-Cal beneficiaries will be enrolled in DMHC-regulated plans. The rest will be enrolled in County-Organized Health System (COHS) managed care or associated with the Fee-For-Service (FFS) program.[9]
- 1.2 million Californians will have health insurance associated with CalPERS.
    - 73.7% will be enrolled in DMHC-regulated plans. The remaining CalPERS enrollees are associated with CalPERS' self-insured health insurance products, which are not subject to state-level health insurance legislation.
- 5.4 million Californians will be enrolled in privately funded self-insured products, which are not subject to state-level health insurance legislation.

[8] Technically, some sources of what are commonly referred to as "health insurance," such as Medicare, are actually "entitlements." For ease of communication CHBRP has grouped all sources together.
[9] This figure also includes the 328,000 dually eligible Medicare and Medi-Cal beneficiaries enrolled in health plans not regulated by DMHC or CDI.

Resource:
Health Insurance Benefit Mandates in California State and Federal Law

December 2021

Prepared by
California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: Health Insurance Benefit Mandates in California State and Federal Law. Berkeley, CA*

ABOUT THIS RESOURCE

The California Health Benefits Review Program (CHBRP) responds to requests from the California Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals (and other health-insurance related legislation).[1,2] This document has been prepared by CHBRP to inform interested parties of existing state and federal health insurance benefit mandate laws that may relate to the subject or purpose of a proposed state health insurance benefit mandate or repeal bill.

This document includes the following:

- Table 1. California Health Insurance Benefit Mandates (by Topic)
- Table 2. California Mandates with Sunset or Contingency Language
- Table 3. Federal Health Insurance Benefit Mandates
- Appendix A. Explanation of Table Terms and Categories
- Appendix B. Discussion of Basic Health Care Services

Benefit Mandate Categories

CHBRP defines health insurance benefit mandates through the lens of its authorizing statute.[3] Therefore, the mandates listed in Tables 1 and 2 fall into one or more of the following categories: (a) offer or provide coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) offer or provide coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; (c) offer or provide coverage permitting treatment or services from a specific type of health care provider; and/or (d) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories. Table 1 includes California's state health insurance benefit mandate laws, and Table 3 includes federal health insurance benefit mandate laws.

Information Included for Listed Mandates

Table 1 identifies relevant California statutes. The table specifies when the law mandates *an offer* of coverage for the benefit. The table also identifies which health insurance markets (group and/or individual, explicitly includes Medi-Cal, Medi-Cal exempt, Medi-Cal excluded) are subject to the mandate. Explanations of these terms are provided in Appendix A.

Table 2 lists California benefit mandate statutes that contain either a sunset clause or contingency language. Sunset clauses specify that the law will no longer be in effect after the listed date. Contingency language specifies that the state law is in effect only so long as a federal law is in effect, or only if federal rulings do not indicate that some or all of the state law would exceed essential health benefits (EHBs).

Table 3 identifies relevant federal statutes, both those in existence prior to passage of the Affordable Care Act (ACA)[4] as well as federal benefit mandates contained in the ACA. Like Table 1, Table 3 identifies the health insurance markets subject to the mandate. Because none of the federal mandates are mandates to *offer* coverage, this information is not included in Table 3.

[1] Additional information about CHBRP is available at: www.chbrp.org.
[2] Completed CHBRP analyses are available at: www.chbrp.org/completed_analyses/index.php.
[3] Available at: http://chbrp.com/about_chbrp/faqs/index.php.
[4] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

Key Facts

- **Applicability of mandate laws:** Not all health insurance is subject to state health insurance benefit mandate laws. CHBRP annually posts estimates of Californians' sources of health insurance, including figures for the numbers of Californians with health insurance subject to state benefit mandates.[5]

- **California insurance regulation:** California has a bifurcated legal and regulatory system for health insurance products. The Department of Managed Health Care (DMHC) regulates health care service plan contracts, which are subject to the Health and Safety Code. The California Department of Insurance (CDI) regulates health insurance policies, which are subject to the California Insurance Code. DMHC-regulated plan contracts and CDI-regulated policies may be subject to state benefit mandate laws, depending upon the exact wording of the law.

- **Federal benefit mandates:** Federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates, unlike state mandates, may apply to Medicare or to self-insured plans. Table 3 only lists federal benefit mandate laws that are applicable to DMHC-regulated plans and CDI-regulated policies, which are also under the purview of state law.

- **Federal-state mandate overlap:** DMHC-regulated plans and CDI-regulated policies may be subject to both state and federal benefit mandate laws. Federal benefit mandates may interact or overlap with state benefit mandates, as in the case of mammography benefits. In addition, state laws that duplicate federal laws allow state-level regulators explicit authority to implement them, as in the case of Essential Health Benefits (EHBs). Some known interactions are noted in the footnotes for Table 1.

- **DMHC rules:** DMHC-regulated health plans are subject to "minimum benefit" laws and regulations, also known as "Basic Health Care Services," that may interact or overlap with state benefit mandate laws. The Basic Health Care Services requirement for DMHC-regulated health plans is noted in Table 1 and further explained in Appendix B.

[5] Available at: www.chbrp.org/other_publications/index.php.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
DMHC-Regulated Health Care Service Plan "Basic Health Care Services" (BHCS)- Mix of law and regulation (see Appendix B)						
0	All health plans regulated by the Department of Managed Health Care (DMHC) are required to cover medically necessary basic health care services, including: (1) Physician services; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system; (7) Hospice care. See Appendix B for further details. Large group health policies regulated by the California Department of Insurance (CDI) have similar requirements.	Multiple Sections - See Appendix B	10112.281		See Appendix B	Not a distinct mandate
Essential Health Benefits						
1	A federal mandate that requires some plans and policies to cover essential health benefits (EHBs) and places limits on cost sharing. The state statutes listed in this row define EHBs and cost sharing for California.[8,9] (also see Table 3)	1367.005 1367.006	10112.27 10112.28		Small Group and Individual[10] as well as Large Group if sold via Covered California[11] (Medi-Cal excluded)[12]	a, b, d
Cancer Benefit Mandates – also see row 37 under "Outpatient Prescription Drug Benefit Mandates"						
2	Breast cancer screening, diagnosis, and treatment	1367.6	10123.8		Not Specified	a
3	Cancer screening tests, with further requirements for biomarker tests	1367.665	10123.20		Not Specified (for biomarkers, explicitly includes Medi-Cal)	b, d
4	Cervical cancer screening	1367.66	10123.18		Group and Individual (Medi-Cal excluded)	a
5	Clinical trials	1370.6	10145.4		Group and Individual (Medi-Cal excluded)	b, d
6	Colorectal cancer screening, prohibits cost sharing	1367.668	10123.207			a, b, d

[6] Defined per CHBRP's authorizing statute, available at: http://chbrp.com/about_chbrp/faqs/index.php

[7] "Mandate to offer" indicates that all health care service plans and health insurers selling health insurance subject to the benefit mandate are required to *offer* coverage for the benefit. The health plan or insurer may comply (1) by including coverage for the benefit as standard in its health insurance products or (2) by offering coverage for the benefit separately and at an additional cost (e.g., a rider). See Appendix A.

