Chapter 4

Expanding and Strengthening U.S. Health Insurance Coverage

Health insurance provides valuable financial protection against costly medical expenses and allows people to access essential healthcare. It can improve quality and length of life, and for some groups like children, the benefits can be particularly long lasting, leading them to grow into healthier and more economically secure adults with healthier children of their own.

This chapter explores the many recent policies undertaken by the U.S. government to help individuals and families access affordable and high-quality health insurance coverage. What is the rationale for many of these interventions and expenditures, and why has the Biden-Harris Administration taken extensive action to ensure more Americans than ever before can access health insurance?

Economists have long understood that private health insurance markets can malfunction on their own and, as a result, leave many people without affordable coverage options (Mankiw 2017). Health insurance works by pooling risk among a group of people and collecting an upfront fee (i.e., premium) to cover the expected costs of their healthcare. For insurance to work properly, not everyone in the pool can become ill and require expensive care at the same time. Because health costs can be predicted to some extent by both the individuals and entities bearing the risk, insurance pools must include people with differing levels of risk (CRS 2023a). For this reason, every high-income country in the world other than the United States either provides or mandates universal health insurance coverage to encourage broad risk pooling (Schneider et al. 2021).

The United States has taken an approach centered around employer-based insurance coverage, with approximately 54 percent of people receiving individual- or family-level coverage through an employer at any point during the year (Keisler-Starkey and Bunch 2024). By providing coverage to employees and their family members, employer-based coverage pools risk (Claxton, Rae, and Winger 2024). For certain people without access to employer-based insurance, such as entrepreneurs and other workers without an offer of coverage, retirees, and those unable to work or with low income, federal programs provide coverage. The United States provides public insurance coverage to retirees, individuals with disabilities, and low-income families through Medicare or Medicaid. Everyone else is able to purchase private health insurance coverage through a marketplace regulated by the government to provide quality insurance options.

Without government intervention, the private market would likely underprovide essential health insurance coverage to many Americans—an outcome the Biden-Harris Administration has worked to avoid. Prior to federal reform under the 2010 Affordable Care Act (ACA), it was difficult for many people without access to employer-based coverage to acquire health insurance (Collins et al. 2017). The ACA addressed the problem by creating a regulated Marketplace for private health insurance coverage, providing government subsidies for Americans to purchase coverage, and expanding Medicaid eligibility to low-income adults in the 40 states and D.C. that have adopted Medicaid expansions (KFF 2024a). As a measure of the ACA's success, the uninsurance rate declined from 14.5 percent in 2013, the year prior to these changes, to 8.6 percent in 2016 (Census 2013; Census 2016). However, the uninsurance rate slowly ticked up over the next four years, and the COVID-19 pandemic made it clear that uninsurance and underinsurance (i.e., when people have gaps in coverage or coverage that does not provide adequate financial protection) remained barriers to people accessing the healthcare they need (Bornstein et al. 2020).

Table 4-1. Notable Biden-Harris Administration Health Insurance Policies

Expanding Access to Marketplace Coverage
• Increased generosity of Premium Tax Credits to help purchase Marketplace coverage
• Created a special open enrollment period in 2021 in response to the pandemic
• Extended the annual open enrollment period to 10 weeks
• Substantially increased funding for advertising and enrollment assistance
• Established a year-round special enrollment period for those with incomes less than 150 percent of the federal poverty level
• Fixed the family glitch to extend financial assistance to eligible family members
•.Protected consumers from junk health plans with short-term duration limits and coverage disclaimers
Protecting and Extending Medicaid Coverage
• Raised federal matching funds to encourage states to adopt ACA Medicaid expansions
• Provided states with the option to extend postpartum Medicaid coverage from 60 days to 12 months
• Required states to provide 12 months of continuous eligibility for children in Medicaid and CHIP
• Minimized declines in coverage following the end of pandemic-era continuous Medicaid coverage
Strengthening Prescription Drug Coverage and Reducing Costs Under Medicare
• Limited out-of-pocket insulin spending under Medicare Parts B and D to $35 per month/prescription
• Expanded the Low-Income Subsidy Program under Medicare Part D
• Capped out-of-pocket prescription drug spending under Part D beginning in 2024
• Gave Medicare the authority to negotiate prices of certain high-price drugs

The Biden-Harris Administration made it a priority to build on and strengthen the success of the ACA to achieve its aim of extending quality health coverage to all Americans. Table 4-1 provides a list of the Administration's notable policies. As a result of the efforts, uninsurance rates reached all-time lows during the last four years. Specifically, the Administration took major steps to build on the three main sources of health insurance for people without access to affordable employer-based coverage: the Marketplace, Medicaid, and Medicare. The Administration expanded access to financial assistance for individuals and families to purchase Marketplace coverage, leading to

unprecedented levels of enrollment. The Administration also put policies in place, including some intended to reduce insurance loss during the end of pandemic-era program expansions, to both expand and protect Medicaid coverage for low-income individuals. Finally, the Administration enhanced the Medicare program by taking steps to improve prescription drug affordability and provide relief to elderly Americans and those with disabilities.

