Expanded Coverage and Savings:

Effects in Massachusetts of Extending the American Rescue Plan Act's Enhanced Marketplace Subsidies

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INTRODUCTION

Passed in the wake of economic disruption and job losses because of the COVID-19 pandemic, the American Rescue Plan Act (ARPA) aims to offer economic relief by pumping $1.9 trillion into the American economy through funding to individuals, government agencies, community organizations, schools, and other entities. The law includes several provisions to improve access to health insurance coverage, including a provision that temporarily enhances premium tax credits (PTCs).[1]

PTCs were initially introduced by the Affordable Care Act (ACA) to help low- and moderate-income families without affordable employer-sponsored insurance (ESI) purchase health insurance on the marketplace. Under the ACA, an individual qualifies for a premium subsidy if their income is below 400 percent of the federal poverty level (FPL) (or about $106,000 per year for a family of four) and the cost of a "benchmark" insurance plan (see text box to the right for more information on how the benchmark plan is determined) in their area exceeds a certain percentage of their income. The PTC is calculated as the difference between the benchmark premium and the individual's required contribution (as a percentage of their income). For people with incomes up to 300 percent FPL (or just under $80,000 a year for a family of four), Massachusetts adds a supplemental subsidy to the federal subsidy, further reducing the percentage of income someone would be expected to pay for their health coverage premium.

ARPA lowers the percentage of income people are expected to pay for insurance in 2021 and 2022 by increasing subsidies, thus making insurance more affordable. ARPA also caps the percentage of income anyone purchasing through the marketplace in 2021 and 2022 will have to pay, at 8.5 percent of their income for a benchmark plan. This effectively expands eligibility for subsidies to individuals and families who were previously ineligible because their incomes were greater than 400 percent of the FPL and there had been no cap on allowable premium expenses.

Benchmark Plan. The Health Connector offers four levels of plans—bronze, silver, gold, and platinum—which are distinguished by the portion of health care costs (outside of premiums) paid by the individual and the insurance plan, respectively, when services are received. For example, bronze plans cover 60 percent of costs on average, with individuals expected to cover 40 percent; the split is 90/10 for platinum plans. Premiums are lowest for bronze plans, highest for platinum. The calculation of subsidies is based on a particular insurance product—the benchmark plan, which the ACA specifies as the second-lowest cost silver plan (70/30 balance) in a market area.

Early evidence indicates that by improving the affordability of coverage, ARPA is already contributing to increased enrollment in the marketplaces nationally. Following a special enrollment period (SEP) that opened in 2021 in response to the public health emergency, and which included ARPA's enhanced PTCs for the first time,[2] enrollment increased to 12.2 million people in August 2021. This represents an increase of over 1.5 million people relative to enrollment in August 2020.[3]

Because Massachusetts already provided additional state-based financial assistance to many marketplace enrollees prior to ARPA, ARPA's enhanced PTCs have slightly different impacts on health insurance coverage and costs in Massachusetts than they do nationally. With the introduction of the enhanced ARPA PTCs, marketplace enrollees in Massachusetts with incomes greater than 400 percent of the FPL gained access to subsidies for the first time, as they did in other states. Additionally, many marketplace enrollees with incomes below 400 percent of the FPL in Massachusetts gained access to even more financial assistance to help cover the costs of premiums. This is because the ARPA premium subsidies are more generous than the pre-ARPA premium subsidies through ConnectorCare at many income levels. In these instances, the state also saves money it was spending on ConnectorCare premium subsidies, since the ARPA premium subsidies render most of the ConnectorCare premium subsidies unnecessary.[4,5]

At income levels where the ARPA subsidies are less generous than those available through ConnectorCare, enrollees continue to receive the more generous ConnectorCare subsidies. In these instances, the amount the state has to spend on ConnectorCare subsidies is reduced since the federally funded ARPA subsidy covers some of what ConnectorCare subsidized pre-ARPA.

Congress is currently considering extending ARPA's enhanced PTCs. A provision to extend these enhanced PTCs through 2025 was included in President Biden's Build Back Better Act that passed the House of Representatives in November 2021 and is currently stalled in the Senate. In this brief, we investigate how these extended subsidies would affect health insurance coverage and costs in Massachusetts in 2023.