[8] Affordable Care Act (ACA), Section 1301, 1302, and Section 1201 modifying Section 2707 of the Public Health Service Act (PHSA). See Table 3 below.

[9] Review report: *California's State Benefits Mandates and the Affordable Care Act's "Essential Health Benefits*, available at: www.chbrp.org/other_publications/index.php.

[10] The EHB coverage requirement applies to non-grandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.

[11] Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via an exchange [ACA Section 1312(f)(2)(B)]. Large-group QHPs would be subject the EHB coverage requirement.

[12] See Appendix A for explicitly includes Medi-Cal, Medi-Cal excluded, and Medi-Cal exempt language.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
7	Mammography	1367.65 (a)	10123.81		Not Specified (DMHC) Group and Individual (CDI)	a, c
8	Mastectomy and lymph node dissection (length of stay, complications, prostheses, reconstructive surgery)	1367.635	10123.86		Not Specified	b, d
9	Prostate cancer screening	1367.64	10123.835		Group and Individual (Medi-Cal excluded)	a
Chronic Conditions Benefit Mandates – also see rows under "Outpatient Prescription Drug Benefit Mandates," which are often relevant to chronic condition treatment						
10	Diabetes education	N/A	10176.6	Offer	Not Specified (CDI)	a
11	Diabetes education, management, and treatment	1367.51	10176.61		Not Specified	a, b, d
12	HIV/AIDS, AIDS vaccine	1367.45	10145.2		Group and Individual (DMHC), Not Specified (CDI) (Medi-Cal excluded)	a
13	HIV/AIDS, HIV Testing	1367.46	10123.91		Group and Individual (Medi-Cal excluded)	a
14	HIV/AIDS, Transplantation services for persons with HIV	1374.17	10123.21		Group and individual (CDI) Not Specified (DMHC)	d
15	Osteoporosis	1367.67	10123.185		Not Specified	a
16	Phenylketonuria	1374.56	10123.89		Not Specified	a
Hospice & Home Health Care Benefit Mandates						
17	Dementing illness exclusion prohibition	1373.14	10123.16		Group and Individual (Medi-Cal excluded)	a, d
18	Home health care	1374.10 (non-HMOs only)	10123.10	Offer	Group (Medi-Cal excluded)	b, d
19	Hospice care	1368.2	N/A[13]		Group (DMHC) (Medi-Cal excluded)	b
Mental Health Benefit Mandates						
20	Alcohol and drug exclusion prohibition	N/A	10369.12		Group (CDI) – not specified	d
21	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group (Medi-Cal excluded)	a
22	Behavioral health treatment for autism and related disorders (also see Table 2)	1374.73	10144.51 10144.52		Not Specified (Medi-Cal exempt)	b
23	Care provided by a psychiatric health facility	1373(h)(1)	N/A		Not Specified (DMHC)	b, d

[13] N/A indicates that the benefit mandate does not apply to products governed under the specified code.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
24	Coverage and premiums for persons with physical or mental impairment	1367.8	10144		Group and Individual (Medi-Cal excluded)	a, d
25	Coverage for mental and nervous disorders, including care provided by a psychiatric health facility	N/A	10125	Offer	Group (CDI)	a
26	Coverage for persons with physical handicap	N/A	10122.1	Offer	Group (CDI)	a, d
27	Coverage for mental illnesses and substance use disorders (in parity with coverage for other medical conditions)	1374.72	10144.5 10123.15		Not Specified (Medi-Cal exempt)	a, b, d
28	Coverage for mental health and substance use disorder in compliance with federal law. [14]	1374.76	10144.4		Large Group and Individual (Medi-Cal excluded)	a, b, d
29	Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	1367.2(b)	10123.6	Offer	Group (Medi-Cal excluded)	b, d
30	Prohibition of lifetime waiver for mental health services	1374.5	10176(f)		Individual (Medi-Cal excluded)	a, d
31	Prohibition on determining reimbursement eligibility from inpatient admission status	1374.51	10144.6		Not Specified	d
32	Medical necessity determination and utilization review of benefits related to mental health and substance use disorders (see also Table 3)	1374.72 1374.721	10144.5 10144.52		Not Specified (Medi-Cal excluded)	a, b, c, d
Orthotics & Prosthetics Benefit Mandates						
33	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group (Medi-Cal excluded)	b
34	Prosthetic devices for laryngectomy	1367.61	10123.82		Not Specified	b
35	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	Group (Medi-Cal excluded)	b
Outpatient Prescription Drug Benefit Mandates						
36	Authorization for nonformulary prescription drugs	1367.24	N/A		Not Specified (DMHC) (Medi-Cal exempt)	d
37	HIV/AIDS, pre-exposure and post-exposure prophylaxis: prohibition of step therapy or prior authorization	1342.74	10123.1933		Not specified	d
38	Oral anticancer medication cost-sharing limits (also see Table 2)	1367.656	10123.206		Group and Individual (Medi-Cal excluded)	d
39	Prescription Medications (also see Table 2) – addresses cost sharing, formularies, and utilization management protocols related to HIV/AIDS medications	1342.72 1342.73 1367.205 1367.41 1367.42 1367.47	10123.192 10123.193 10123.1931 10123.1932 10123.201 10123.65		Varied: some Not Specified (some Medi-Cal exempt) and some Small Group and Individual (Medi-Cal excluded)	b, d

[14] ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA). See Table 3 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
40	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A		Not Specified (DMHC)	d
41	Prescription drugs: coverage of "off-label" use	1367.21	10123.195		Not Specified (DMHC), Group and Individual (CDI)	d
42	Prescription drugs: prorating cost sharing for partial fill for Schedule II controlled substance	1367.43	10123.203		Not specified	d
43	Prior authorization requests for prescription drugs	1367.241	10123.191		Not Specified (Medi-Cal exempt)	d
44	At home tests for sexually transmitted diseases (STDs), in network only	1367.34	10123.208		Not Specified (Medi-Cal exempt)	a, b
45	Step Therapy	1367.244 1367.206	10123.197 1367.241		Not Specified (Medi-Cal exempt)	d
Pain Management Benefit Mandates						
46	Acupuncture	1373.10 (non-HMOs only)	10127.3	Offer	Group (Medi-Cal excluded)	c, d
47	General anesthesia for dental procedures	1367.71	10119.9		Not Specified	b
48	Pain management medication for terminally ill	1367.215	N/A		Not Specified (DMHC)	b
Pediatric Care Benefit Mandates						
49	Asthma management	1367.06	N/A		Not Specified (DMHC)	a
50	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5		Group (Medi-Cal excluded)	b
51	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group (Medi-Cal excluded)	b
52	Coverage for the effects of diethylstilbestrol	1367.9	10119.7		Not Specified (DMHC) Group and Individual (CDI)	a
53	Screening children at risk for lead poisoning for blood lead levels	1367.3(b)(2)(D)	10123.5 10123.55		Group (DMHC), Group (CDI) (Medi-Cal excluded)	b
54	Screening children (and adults) for adverse childhood experiences (ACEs)	1367.34	10123.51		Not Specified	a, b
55	Screening children for blood lead levels	N/A	10119.8	Offer	Individual or Group (CDI)	b
Provider Reimbursement Mandates						
56	Emergency 911 transportation[15]	1371.5	10126.6		Not Specified	d
57	Licensed or certified providers	1367(b)	N/A		Not Specified	c, d

