HARVARD T.H. CHAN | SCHOOL OF PUBLIC HEALTH

Department of Health Policy and Management

Benjamin D. Sommers, M.D., Ph.D.
Huntley Quelch Professor of Health Care Economics

Professor of Medicine
Harvard Medical School

Brigham and Women's Hospital

September 23, 2020

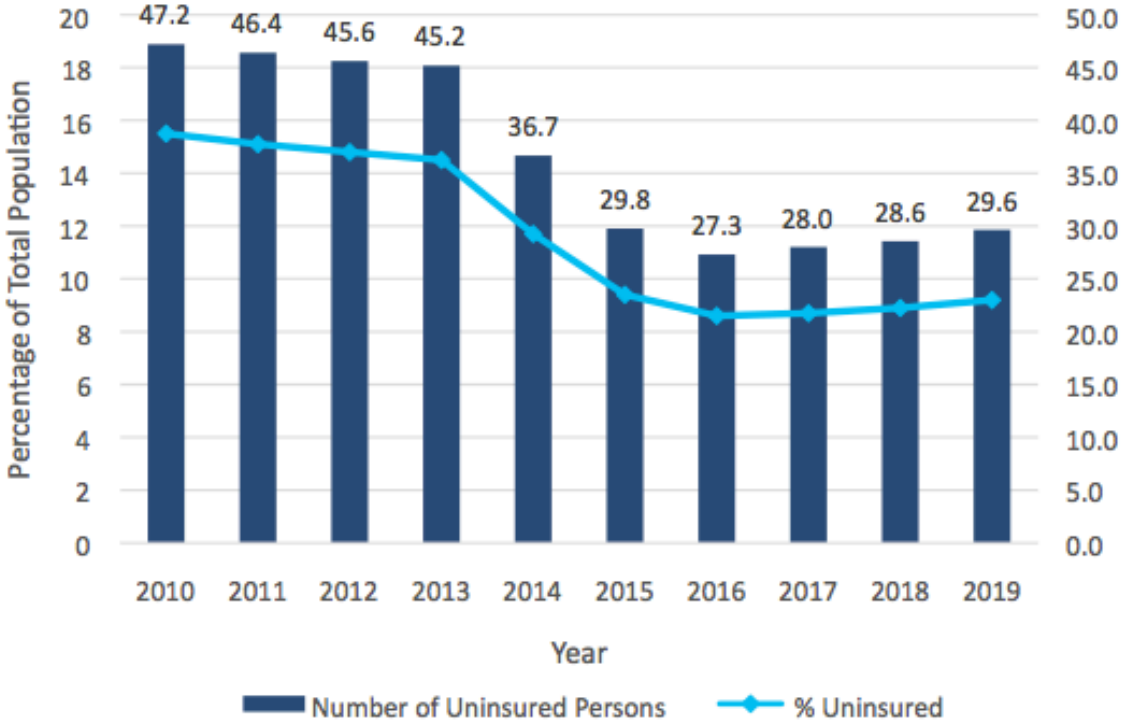
My name is Benjamin Sommers, and I am the Huntley Quelch Professor of Health Care Economics at the Harvard T.H. Chan School of Public Health, and a Professor of Medicine at Harvard Medical School. I am a health economist and primary care physician, and my areas of focus are health insurance, affordability of care, Medicaid, and health care disparities. I would like to thank Chairwoman Eshoo, Ranking Member Burgess, and the distinguished members of the committee for inviting me here today to discuss the role of the Affordable Care Act in responding to the COVID-19 pandemic to protect health insurance coverage in the U.S. My testimony draws largely on a series of academic studies conducted by my colleagues and me since the passage of the Affordable Care Act in 2010.

In order to examine the challenges currently facing the nation in terms of health insurance, it is important to understand the composition of the uninsured population in the U.S. prior to this year's public health and economic crisis; the changes in coverage brought about by the Affordable Care Act over the past decade; and what we know so far about how health insurance coverage has been affected since the pandemic hit the U.S. in March 2020.

The Uninsured Population in the U.S.