METHODOLOGY

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), the Blue Cross Blue Shield of Massachusetts Foundation simulated health care coverage and costs in Massachusetts in 2023 under two scenarios: (1) current law (in which the enhanced ARPA subsidies will have expired) and (2) if the enhanced ARPA subsidies are extended (as would be the case under the Build Back Better Act.) HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. In a notable example of our early work, we simulated health reform policies that yielded a road map for the landmark 2006 health care reform legislation in Massachusetts that expanded coverage and created a subsidized private insurance market for low-income residents, among other policies.[6]

For the purposes of this analysis, we calibrated HIPSM using detailed enrollment and cost data from MassHealth and the Massachusetts Health Connector Authority. We simulated results for 2023, as this is when ARPA's enhanced premium subsidies will expire if not extended by Congress. Additionally, we assume that by 2023, Medicaid enrollment will be close to returning to pre-pandemic levels, following significant increases due to pandemic-related job loss and the continuous coverage requirement of the Families First Coronavirus Response Act.[7]

RESULTS

We estimate that ARPA's enhanced PTCs would have the following effects on health insurance coverage and costs in Massachusetts in 2023:

- 8,000 additional people would gain coverage.
- The state government would save $133 million for the year.
- Average spending on premiums would fall by $199 for the year among those enrolled in subsidized coverage through the Health Connector.

Following is a closer look at each of these effects.

COVERAGE CHANGES

We estimate that ARPA's enhanced PTCs would reduce the number of people who are uninsured in Massachusetts by 8,000 people relative to pre-ARPA current law (Table 1). Enrollment in private nongroup plans would increase by 10,000, with 2,000 of those switching from ESI. Most people switching from ESI to the nongroup market have incomes above 400 percent of FPL and were paying more than 9.83 percent of their income on their ESI premiums; they are newly eligible for marketplace subsidies, which cap their contribution to the benchmark plan at 8.5 percent of their income and thus make coverage more affordable for these families.[8]

TABLE 1. HEALTH INSURANCE COVERAGE DISTRIBUTION OF THE NONELDERLY IN 2023 (THOUSANDS OF PEOPLE)

	PRE-ARPA	ARPA PTCS	CHANGE	CHANGE (PERCENT)
Employer	3,182	3,180	-2	0.0%
Private nongroup	392	402	10	2.6%
Marketplace with PTC, <300% FPL	228	229	1	0.3%
Marketplace with PTC, 300–400% FPL	18	26	7	40.1%
Marketplace with PTC, >400% FPL	0	23	23	N/A
Unsubsidized nongroup	145	124	-21	-14.4%
Medicaid/CHIP	1,629	1,629	0	0.0%
Other coverage	77	77	0	0.0%
Uninsured	239	231	-8	-3.5%
TOTAL	**5,519**	**5,519**	**0**	**0.0%**

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

Nearly all of the increased enrollment in nongroup plans is among those with incomes above 300 percent of FPL. This is because people with incomes below 300 percent of FPL were already eligible for generous subsidies through ConnectorCare, resulting in high take-up rates in this group. People with incomes between 300 percent and 400 percent of FPL were eligible for the standard ACA premium subsidies prior to ARPA but not additional ConnectorCare subsidies, so the introduction of the enhanced ARPA subsidies leads to substantial enrollment increases among this group. People with incomes above 400 percent of FPL were previously ineligible for any premium subsidies, so the introduction of the enhanced ARPA subsidies leads to a substantial increase in enrollment in this income group.

STATE SAVINGS

We estimate that the state government would save $133 million in 2023 under ARPA's enhanced PTCs relative to pre-ARPA current law (Table 2). More generous federal PTCs mean that the state spending on ConnectorCare subsidies decreases significantly. The cost for enhanced premium subsidies through ConnectorCare is shared between the federal government and Massachusetts under the terms of its 1115 Medicaid Demonstration waiver; while state (and federal) spending on enhanced premium subsidies through ConnectorCare goes down, federal spending on PTCs goes up. The net effect of these changes is that federal government spending would increase by $231 million, while state government spending would fall by $133 million.

TABLE 2. TOTAL SPENDING FOR THE NONELDERLY IN 2023* *(millions of dollars)*

		PRE-ARPA	ARPA PTCS	CHANGE†
HOUSEHOLD	Premiums	$7,317	$7,250	-$67
	Other health care spending	$5,615	$5,617	$1
	Subtotal, household	**$12,932**	**$12,866**	**-$66**
FEDERAL GOVERNMENT	Medicaid	$7,369	$7,369	$-1
	Marketplace PTC	$918	$1,256	$338
	Marketplace CSR	$0	$0	$0
	Federal share of ConnectorCare	$193	$87	-$106
	Subtotal, federal government	**$8,480**	**$8,712**	**$231**
STATE GOVERNMENT	Medicaid	$5,025	$5,025	$0
	Marketplace PTC	$150	$17	-$133
	Marketplace CSR	$91	$91	$0
	Subtotal, state government	**$5,266**	**$5,133**	**-$133**

Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.
*These estimates do not include spending on long -term services and supports.
† Change may not sum from information as presented due to rounding.

Table 3 provides a comparison of the subsidies available in Massachusetts through ConnectorCare prior to ARPA and the newly enhanced subsidies available under ARPA.