[15] The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 3 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
58	Medical transportation services – direct reimbursement	1367.11	10126.6		Not Specified	d
59	OB-GYNs as primary care providers[16]	1367.69 1367.695	10123.83 10123.84		Not Specified	c, d
60	Pharmacists – compensation for services within their scope of practice	1368.5	10125.1	Offer	Not Specified (DMHC) Group (CDI)	c, d
61	Telehealth	1374.13 1374.14	10123.85 10123.855		Not Specified (explicitly includes Medi-Cal)	c, d
Reproductive Benefit Mandates						
62	Contraceptive devices (including devices requiring a prescription) and sterilization, and contraceptive education and counseling	1367.25	10123.196		Group and Individual (explicitly includes Medi-Cal)	b
63	Fertility preservation services	1374.551	N/A		Not specified (Medi-Cal exempt)	a, b
64	Infertility treatments	1374.55	10119.6	Offer	Group (Medi-Cal excluded)	a, b, d
65	Maternity services	N/A	10123.865 10123.866		Group and Individual (CDI)	b
66	Maternity – amount of copayment or deductible for inpatient services	1373.4	10119.5		Not Specified (Medi-Cal excluded)	d
67	Maternity – minimum length of stay[17]	1367.62	10123.87		Not Specified (DMHC) Group and Individual (CDI)	d
68	Maternal mental health	1367.625	10123.867		Not Specified	a
69	Participation in the statewide prenatal testing Expanded Alpha-fetoprotein (AFP)[18] program	1367.54	10123.184		Group and Individual (Medi-Cal excluded)	b
70	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group (Medi-Cal excluded)	b
71	Annual supply of self-administered hormonal contraceptives	1367.25	10123.196		Group and Individual (Medi-Cal excluded)	d
72	Reproductive health care services	1367.31	10123.202		Not Specified (Medi-Cal exempt)	d
Sterilization						

[16] The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 3 below.
[17] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery *if* the plan covers maternity services. See Table 3 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
73	Sterilization rationale exclusion prohibition	1373(b)	10120		Not Specified	d
Surgery Benefit Mandates						
74	Jawbone or associated bone joints	1367.68	10123.21		Not Specified (DMHC) Group and Individual (CDI)	a
75	Reconstructive surgery[19]	1367.63	10123.88		Not Specified (Medi-Cal exempt)	b
Other Benefit Mandates						
76	Blindness or partial blindness exclusion prohibition	1367.4	10145		Group and Individual (Medi-Cal excluded)	a, d
77	COVID-19 diagnostic and screening testing	1342.2	10110.7		Not Specified	a, b, d
78	Cost sharing limits - for essential health benefits (EHBs), prohibits lifetime and annual dollar coverage limits (also see Table 3)	1367.001	10112.1		Group and Individual (Medi-Cal excluded)	b, d
79	Cost sharing limits - family cost sharing limits (also see Table 3)	1367.006 1367.007	10112.28 10112.29		Varied: Large Group, Small Group, Individual (Medi-Cal excluded)	d
80	Cost sharing limits - preventive services without cost sharing (in compliance with federal laws and regulations)[20] (also see Table 3)	1367.002	10112.2		Group and Individual (Medi-Cal excluded)	b, d
81	Public health emergency (CA governor declared) disease prevention/mitigation services	1342.3	10110.75		Not Specified	a, b, d
82	Second opinions	N/A	10123.68		Not Specified (CDI)	c

[19] The federal Women's Health and Cancer Rights Act of 1998 requires coverage for post mastectomy reconstructive surgery. See Table 3 below.
[20] ACA, Section 1001 modifying Section 2713 of the PHSA. See Table 3 below.

Table 2. California Mandates with a Sunset or Contingency Clause in Existing Code (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Disabling Clause (Type and Language)
Cancer Benefit Mandates				
1	Oral anticancer medication cost-sharing limits	1367.656	10123.206	SUNSET – 1367.656(b) and 10123.206(b): "This section shall remain in effect only until January 1, 2024, and as of that date is repealed."
Chronic Conditions Benefit Mandates				
2	HIV/AIDS, antiretroviral drug treatments	1342.72	10123.1931	SUNSET – 1342.72(c) and 10123.1931(b): "This section shall remain in effect only until January 1, 2023, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2023, deletes or extends that date."
Mental Health Benefit Mandates				
3	Behavioral health treatment for autism and related disorders	1374.73	10144.51 10144.52	CONTINGENCY – 1374.73(a)(2) and 10144.51(a)(2): "[This] section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act."
Outpatient Drug Benefit Mandates				
4	Prescription cost sharing	1342.71 1342.73 1367.205 1367.41 1367.42	10123.192 10123.193 10123.1932 10123.201	SUNSET – 1342.73(d) and 10123.1932(c): "This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2024, deletes or extends that date."
Other Benefit Mandates				
5	Family cost sharing limits	1367.006 1367.007	10112.28 10112.29	CONTINGENCY – 1367.006(c)(2) and 10112.28(c)(2): "The [annual out-of-pocket] limit shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA." CONTINGENCY – 1367.007(a)(2) and 10112.29(a)(2): "The dollar amounts [of the small employer deductible] shall be indexed consistent with Section 1302(c)(4) of PPACA and any federal rules or guidance pursuant to that section."
6	Preventive services without cost sharing (in compliance with federal laws and regulations)[21]	1367.002	10112.2	CONTINGENCY - 1367.002 and 10112.2: "To the extent required by federal law, a group or individual [health plan shall] comply with Section 2713 of the federal Public Health Service Act [as added by] Section 1001 of the federal Patient Protection and Affordable Care Act."

[21]ACA, Section 1001 modifying Section 2713 of the PHSA.