Last week, the Census Bureau released its estimates on the uninsured population in the U.S. from 2019, prior to the pandemic. Based on data from the American Community Survey, the number of U.S. residents without health insurance was 29.6 million, representing 9.2% of the population.[1] These numbers were fairly similar to the prior year (Figure 1), though they indicate a modest increase in the uninsured rate since 2016, when it was 8.6% (27.3 million people), which was the lowest level in U.S. history. Nonetheless, current rates reflect a dramatic reduction in the uninsured population since 2010, before the implementation of the Affordable Care Act, when there were nearly 50 million people without health insurance in the country.

Figure 1: Percentage and Number of Uninsured People in the U.S., 2010-2019



Notes: Statistics are from the American Community Survey, 2010-2019, for the full U.S. population (all ages). Figure created by Peggah Khorrami and Aditi Bhanja.

The risk of being without health insurance varies widely across groups. The highest risk age group for lacking coverage is non-elderly adults (19-64), with roughly 11% lacking insurance in 2019. In contrast, due to more generous Medicaid eligibility and the Children's Health Insurance Program, only 5% of children are uninsured, and only 1% of adults over age 65 are uninsured given near-universal coverage from Medicare. Other than age, one of the strongest predictors of lacking coverage is income, with 16% of those with incomes below the federal poverty level uninsured, 11% uninsured among those between 100% and 400% of poverty, and just 3% uninsured among those above 400% of poverty. The U.S. also has large disparities in coverage by race and ethnicity, with significantly higher uninsured rates among Blacks (9.6%), Latinos (16.7%), and Native Americans (19.6%)[2] than whites (5.2%) or Asian Americans (6.2%).[1]

One important feature of the uninsured population is that it is not a static group of people who are all uninsured for long periods of time. Research over the past three decades has shown that people frequently move in and out of different types of coverage, and many experience multiple episodes over time without insurance.[3,4] In addition, programs with income-based eligibility

rules like Medicaid and the ACA's Marketplace subsidies require re-verification of eligibility at least once annually, which produces frequent disruptions in coverage – often called "churning."[5,6] In addition, many pregnant women lose eligibility 3 months after delivery, since the income criteria for parental coverage are more restrictive than during pregnancy.[7] Thus, increases in the uninsured rate can result from several different phenomena – the loss of private coverage due to job losses; decreased new enrollment in subsidized programs; and disenrollment from publicly-subsidized insurance due to eligibility changes, red tape, or lack of affordability.[8]

Role of the Affordable Care Act

The Affordable Care Act (ACA) implemented several large policy changes designed to expand health insurance to the uninsured population. First, in 2010, young adults under age 26 were allowed to remain on their parents' plans, which led to two to three million more young adults gaining insurance.[9] Then, in 2014, private health insurance become available from the new health insurance Marketplaces (either federally-facilitated or state-based), with premium subsidies for those with incomes below 400% of the federal poverty level and major new consumer protections in the non-group insurance market. Also in 2014, Medicaid eligibility in participating states was expanded to non-elderly adults with incomes below 138% of the federal poverty level.