The federal government picks up the full cost of subsidies (including costs that used to be paid for by the state) for:

- Enrollees with incomes below 150 percent of FPL.
- Most people with incomes between 150 percent and 300 percent of FPL. For most people in this income range, the subsidies from ARPA are more generous than the pre-ARPA subsidies with ConnectorCare, so the federal government picks up the full cost of the subsidies.

The federal government picks up a bigger portion of the cost of subsidies (including costs that used to be paid for by the state) for the few people with income levels where pre-ARPA subsidies with ConnectorCare are more generous than the ARPA subsidies (mostly between 250 and 300 percent FPL). In these instances, the federal government would pay the subsidy costs up to the level indicated by the ARPA subsidy schedule; then, the state and federal government would share in funding the additional costs to reach the ConnectorCare subsidy levels. Because ConnectorCare eligibility cuts off at 300 percent of FPL, state spending is unaffected by the introduction of more generous subsidies at income levels above 300 percent FPL.

TABLE 3. PREMIUM TAX CREDIT PERCENTAGE OF INCOME LIMITS FOR BENCHMARK COVERAGE

INCOME (PERCENT OF FPL)	MASSACHUSETTS SUBSIDY SCHEDULE (PRE-ARPA)	ARPA SUBSIDY SCHEDULE
Below 138% FPL	0.0	0.0
138%–150% FPL	0.0	0.0
151%–200% FPL	2.16–2.88	0.0–2.0
201%–250% FPL	3.35–4.18	2.0–4.0
251%–300% FPL	4.17–5.00	4.0–6.0
301%–400% FPL	9.83	6.0–8.5
Above 400% FPL	N/A	8.5

Sources: Data on premium tax credit percentage-of-income limits are from Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability, CFR 601.105, (2020); American Rescue Plan Act of 2021, Pub. L. No. 117-2; Improving Health Insurance Affordability Act of 2021, S.499 117th Cong. (2021–22); Massachusetts Health Connector Authority, "Massachusetts Cost Sharing Subsidies in ConnectorCare: Design, Administration, and Impact," August 2021.

Notes: ConnectorCare plans are grouped into different plan types by a range of incomes. Each plan type has a minimum premium contribution amount associated with it. The percentage of income limits for ConnectorCare plans are calculated by dividing the minimum per-person premium contribution amount by the high and low values of the income range associated with that plan type for an individual. ConnectorCare subsidies are not available above 300 percent of FPL, so the pre-ARPA subsidy schedule in Massachusetts reflects the national pre-ARPA schedule above 300 percent of FPL. N/A = not applicable because no subsidies are available at this income level.

HOUSEHOLD PREMIUM SAVINGS

We estimate that average annual spending on premiums would decline by $199 in 2023, among those enrolled in subsidized coverage through the Health Connector under the extended ARPA subsidies scenario (Table 4).[9] This group includes both existing Health Connector enrollees and those who were previously uninsured or had ESI, but now take up coverage in the Health Connector.

For people with incomes below 300 percent of FPL who purchase subsidized coverage through the Health Connector, average annual spending on premiums declines by $114 in 2023. Before ARPA, people in this income group were eligible for subsidies available through ConnectorCare that were more generous than standard ACA subsidies. For example, those with incomes below 150 percent of FPL were already eligible for plans with no premium through ConnectorCare. As a result, spending on premiums is unaffected for many with incomes below 150 percent of FPL. However, the ARPA's enhanced PTCs are more generous than those previously available for many income levels between 150 percent and 300 percent of FPL, so many enrollees in this income range see modest declines in premium spending.

For people with incomes between 300 percent and 400 percent of FPL who purchase subsidized coverage through the Health Connector, average annual spending on premiums declines by $431 in 2023. Because eligibility for ConnectorCare subsidies ends at 300 percent of FPL, the introduction of ARPA's enhanced PTCs provide many in this income group with significantly more generous subsidies than those available prior to ARPA (standard ACA subsidies).

For people with incomes above 400 percent of FPL who purchase subsidized coverage through the Health Connector, average annual spending on premiums declines by $788 in 2023. People in this income group were previously ineligible for any premium subsidies, so ARPA's enhanced PTCs contribute to considerable savings for many people. Some people in this group were previously uninsured (and thus paid $0 in premiums), but now choose to enroll in subsidized marketplace coverage.

TABLE 4. AVERAGE SPENDING ON PREMIUMS UNDER PRE-ARPA CURRENT LAW AND ARPA PTCS IN 2023, BY INCOME GROUP *(dollars per person; average within family.* Limited to people with subsidized nongroup coverage under the reform scenario.)*

INCOME GROUP	PRE-ARPA	ARPA PTCS	CHANGE
Below 300% FPL	$578	$464	-$114
300–400% FPL	$3,013	$2,582	-$431
Above 400% FPL	$4,917	$4,129	-$788
Total, all incomes	$1,162	$963	-$199

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

*For this metric, we look at total premium spending within a family/household and divide it by the number of people within that household, to get average premium spending for all members of that household.