Table 3. Federal Health Insurance Benefit Mandates[22]

#	Federal Law	Topic Addressed by Benefit Coverage Mandate[23]	Markets Subject to the Mandate[24]	Mandate Category
Federal Mandates in Existence Prior to the Passage of the Affordable Care Act of 2010 (ACA)				
1	Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act	Requires coverage for pregnancy and requires the coverage be in parity with other benefit coverage.	Group (15 or more)	d
2	Newborns' and Mothers' Health Protection Act of 1996	If maternity is covered, requires that coverage include at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).	Group	d
3	Women's Health and Cancer Rights Act of 1998	If mastectomy is covered, requires coverage for certain reconstructive surgery and other post-mastectomy treatments and services.	Group	b
4	Mental Health Parity and Addiction Equity Act of 2008, modified by the Affordable Care Act of 2010 [ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA)]	If mental health or substance use disorder (MH/SUD) services are covered, requires that cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits.[25]	Group and Individual	d
Federal Mandates in the Affordable Care Act of 2010 (ACA)				
5	Section 1001 modifying Section 2711 of the PHSA	Prohibits lifetime and annual limits on the dollar value of benefits. [26]	Group and Individual	d
6	Section 1001 modifying Section 2713 of the PHSA	Preventive services without cost sharing.[27,28] As soon as 12 months after a recommendation appears in any of three sources, benefit coverage is required. The four sources are: • 'A' and 'B' rated recommendations of the United States Preventive Services Task Force (USPSTF)[29]; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[30]; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)[31]; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA.[32]	Group and Individual	a, d
7	Section 1001 modifying Section 2719A(b) of the PHSA	If emergency services are covered, requires coverage for these services regardless of whether the participating provider is in or out of network, with the same cost-sharing levels out of network as would be required in network, and without the need for prior authorization.	Group and Individual	d
8	Section 1001 modifying Section 2719A(d) of the PHSA	Prohibits requiring prior authorization or referral before covering services from a participating health care professional who specializes in obstetrics or gynecology.	Group and Individual	d
9	Section 1201 modifying Section 2704 of the PHSA	Prohibits "preexisting condition" benefit coverage denials.	Group and Individual[33]	d

10	Section 1301, 1302, and Section 1201 modifying Section 2707 of the PHSA	Requires coverage of essential health benefits (EHBs), and, for plans and policies that provide coverage for EHBs, and places limits on cost sharing. The 10 EHB categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[34]	Small Group and Individual[35] In 2017, Large Group sold via Covered California[36]	a, b, d

[22] CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: http://chbrp.com/about_chbrp/faqs/index.php.
[23] All listed federal health insurance benefit mandates are benefit coverage mandates. CHBRP is aware of no federal "mandates to offer."
[24] Unless otherwise noted, the federal mandates in the ACA do not apply to grandfathered health plans (Section 1251).
[25] California law requires compliance with this mandate. See Table 1 above (categorized with "Mental Health Benefit Mandates").
[26] Annual limits and lifetime limits apply to grandfathered plans, with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits [ACA Section 1251(a)(4)].
[27] California law requires compliance with this mandate. See Table 1 above (categorized with "Other Benefit Mandates").
[28] For more information on the preventive services coverage requirement, see CHBRP's resource, *Federal Preventive Services Benefit Mandate and the California Benefit Mandates*, available at: www.chbrp.org/other_publications/index.php.
[29] Available at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[30] Available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
[31] Regulations published in the Federal Register (Vol. 75, No 137, July 19, 2010) clarified which HRSA guidelines were applicable. The guidelines appear in two charts: Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at: http://brightfutures.aap.org/clinical_practice.html; and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html.
[32] Available at: https://www.hrsa.gov/womens-guidelines/index.html
[33] Applies to grandfathered group market health plans and grandfathered individual market plans [ACA Section 1251(a)(4)].
[34] California has laws in place to define EHBs for the state. See Table 1 above (categorized with "Essential Health Benefits").
[35] The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.
[36] Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via a health insurance exchange [ACA Section 1312(f)(2)(B)]. Large group QHPs would be subject to the EHB coverage requirement.

APPENDIX A EXPLANATION OF TABLE TERMS AND CATEGORIES

Code: A health insurance benefit mandate is a law requiring health insurance products (plans and policies) to provide, or in some cases simply to offer coverage for specified benefits or services. Because California has a bifurcated regulatory system for health insurance products, a benefit mandate law may appear in either of two codes, or in both:

- Health & Safety Code: The California Department of Managed Health Care (DMHC) regulates and licenses health care services plans as per the California Health and Safety Code.[37] In addition to commercial enrollees,[38] a majority of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[39]
- Insurance Code: The California Department of Insurance (CDI) licenses disability insurance carriers and regulates disability insurance, which includes health insurance policies, per the California Insurance Code.[40]

Mandated Benefit Coverage or Mandated Offer of Benefit Coverage: In the language of either code section, the law may mandate coverage of benefits or may mandate that coverage for the benefits be offered.

- "Mandate to cover" means that all health insurance subject to the law must cover the benefit.
- "Mandate to offer" means all health care service plans and health insurers selling health insurance subject to the mandate are required to offer coverage for the benefit for purchase. The health plan or insurer may comply with the mandate either (1) by including the benefit as standard in its health insurance products, or (2) by offering coverage for the benefit separately at an additional cost (e.g., a rider).

Markets Subject to the Mandate: In the language of either code, the law may (or may not) specify which market(s) are subject to the mandate.

- The individual market includes health insurance products issued to an individual to provide coverage for a person and/or their dependents.
- The group markets include health insurance products issued to employers (or other entities) to provide coverage for employees (or other persons) and/or their dependents. The large group market includes plans or policies with 101 or more enrollees. The small group market includes plans and policies with 100 or fewer (at least 1) enrollees.
- Technically not in a "market," the majority of Medi-Cal beneficiaries are enrolled in a DMHC-regulated plan. These beneficiaries are not considered to be in "group" market plans. These beneficiaries' plans may or may not be subject to the mandates listed in this document. Where possible, notes have been added to Table 1 indicating whether or not these beneficiaries' plans are or are not subject to the listed benefit mandate. The added notes are:
  - Explicitly includes Medi-Cal: the law explicitly requires compliance from health insurance products enrolling Medi-Cal beneficiaries.

[37] Available at: http://leginfo.legislature.ca.gov/faces/home.xhtml
[38] This group includes enrollees in DMHC-regulated plans associated with the California Public Employees' Retirement System (CalPERS) but not persons enrolled in CalPERS' self-insured plan (which is subject only to federal law).
[39] See CHBRP's *Estimates of Sources of Health Insurance*, a resource available at https://chbrp.org/other_publications/index.php
[40] Available at: http://leginfo.legislature.ca.gov/faces/home.xhtml

- Medi-Cal exempt: the law explicitly exempts from compliance health insurance products enrolling Medi-Cal beneficiaries.
- Medi-Cal excluded: the law specifies that it is applicable to group and/or individual market health insurance products – as Medi-Cal beneficiaries are enrolled in neither ,[41] CHBRP assumes that health insurance products enrolling Medi-Cal beneficiaries are not required to comply.

Mandate Category: As per CHBRP's authorizing statute, the listed mandates fall into one or more types. A particular mandate law can require that subject health insurance do one or more of the following:

a. Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition. An example would be a mandate that requires coverage for all health care services related to the screening and treatment of breast cancer.

b. Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service. An example would be a mandate to cover reconstructive surgery.

c. Offer or provide coverage for services from a specified type of health provider that fall within the provider's scope of practice. An example would be a mandate that requires coverage for services provided by a licensed acupuncturist.

d. Offer or provide any of the forms of coverage listed above per specific terms and conditions. For example, the mental health parity law requires coverage for serious mental health conditions to be *on par* with other medical conditions, so that mental health benefits and other benefits are subject to the same copayments, limits, etc.