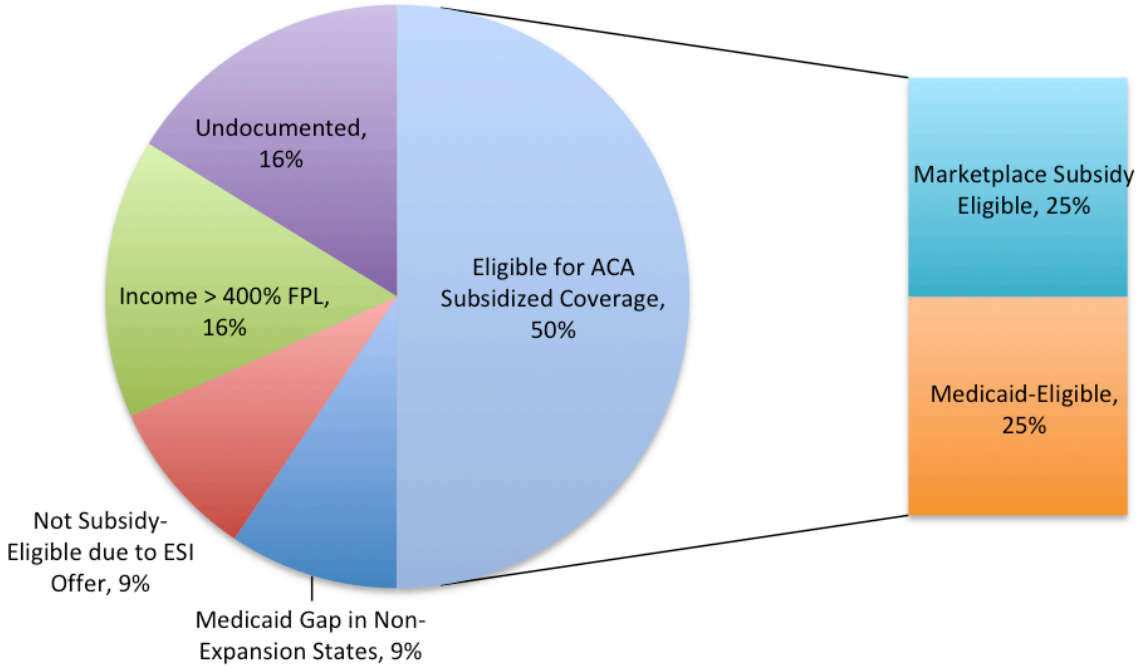
The result was a rapid decrease in the uninsured rate, discussed earlier and depicted in Figure 1. Roughly 20 million U.S. residents gained insurance between 2010 and 2016 from the provisions of the ACA.[10] Research indicates that Medicaid accounted for about 60% of the law's coverage gains after 2014, evenly split between newly-eligible individuals and the "welcome mat" effect, in which previously-eligible but uninsured individuals signed up for Medicaid after the law's implementation. Marketplace subsidies accounted for roughly 40% of the law's coverage gains, and states running their own Marketplaces were nearly twice as effective at expanding coverage as states using the federal Marketplace. Evidence suggests that the individual mandate did not play a major role in boosting overall enrollment under the ACA.[11]

The large gains in coverage under the ACA have been studied in dozens of academic studies over the past decade to understand their downstream effects. The research literature shows that the ACA's coverage expansion led to improved affordability of medical care;[12] narrowed racial and ethnic disparities;[13] better access to preventive care, prescription drugs and chronic disease management;[14] enhanced well-being and self-reported health;[15] and improved health outcomes including surgical conditions,[16] heart disease,[17] cancer,[18] and overall survival.[19,20]

Of the remaining 30 million uninsured individuals prior to the COVID pandemic in 2019, more than half were likely eligible for public or private coverage (Figure 2). An estimated 7.5 million were eligible for Medicaid but not enrolled. This was due to a variety of factors, including

difficulty navigating the application process, not being aware of the eligibility criteria, and difficulty completing the renewal process to maintain coverage. A similar 7.5 million were eligible for subsidized Marketplace coverage but were not enrolled, which surveys indicate was primarily due to affordability issues and lack of awareness.[21] More than 2 million were low-income adults in the so-called Medicaid gap, living in non-expansion states with incomes too high to qualify for Medicaid but too low to receive Marketplace subsidies. The remainder of the pre-COVID uninsured were not eligible for subsidized coverage due to incomes above 400% of the poverty level, immigration status, or having an affordable employer offer of coverage.[22]

Figure 2: The U.S. Uninsured Population By Estimated Program Eligibility, Pre-COVID



Notes: Figure reflects 2018 population estimates, adapted from Sommers 2020[22] and Blumberg 2018.[23] ESI = Employer Sponsored Insurance.

Put simply, a major driver of the uninsured rate in the U.S. in the post-ACA era is how easy or hard policies make it for eligible people to sign up and keep their coverage. The rise of the uninsured rate over the past 3 years coincides with policies under the current administration that shortened the open enrollment period, reduced outreach and advertising that informed consumers of their coverage options, created major uncertainty for insurers, and permitted states to enact new restrictions on Medicaid eligibility including work requirements.[24-26]