CONCLUSION

ARPA temporarily enhances marketplace premium tax credits for 2021 and 2022. The Build Back Better Act that passed the House of Representatives and is currently stalled in the Senate would extend these subsidies through 2025. Early evidence suggests that ARPA's enhanced PTCs are already contributing to increased marketplace enrollment nationwide. In this brief, we evaluate the coverage and cost effects of extending the enhanced subsidies in Massachusetts in 2023. We estimate that, if extended, the enhanced subsidies would reduce the number of people who are uninsured in Massachusetts by 8,000 people and reduce household spending on premiums. We also find that extending the subsidies would save the state $133 million in spending on ConnectorCare subsidies in 2023. These financial gains for the state create the possibility for even greater coverage gains and household premium reductions for Massachusetts if they are used to reach more individuals who are not insured or to further address health care affordability concerns for Massachusetts families. Forthcoming Blue Cross Blue Shield of Massachusetts Foundation policy and research work will help shine a light on those populations who are most likely to face uninsurance, and identify policy solutions that might aid in the ongoing effort to reach near universal insurance coverage.

ENDNOTES

1 For more information on ARPA, please see: Robert W. Seifert and Maria Schiff, "Impact of the American Rescue Plan Act on the Massachusetts Health Care System," Blue Cross Blue Shield of Massachusetts Foundation, October 2021, https://www.bluecrossmafoundation.org/publication/impact-american-rescue-plan-act-massachusetts-health-care-system.

2 The 2021 SEP ran from February 15 to August 15, 2021, in the 36 states that use the HealthCare.gov platform. SEP dates vary for the 15 states that use state-based marketplaces. The enhanced subsidies from ARPA were implemented by HealthCare.gov on April 1, 2021 (see Department of Health & Human Services, "2021 Final Marketplace Special Enrollment Period Report," September 2021, https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf).

3 Effectuated enrollment was 10.6 million in August 2020 (see Department of Health & Human Services, "Biden-Harris Administration Announces Record-Breaking 12.2 Million People Are Enrolled in Coverage Through the Health Care Marketplaces," September 15, 2021, https://www.hhs.gov/about/news/2021/09/15/biden-harris-administration-announces-2-8-million-people-gained-affordable-health-coverage-during-2021-special-enrollment.html).

4 It is important to note that for marketplace enrollees with incomes below 300 percent of the FPL, the state also subsidizes their cost sharing to reduce the co-pays and deductibles these members would otherwise have to pay when they access care; the enhanced ARPA PTCs affect only the premiums a member pays—not the cost-sharing they are responsible for when they access care—and therefore ARPA did not reduce the state's spending on these cost-sharing reductions (CSRs.)

5 The state still pays for a small share of premium subsidy costs for some of these members, which are not picked up by the enhanced ARPA PTCs. For example, the federal PTCs cover the share of the premium for "essential health benefits" (EHB, the minimum standard of benefits that is required to be covered according to the ACA). State subsidies are still required to cover the cost of any covered benefits beyond the EHB package for members with a $0 enrollee contribution.

6 Linda J. Blumberg, John Holahan, Alan Weil, Lisa Clemans-Cope, Matthew Buettgens, Fredric Blavin, and Stephen Zuckerman. "Building the Roadmap to Coverage: Policy Choices and Cost and Coverage Implications," Blue Cross Blue Shield of Massachusetts Foundation, 2005.

7 The continuous coverage requirement prohibited states from disenrolling beneficiaries during the public health emergency. As a result, Medicaid enrollment has grown each month since March 2020 (see Matthew Buettgens and Andrew Green, "What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?" Urban Institute, 2021, https://www.urban.org/research/publication/what-will-happen-unprecedented-high-medicaid-enrollment-after-public-health-emergency). At the time of writing, the public health emergency is set to expire in April 2022. However, further extensions are possible, and recent CMS guidance allows states up to 14 months to return to typical eligibility processing. As a result, states will likely still be completing redeterminations throughout 2023, though we assume that all redeterminations are already complete by 2023 for the purposes of this analysis.

8 Recently released guidance from the Centers for Medicare & Medicaid Services (CMS) adjusts the threshold that defines unaffordable ESI coverage from 9.83 to 9.7 percent of income. This change does not affect the estimates.

9 We focus specifically on those with nongroup coverage under the ARPA scenario, as this reform is targeted at the nongroup market. Since the reform largely does not affect ESI, which is how most people get health insurance (Table 2), the effects of the reform among the total population are relatively muted.


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