[41] DMHC and healthcare.gov specify that individual health plans are plans that you buy on your own, for yourself, or for your family and group health plans are obtained through your job, union, or as a retiree for employees/retirees and their families (see https://www.dmhc.ca.gov/HealthCareinCalifornia/TypesofCoverage.aspx and https://www.healthcare.gov/glossary/group-health-plan/). Enrollment of Medi-Cal beneficiaries in DMHC-regulated plans seems to fit neither definition.

APPENDIX B DISCUSSION OF BASIC HEALTH CARE SERVICES[42]

The California Department of Managed Health Care (DMHC) regulates health care service plans, which are subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended, which was codified in the Health and Safety Code.[43] The Knox-Keene Act requires all health care service plans, except specialized health care service plans, to provide coverage for all medically necessary basic health care services.

This requirement is based on several sections of the Knox-Keene Act rather than one straightforward provision, and so is not technically a health insurance benefit mandate as defined by CHBRP's authorizing statute. Specifically, subdivision (b) of Section 1345 defines the term "basic health care services" to mean all of the following: (1) Physician services, including consultation and referral; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage and ambulance transport services provided through the 911 emergency response system; (7) Hospice care pursuant to Section 1368.2. "Basic health care services" are also further defined in Section 1300.67 of Title 28 of the California Code of Regulations.

In addition, subdivision (i) of Section 1367 of the Health and Safety Code provides the following: A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

Although the Act does not explicitly state that "basic health care services" means all "medically necessary" basic health care services, there are numerous provisions within the Knox-Keene Act that reference "medical necessity" and that place requirements on plans in terms of what they must do when denying, delaying, or modifying coverage based on a decision for medical necessity (Section 1367.01). In addition, Section 1300.67 of Title 28 of the California Code of Regulations, which further defines "basic health care services," does further clarify that "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve…"

The entire Knox-Keene Act and the applicable regulations can be accessed online on the DMHC's website at www.dmhc.ca.gov.

[42] The text in this appendix was adapted from a document prepared by the Department of Managed Health Care.
[43] Health and Safety Code Section 1340 et seq.

ABOUT CHBRP

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

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report. Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications are available at http://www.chbrp.org/

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Adara Citron, MPH, Principal Policy Analyst
Sabrina Woll, Policy Associate
Karen Shore, **PhD,** Contractor*
An-Chi Tsou, PhD, Contractor*

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org

* Independent Contractor with whom CHBRP works to support legislative analyses and other special projects on a contractual basis.

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Garen Corbett, MS
Director

Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org

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ISSUE BRIEFS / JANUARY 20, 2022

A Racial Equity Framework for Assessing Health Policy

TOPLINES

Public policy is a powerful determinant of racial inequity in health, but we lack tools for examining how the entire policymaking process impacts racial inequities

The Racial Equity and Policy (REAP) framework provides a conceptually sound, empirically grounded basis for systematically assessing racial equity in health policy

AUTHORS

Jamila Michener

Abstract

- **Issue:** Despite enduring racism and the need for greater racial equity, there is limited consensus among analysts, academics, and public officials on how to assess policy for its impact on racial equity. Without instructive conceptual frameworks, our ability to identify, examine, and eradicate racial inequity through health policy will be limited.

- **Goal:** To establish a conceptually nuanced, empirically informed, and practically useful framework for analyzing the racial equity implications of health policies.

- **Key Findings and Conclusions:** Analysts, academics, and public officials seeking to evaluate policy through a racial equity lens should consider multiple dimensions of the policy process, including design, implementation, evaluation, feedback, and key aspects of the policy environment. We can gain important insights by systematically probing how racism is structurally produced or reproduced through each of these specific dimensions. In doing so, it is especially crucial to examine the ways that policy: 1) creates or reflects disproportionality in the allocation of benefits and burdens to racial groups, 2) operates through forms of institutional decentralization, and 3) includes or neglects the voices of racially marginalized populations. The Racial Equity and Policy (REAP) framework provides a conceptually sound, empirically grounded basis for systematically assessing racial equity in health policy.

Introduction

Racial equity took center stage in 2020, when COVID-19 and extraordinary uprisings against racial violence converged to expose the depth of racial injustice entrenched in American social, economic, and political life. In the face of a pandemic that devastated Black and Latinx communities and a faltering economy that left many of those same communities in a state of material deprivation, antiracism emerged as a renewed clarion call. The conversation around racial justice has aptly stressed the centrality of structural racism — racial inequity that is "produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government."[1]

Public policy is among the most enduring and powerful structures shaping racial inequity in health.[2] Both historically and contemporarily, public policies have been instruments through which government has created, maintained, and exacerbated racial disparities through domains such as housing, healthcare, and welfare.[3] Of course, policy has also been employed to reduce and redress racial disparities.[4] Altogether, the trajectory of U.S. public policy vis-à-vis racism has not been uniform, progressive, or linear.

This issue brief presents a framework for systematically assessing health policy through the lens of racial equity.

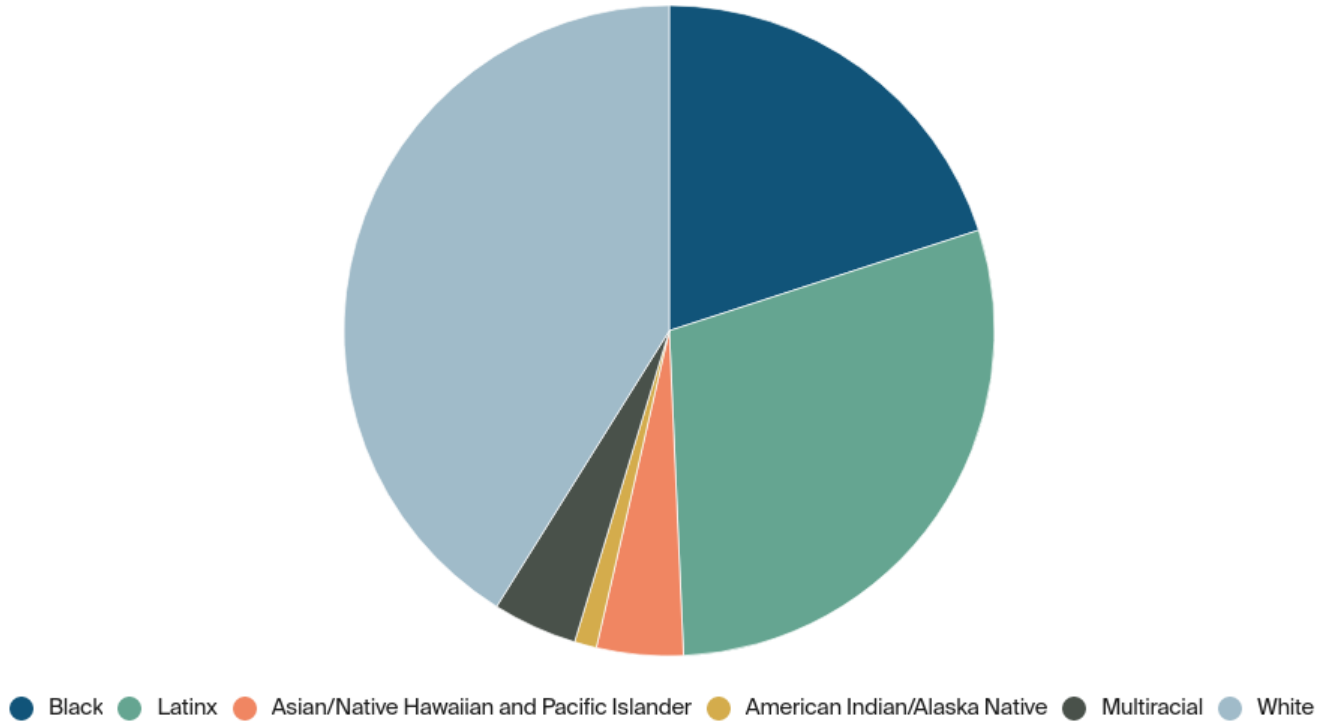
Medicaid's Centrality in Assessing Equity