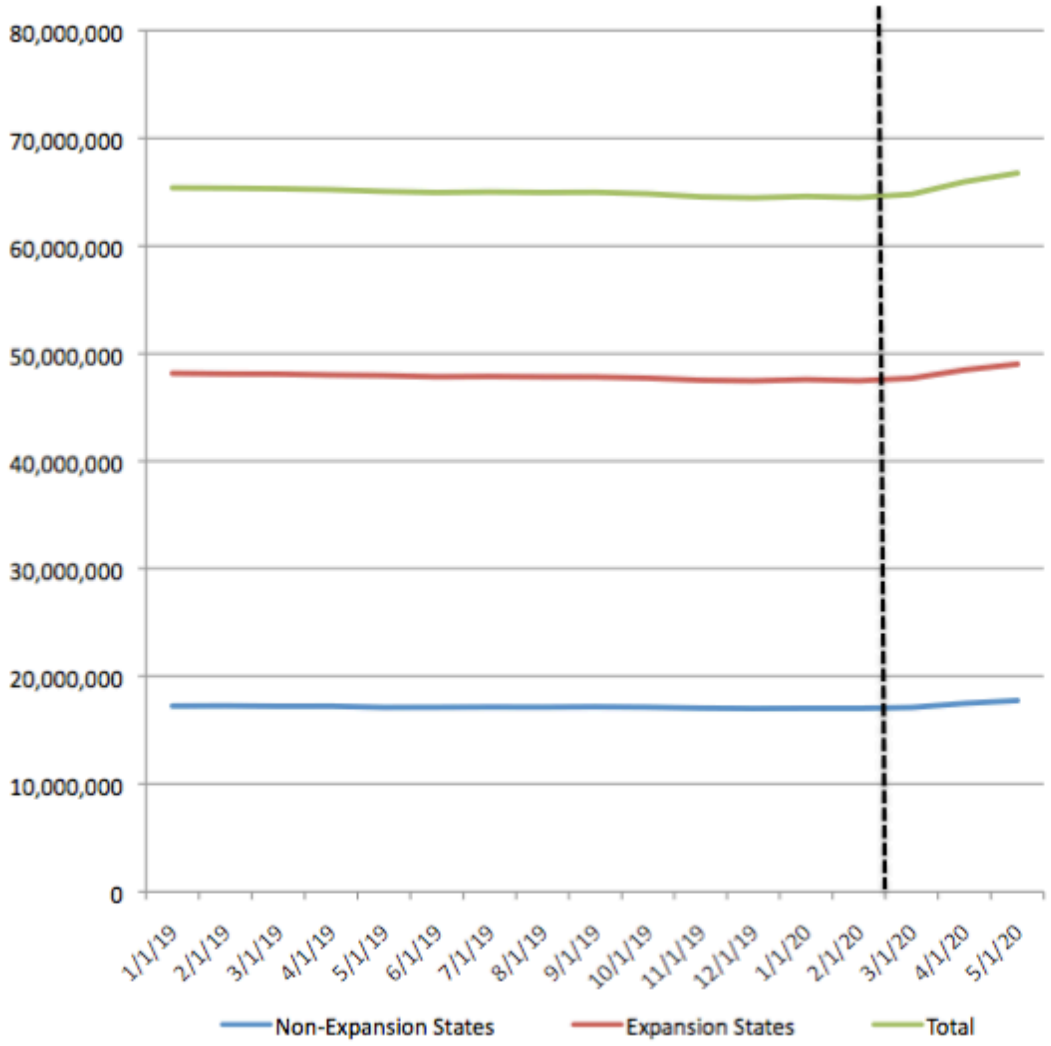
Finally, there are strong linkages between the ACA and health insurance for working families. The ACA plays a critical role in providing coverage options for those who work in industries unlikely to offer employer-sponsored insurance (ESI). Research shows that the ACA boosted coverage rates most dramatically for workers in blue collar fields such as agriculture, construction, and service jobs.[27] Furthermore, the ACA offers important coverage options to workers who have recently lost their jobs, a critical consideration relevant to the COVID pandemic. Prior to the ACA's implementation, when U.S. workers with ESI lost their jobs, roughly 1 in 4 no longer had that type of insurance by the end of the year. While some enrolled in Medicaid or a non-group private plan, the overall risk of becoming uninsured went up by roughly 5 percentage points after job loss (a roughly 14% relative increase). In contrast, in the post-ACA period of 2014-2016, after losing a job, workers did not experience any overall increase in the risk of being uninsured. While rates of ESI fell by a similar margin after job loss as in the pre-ACA years, large increases in Medicaid and Marketplace coverage more than offset that loss.[28] *In other words, the ACA provides a highly effective safety net for workers who lose their jobs.*