Given its immense footprint across the U.S. health care system, Medicaid is an obvious choice for applying a framework intended to have broad applicability to public policy. With over 80 million enrollees, Medicaid is the largest public health insurance provider in the United States. It accounts for over 28 percent of all spending by states and more than 9 percent of federal outlays.[5] The racial composition of people covered by Medicaid further underscores the program's importance in efforts to address racial equity concerns in health care: nationwide, 30 percent of nonelderly Medicaid beneficiaries are Latinx, 20 percent are Black, and nearly 10 percent comprise additional minoritized racial or ethnic groups, including Asian/Native Hawaiian, American Indian/Alaska Native, and people who identify as multiracial (Exhibit 1).[6]

On a state level, Black, Latinx, Asian, Native, and multiracial Americans compose a majority of Medicaid beneficiaries in 25 states. In many states, people of color account for large majorities, including in Hawaii (87%), California (79%), Texas (79%), Georgia (68%) Florida (65%), and New York (64%).[7]

EXHIBIT 1

Distribution of Nonelderly Medicaid Beneficiaries by Race/Ethnicity



Source: Jamila Michener, *A Racial Equity Framework for Assessing Health Policy* (Commonwealth Fund, Jan. 2022). https://doi.org/10.26099/ej0b-6g71

People of color rely heavily on Medicaid because of existing social and economic inequality. For example, Black and Latinx Americans are more likely to be living in poverty, to work in occupations where employers do not offer health care, and to face a variety of health problems. Medicaid acts a safety net, catching those who would otherwise experience these compounding disadvantages without health insurance and be made even more economically precarious as a result.

Because Medicaid is highly fragmented and decentralized — with the federal government, states, and even localities making ever-evolving decisions about how to fund, design, and administer it —there are numerous touchpoints where inequities rooted in policy can materialize.[8] For example, state programs vary in terms of:

- Which optional benefits they offer, such as dental, vision, podiatry, or physical therapy.

- The kinds of waivers they pursue for things like work-reporting requirements or home- and community-based services.
- The terms of provider payment as set through contracts and fee schedules.
- How much they invest in outreach to ensure eligible people receive benefits.
- How they oversee program administration.

Each of these Medicaid policy decisions has implications for how benefits (and sometimes burdens) are distributed across racial groups and for how policies interact with the preexisting social and economic disadvantages that are unequally borne across racial groups. Yet policymakers approach many of these decisions without clear consideration of the repercussions their choices have for racial inequity. The framework presented here provides guidance on such matters.

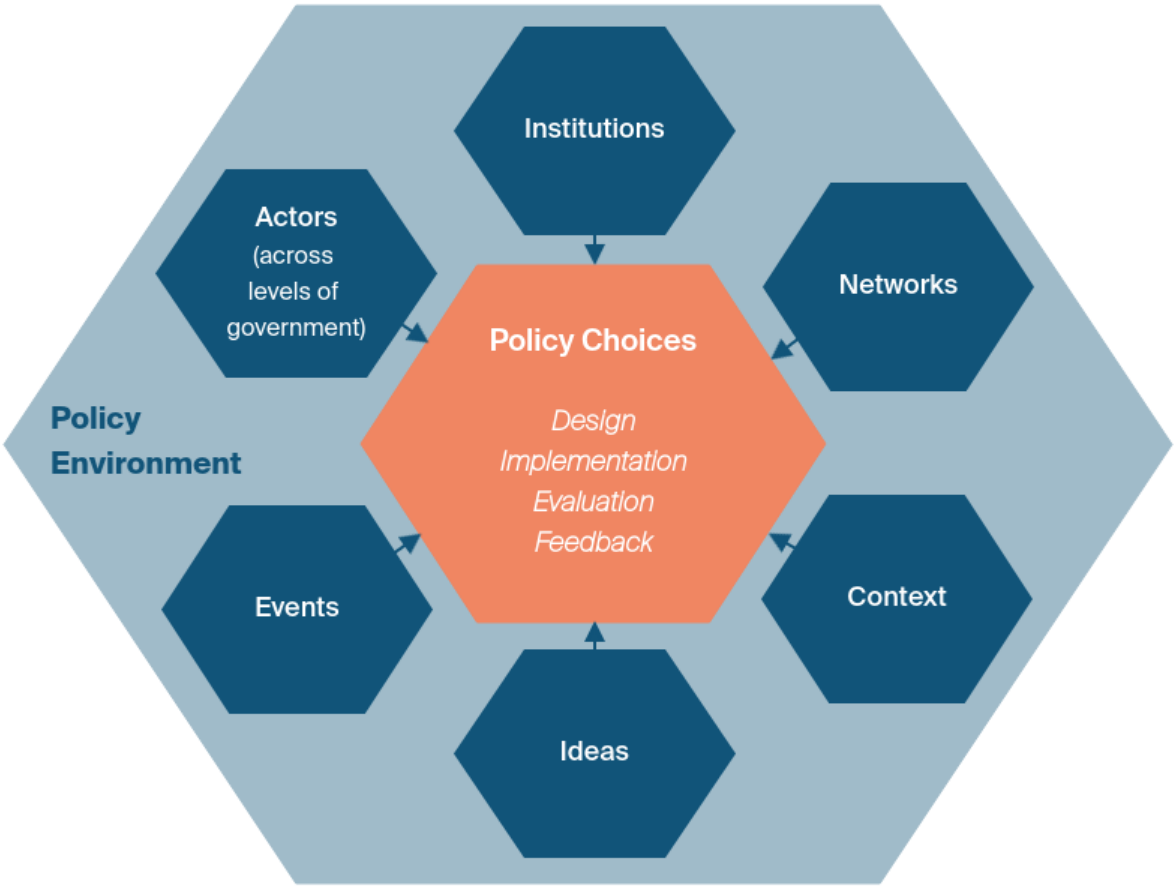
A Policy Process Perspective

Comprehensively evaluating health policy in terms of racial equity necessitates examining policy as a process, not only an output. Just as a focus on structural racism usefully draws attention to systems of laws, rules, and practices that go far beyond individualized instances of discrimination, concentrating on policy processes directs attention away from discrete policies and toward the broader systems that produce them.

As a starting point, this framework draws from popular models of policymaking that reflect fundamental elements of the policy process (Exhibit 2).[9] At the core of the process are choices. Choices about the contours and characteristics of policies are made at different stages of the policy process: when policy is being designed, implemented, evaluated, and even as the effects of policy feed back into larger political processes to shape future policy trajectories.[10] At any given stage, those choices are embedded within a larger policy environment. Features of that environment — like **institutions, actors, networks, contexts, events,** and **ideas** — operate simultaneously to produce and structure policy choices. To identify, assess, and eliminate racial inequity in health policy, it is necessary to understand how it emerges within and through the various dimensions of the policy process specified here.

EXHIBIT 2

Policy Process and the Policy Environment



Source: Jamila Michener, *A Racial Equity Framework for Assessing Health Policy* (Commonwealth Fund, Jan. 2022). https://doi.org/10.26099/ej0b-6g71

For example, **institutions** create the rules and constraints that structure the behavior of policy actors. In the case of Medicaid, although Congress passed the Affordable Care Act (ACA) with the intention that every state would be required to expand eligibility, legal institutions — specifically, the U.S. Supreme Court — prevented the federal government from mandating the expansion.[11] The Court's decision shaped the options available to a variety of **actors:** state lawmakers can support (or oppose) Medicaid expansion; state and national interest groups can lobby for or against it; state and local grassroots organizations can pressure lawmakers to expand (or not); individual constituents can vote based on their preferences for expansion; and so on.

Corollary institutional processes on the state level have made legal institutions particularly critical for the trajectory of Medicaid expansion. For example, when elected officials in Missouri refused to implement a state ballot initiative that required Medicaid

expansion, state courts intervened, ultimately deciding that lawmakers must carry out the will of the state's voters.

A range of institutions and actors play potentially pivotal roles in the policy process. Exemplifying this are the varied policy solutions proposed for closing the Medicaid coverage gap. Some, like the Medicaid Saves Lives Act,[12] would rely on federal agencies like the Centers for Medicare and Medicaid Services to administer a new program providing Medicaid benefits for uninsured people in nonexpansion states. Other proposals, such as the COVER Now Act,[13] focus on empowering individual counties and municipalities to expand Medicaid in their jurisdictions. Still other proposals involve amending the ACA to remove the minimum income cutoff for participation in the law's private health insurance marketplaces, so that Medicaid beneficiaries can get coverage through marketplace plans.[14]

Notwithstanding their specifics, each policy reflects the operation of a distinct set of actors and institutions at varying levels of government, taking different pathways in response to the policy environment. Institutions form the boundaries these actors work within (and sometimes against) to determine which policy choices to oppose or support.

Just as policy choices are structured by institutions and actors, they are also simultaneously shaped by other key aspects of the policy environment, including:

- **Ideas:** Framing the discourse, logic, and justification for policy, ideas are an ever-present part of the policy environment that can sometimes channel racism.[15] For example, ideas about how "deserving" certain populations are, along with racial stereotypes and racial resentment, are correlated with lower levels of public support for programs that are perceived as mainly benefitting people of color (such as Medicaid).[16]

- **Events:** Critical events that bring policy issues into sharp relief also often accentuate existing racial inequities. For instance, the COVID-19 pandemic was a focusing event, bringing racial disparities in infection and mortality to the forefront of health policy agendas.[17]

- **Networks:** Policy actors are not discrete agents of change. Patterns of relationships between policymakers, local residents, interest groups, and other actors are crucial aspects of a given policy environment, with implications for outcomes that matter for racial equity. Medicaid expansion is illustrative of the role of networks: research shows that Republican-leaning states have been most likely to embrace Medicaid expansion when the power of organized business associations outweighs the influence of cross-state networks of ideologically conservative organizations.[18]

- **Contexts:** Policy actors and institutions are embedded within specific economic, social, and political contexts that fundamentally shape efforts to enact, implement, and advance equitable health policy. For example, an approach to achieving health equity taken in Minnesota cannot be applied blithely in Mississippi.[19]

Together, institutions, actors, ideas, events, networks, and contexts create a policy environment that structures policy choices. Policy environments shape choices made not only when a law or regulation is first designed but also when it is being implemented, when it is being measured to assess its effect on outcomes, when it interacts with related policies, and when it feeds back into the political system in ways that constrain or enable future policy choices.

Racial Equity and Policy (REAP) Framework

The Racial Equity and Policy framework (REAP) draws on these core insights about policy process and environment to present a set of questions and considerations that policymakers, analysts, academics, and others should attend to when assessing the racial equity implications of policy (Exhibit 3). These questions are meant as starting points, sensitizing us to the kinds of inquiries that are important for analyzing policy through the lens of racial equity. It is both appropriate and ideal to think of the REAP framework as a baseline to build upon as the specifics of policy analysis are elaborated.

Three key considerations that emerge from a process-oriented perspective on racial equity and health policy are *disproportionality, decentralization,* and *voice.* These themes pervade the questions embedded within the REAP framework because they are indicative of structural mechanisms through which racial inequities emerge in policy.

- **Disproportionality** refers to the way policies differentially allocate benefits and burdens to racial groups. Disproportionality can involve disparities in the distribution of beneficiaries of a given policy, such as the proportion of Medicaid beneficiaries who are Black; incongruity in the proportion of a racial group affected by a policy, such as the proportion of Black people who are Medicaid beneficiaries; disparities in benefit size and take-up; and differences in the share of benefits that some racial groups receive relative to others.[20]

- **Decentralization** concerns the level of government through which a given policy benefit or burden is designed or implemented. In the U.S. system of federalism, national, state, and local governments have the power to affect a wide variety of policy outcomes — often with striking consequences for racial equity.[21]

- **Voice** relates to the ability of communities of color to shape the policy environment. Equity and voice are intertwined, because policy processes that

incorporate the voices of people of color are better positioned to facilitate racially equitable outcomes.

The REAP framework highlights questions about disproportionality, decentralization, and voice that are crucial to assessing racial equity within a given policy environment (that is, with respect to institutions, actors, networks, events, contexts, and ideas). But to be clear: disproportionality, decentralization, and (lack of) voice are not definitive markers of "racist" policy. We cannot mechanically characterize a policy as racist simply because it has these characteristics. Instead, these factors indicate likely channels through which racism can operate. The REAP framework alerts us to their importance and points us toward key considerations to guide assessments of public policy and racial inequity.