Coverage Changes and the COVID Pandemic

The COVID pandemic and associated economic downturn have led to a historically large and rapid rise in the unemployed rate in 2020, which threatens to leave millions of Americans without health insurance. Analysts have predicted that between 20 and 30 million people may lose their ESI during the crisis.[29] While it is too soon to know the long-term impact, preliminary data sources indicate a rise in the uninsured rate and a shift from employer coverage to Marketplace insurance and Medicaid – though smaller than some original estimates. A report analyzing a new survey launched in April 2020 by the Census Bureau found that 3.3 million adults lost their ESI between April and July, and 1.9 million became uninsured.[30] Notably this report was unable to compare these trends to the pre-COVID February baseline.

Enrollment statistics from the states and federal government show that the ACA is playing an important role in covering families who have lost their coverage from work. Data from the Centers for Medicare and Medicaid Services (CMS) collected from all 50 states show a sharp increase in Medicaid enrollment beginning in March of 2020 (Figure 3). Overall, enrollment increased by nearly 2.3 million from February until May, the most recent month with data for all 50 states. When splitting these trends out by state Medicaid expansion status, the totals were a 1.5 million increase in expansion states (from 47.5 million in February to 49.0 million in May, a 3.1% increase) and 700,000 in non-expansion states (from 17.0 million to 17.7 million, a 4.1% increase). It is likely that states that have not expanded Medicaid will see increasing numbers of people in the "Medicaid gap," who are not eligible for any subsidized coverage.[29]

Figure 3: Monthly Medicaid Enrollment Before and After Beginning of the COVID Crisis, By State Expansion Status



Notes: Dashed line indicates beginning of COVID-pandemic in the U.S., in March 2020. Data from Centers for Medicare and Medicaid Services, available at https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme

Meanwhile, private Marketplace coverage has also increased during this time, based on my team's unpublished analysis of federal and state enrollment reports for 2020. While Marketplace coverage is typically only available during designated open enrollment periods, the loss of another form of insurance allows individuals to sign up for a "special enrollment period" (SEP). In addition to these standard SEPs, most state-based marketplaces have enacted broader

enrollment periods to allow for more people to sign up for coverage since the pandemic began. The federal marketplace – *Healthcare.gov* – has not broadened its SEP criteria. Based on publicly-available data through mid-2020, 457,000 individuals have enrolled in fully state-based Marketplaces under Special Enrollment Periods across 12 states plus Washington DC. This represents a 15% increase compared to the 3.1 million people originally enrolled in these states' Marketplace plans in 2020. Meanwhile, the 38 states using *Healthcare.gov* have enrolled 892,000 people via SEPs, up from 704,000 in 2019; even with this increase compared to last year, the federal SEP enrollment reflects only 11% of 8.3 million covered lives in the federal Marketplace, substantially below the state-based Marketplaces' new enrollment.

Conclusion

Nearly a decade of research demonstrates that the Affordable Care Act has expanded insurance to 20 million people in the U.S., improving their financial security, access to care, and health. The COVID pandemic threatens to leave millions of Americans without health insurance due to widespread unemployment and lost income. The ACA can serve as a critical lifeline for those affected by the pandemic, particularly lower-income families, communities of color, and blue collar workers. Policymakers should maximize the law's potential benefits by supporting aggressive outreach and assistance to help eligible people get enrolled and stay enrolled in coverage during this crisis and beyond.