EXHIBIT 3

REAP Framework: Key Questions and Considerations

	Decentralization	Disproportionality	Voice
Institutions	Are key institutions located at the national, state, and/or local level?	How do they affect communities of color?	Do they give meaningful voice to people of color and those most affected by policy?
Actors	Are key actors operating at the national, state, or local level?	Are they from, or do they represent, communities of color?	Do they meaningfully engage and incorporate communities of color and center their interests in the policy process?
Networks	How are key actors connected? Are networks of relationships between the actors structuring policy operating at the state, local, or national level or across all levels?	How are people and communities of color positioned within policy networks?	Whose voices are most powerfully connected across and within networks?
Events	What are the relevant events or policies at the national, state, or local level?	How have these events or policies affected communities of color?	How salient or significant are the effects of events or policies on communities of color?
Contexts	What are the economic and political contexts within which policy is being enacted and implemented?	Are they disproportionately affecting communities of color?	What role do communities of color have in shaping these contexts?
Ideas	What ideas are reflected in policy outputs and discourse, and how do these vary at the national, state, and local levels?	How are communities of color constructed or depicted in policy ideas?	What role do communities of color play in shaping policy discourse and ideas?

Source: Jamila Michener, *A Racial Equity Framework for Assessing Health Policy* (Commonwealth Fund, Jan. 2022). https://doi.org/10.26099/ej0b-6g71

Key Considerations: Ideas

Drawing on Medicaid, let us consider one dimension of the policy environment as an instructive example: *ideas.* Asking detailed questions about how ideas factor into the policy process sensitizes us to the multifaceted ways that racial inequity can manifest in health care legislation and regulatory action.

Ideas about Medicaid beneficiaries vary from state to state (decentralization).[22] Those ideas shape the policy environments in which choices like Medicaid expansion are made. And they can reflect racial meanings and stereotypes about communities of color (disproportionality).

For example, perceptions of Medicaid may be less positive in states with high levels of racial resentment. This larger reality, in combination with other aspects of the policy environment — like the number of legislators opposing Medicaid in response to perceived public sentiment — can make Medicaid expansion less possible or make Medicaid work requirements linked to expansion more popular.[23]

Unfavorable racialized ideas about Medicaid can also have repercussions for policy implementation, such as by creating a context where street-level bureaucrats treat Medicaid beneficiaries less respectfully. Furthermore, ideas about Medicaid beneficiaries may inform the ways state actors evaluate Medicaid policy — what metrics they consider and whether they invite beneficiaries to participate in evaluation processes (voice).

Whether in terms of design, implementation, or evaluation, all these propositions suggest a role for interrogating ideas in terms of decentralization, disproportionality, and voice. For each dimension of the REAP framework, similar patterns of questions can reveal insights and perspectives that underline key concerns for racial equity.

Applying the REAP Framework

The REAP framework can complement growing initiatives to systematically track racial data (for example, Boston University's COVID Racial Data Tracker[24]) or policies related to racial inequity. Even once such efforts identify key patterns via data or catalog policies vis-à-vis racial outcomes, the task of discerning the reasons for observed racial differences — whether and how they are a function of policy design, implementation, and structures — requires nuance and deep knowledge of policy and political processes. The temptation may be toward simplicity, to look at the effects of policy and designate a policy as racist if it disproportionately affects people of color negatively. This is certainly one important metric by which we can evaluate a policy's racial inequity (hence the relevance of disproportionality), but it is not the only standard.

Instead, to understand whether and how policies advance or erode racial equity, a comprehensive view of policy processes and environments is necessary. Such a view should attend not only to direct outcomes but also to the other dimensions of the political process outlined in this brief.

Insights from the REAP Framework: Medicaid Work Requirements and American Indians

For most of the history of Medicaid, the federal government did not allow employment to be a criterion for determining Medicaid eligibility. In January 2018, the Centers for Medicare and Medicaid Services (CMS) dramatically altered course, signaling an open stance toward Section 1115 waivers that include work reporting requirements as a condition for Medicaid enrollment. Among many critiques that emerged over the fairness, efficiency, and effectiveness of work requirements, some of the pushback concerned their racial equity implications.[25] In particular, the applicability of the requirements to American Indian and Native communities was a key concern.

Initially, CMS notified Indian tribal leaders that federal civil rights laws prevented any exemption of American Indian and Alaska Native (AIAN) populations from work requirements.[26] Months later, CMS walked that back, giving states discretion for deciding whether to exempt AIAN communities.

A policymaker, advocate, researcher, or concerned onlooker trying to understand this policy arena could draw on the REAP framework for insight into what kinds of information to gather, what questions to ask, and what factors to consider. These questions would depend on the stage of policy development.

Decentralization. Interested policymakers or advocates could begin by asking which key institutions are involved in deciding whether to exempt AIAN populations at the policy enactment stage and whether those institutions are *decentralized*. CMS was a central entity at the federal level, but the Indian Health Service also had much as stake. Even more, state and local tribes across the country were critical institutions, as were state health agencies. Identifying this institutional decentralization is a first step for charting where and whom to engage to advance equity. If an enactment decision had already been made and implementation was at issue, the suite of institutional actors emphasized could be overlapping, but for different reasons. Would CMS have any oversight processes to ensure that the work requirements were not unduly causing mass disenrollment? Would state agencies track such outcomes?

Disproportionality. Interested policymakers and advocates should also gather detailed information about disproportionalities among the institutions involved. They might emphasize the federal government's reliance on Medicaid as a key policy lever for addressing the health needs of AIAN populations, highlight the significance of Medicaid to the IHS, pinpoint the states with the largest AIAN beneficiary

populations and therefore the most at stake, and center the unequal material circumstances of tribal governments.

Voice. Policymakers and advocates should then consider whose voices ring loudest in decision-making processes. Who is CMS engaging or excluding? Are CMS and IHS communicating? Are state and federal decisionmakers substantively engaging tribal communities? If work requirements were already being implemented, were there processes for gathering feedback from tribal communities on how they were experiencing the policy? Input and influence from those most affected is a critical indicator of equitable policy processes.

Conclusion

REAP is a conceptual tool meant to provide researchers, policymakers, and others with guidance on how to assess the racial equity implications of policy. It can also benefit those who are collecting systematic data on health policies by providing a lens through which to methodically assess what those policies mean for racial equity and why. The REAP framework recognizes that even when researchers and other stakeholders have thorough information about policies, we still need the means to make sense of how those policies affect racial equity.

ACKNOWLEDGMENT

The author thanks Tiffany N. Ford, postdoctoral associate at Cornell University, for editorial assistance.

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PUBLICATION DETAILS

DATE

January 20, 2022

CONTACT

Jamila Michener, Associate Professor, Department of Government; Codirector, Cornell Center for Health Equity, Cornell University

jm2362@cornell.edu

CITATION

Jamila Michener, *A Racial Equity Framework for Assessing Health Policy* (Commonwealth Fund, Jan. 2022).
https://doi.org/10.26099/ej0b-6g71

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Race Based Disparities,
Policy Options,
Medicaid