REFERENCES

1. Keisler-Starkey K, Bunch LN. Income, poverty, and health insurance coverage in the United States: 2019. Washington, DC: U.S. Census Bureau; 2020.
2. The Native American uninsured estimate is from the 2018 American Community Survey Public Use Microdata, since the Census Bureau's recently published report (endnote 1) does not include an estimate for this group.
3. Swartz K. Dynamics of people without health insurance. Don't let the numbers fool you. Jama 1994;271:64-6.
4. Short PF, Graefe DR. Battery-powered health insurance? Stability in coverage of the uninsured. Health Aff (Millwood) 2003;22:244-55.
5. Goldman AL, Sommers BD. Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act. Health Aff (Millwood) 2020;39:85-93.
6. Sommers BD, Gourevitch R, Maylone B, Blendon RJ, Epstein AM. Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many. Health Aff (Millwood) 2016;35:1816-24.
7. Daw JR, Hatfield LA, Swartz K, Sommers BD. Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth. Health Aff (Millwood) 2017;36:598-606.
8. Gordon SH, Sommers BD, Wilson IB, Galarraga O, Trivedi AN. Risk Factors for Early Disenrollment From Colorado's Affordable Care Act Marketplace. Med Care 2019;57:49-53.
9. Sommers BD, Schwartz K. 2.5 million young adults gain health insurance due to the Affordable Care Act. Washington, DC: Department of Health and Human Services; 2011.
10. Uberoi N, Finegold K, Gee E. Health Insurance Coverage and the Affordable Care Act, 2010-2016. Washington DC: U.S. Department of Health & Human Services; 2016.
11. Frean M, Gruber J, Sommers BD. Premium subsidies, the mandate, and Medicaid expansion: Coverage effects of the Affordable Care Act. J Health Econ 2017;53:72-86.
12. Collins SR, Rasmussen PW, Doty MM. Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period. New York, NY: The Commonwealth Fund; 2014.
13. Buchmueller TC, Levinson ZM, Levy HG, Wolfe BL. Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage. Am J Public Health 2016:e1-e6.
14. Sommers BD, Maylone B, Blendon RJ, Orav EJ, Epstein AM. Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults. Health Aff (Millwood) 2017;36:1119-28.
15. Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act. Jama 2015;314:366-74.
16. Loehrer A, Chang DC, Scott JW, et al. The Affordable Care Act Medicaid expansion and changes in the care of surgical conditions. JAMA Surgery 2018;153:online e175568.

17. Khatana SAM, Bhatla A, Nathan AS, et al. Association of Medicaid Expansion With Cardiovascular Mortality. JAMA cardiology 2019.
18. Liu Y, Colditz GA, Kozower BD, et al. Association of Medicaid Expansion Under the Patient Protection and Affordable Care Act With Non–Small Cell Lung Cancer Survival. JAMA oncology 2020;6:1289-90.
19. Swaminathan S, Sommers BD, Thorsness R, Mehrotra R, Lee Y, Trivedi AN. Association of Medicaid Expansion With 1-Year Mortality Among Patients With End-Stage Renal Disease. Jama 2018;320:2242-50.
20. Goldin J, Lurie IZ, McCubbin J. Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach. Cambridge, MA: National Bureau of Economics Research; 2019.
21. Collins SR, Gunja MZ, Doty MM, Beutel S. To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not. New York: Commonwealth Fund; 2015.
22. Sommers BD. Health Insurance Coverage: What Comes After The ACA? Health Aff (Millwood) 2020;39:502-8.
23. Blumberg LJ, Holahan J, Karpman M, Elmendorf C. Characteristics of the Remaining Uninsured: An Update. Washington, DC: Urban Institute; 2018.
24. Sommers BD, Clark KL, Epstein AM. Early Changes in Health Insurance Coverage under the Trump Administration. New England Journal of Medicine 2018;378:1061-3.
25. Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements - Results from the First Year in Arkansas. N Engl J Med 2019.
26. Aaron HJ, Fiedler M, Ginsburg PB, Adler L, Rivlin AM. Turmoil in the Individual Insurance Market - Where It Came From and How to Fix It. N Engl J Med 2017;377:314-5.
27. Agarwal S, Goldman AL, Sommers BD. Blue-Collar Workers had Greatest Insurance Gains after ACA Implementation. Health Aff (Millwood) 2019;38:1140-4.
28. Agarwal SD, Sommers BD. Insurance Coverage after Job Loss — The Importance of the ACA during the Covid-Associated Recession. New England Journal of Medicine 2020.
29. Garfield R, Claxton G, Damico A, Levitt L. Eligibility for ACA Health Coverage Following Job Loss. Washington, DC: Kaiser Family Foundation; 2020.
30. Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured. Washington, DC: Urban Institue and the Robert Wood Johnson Foundation; 2020.