This chapter begins with a brief overview of recent changes in insurance coverage in the United States and evidence on the benefits of health insurance. The remaining sections review the major developments in health insurance policy over the last four years as they relate to the Marketplace, Medicaid, and Medicare programs.

The Role of Health Insurance

The United States reached record high rates of insurance coverage over the last four years. The share of people with insurance coverage increased from 91.4 percent in 2021 to 92.1 percent in 2023, which is the most recent year of data available (see figure 4-1). The growth in coverage under the Biden-Harris Administration reverses a decline observed between 2017 and 2019 and builds onto the coverage increase between 2013 and 2016 associated with the ACA.

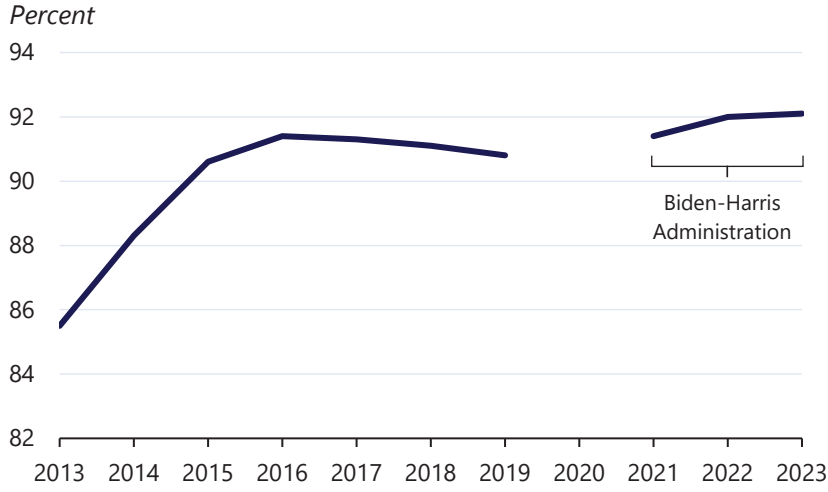
Insurance Coverage and Financial Protection

The primary purpose of health insurance is to protect against unexpected healthcare expenses. Not only is healthcare costly, but there is uncertainty around when an individual might become sick or injured and require care. Health insurance reduces risk exposure by allowing people to pay a premium to cover the healthcare expenses associated with any negative health event.

Health insurance coverage has been shown to reduce out-of-pocket medical expenditures. For example, the introduction of Medicare in 1965 led to a 40 percent decline in out-of-pocket spending for those in the top quartile of healthcare expenditures (Finkelstein and McKnight 2008). In a 2008 randomized lottery for expanded Medicaid coverage in Oregon, low-income adults gaining coverage saw substantial decreases in out-of-pocket spending, including the near elimination of catastrophic expenditures (Baicker et al. 2013).

Protection against medical expenditure risk affects people's overall financial security. An analysis of the Oregon lottery found that Medicaid

Figure 4-1. U.S. Insurance Coverage Rate, 2013–2023



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Source: American Community Survey Tables for Health Insurance Coverage.
Note: Respondents are considered to have insurance coverage if they have a current source of coverage other than the Indian Health Service. The ACS did not release 2020 health insurance coverage estimates due to the pandemic's impact on data collection.
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coverage reduced the likelihood of borrowing money or skipping bills to pay for medical care by 58 percent (Baicker et al. 2013), with a 25 percent reduction in unpaid medical bills being sent to a collection agency (Finkelstein et al. 2012).

Quasi-experimental studies of Medicaid and insurance expansions in other states have similar findings, indicating that expanded coverage reduces medical debt and leads to better financial outcomes, including higher credit scores and better terms of credit, fewer payday loans, and a reduction in personal bankruptcies (e.g., Gross and Notowidigdo 2011; Mazumder and Miller 2016; Allen et al. 2017; Hu et al. 2018; Caswell and Waidmann 2019; Brevoort, Grodzicki, and Hackmann 2020; Miller et al. 2021). Research indicates the transition to Medicare coverage at age 65 leads to similar financial protection (Barcellos and Jacobson 2015; Caswell and Goddeeris 2020; Goldsmith-Pinkham, Pinkovskiy, and Wallace 2023).

Growing evidence suggests that expanded access to health insurance can prevent low-income families from having to go without other necessities to pay for essential medical care. Studies of the ACA Medicaid expansions beginning in 2014, which have been shown to reduce out-of-pocket medical spending among low-income adults (Abramowitz 2020), find lowered rates of food insecurity (Moellman 2020) and housing eviction (Allen et al. 2019), indicating the expansions made households better able to meet their basic

needs. Additionally, families gaining eligibility for financial assistance to purchase Marketplace coverage under the ACA saw a 25 percent decline in their rate of home payment delinquency (Gallagher, Gopalan, and Grinstein-Weiss 2019).

Insurance Coverage and Health

In addition to offering financial protection, health insurance has the potential to improve health if it increases access to effective medical care. The effect is often observed among low-income populations who may be unable to otherwise afford healthcare and who also have worse health outcomes than higher income groups.

Following the ACA Medicaid expansions, low-income adults reported improved ability to access medical care across a range of measures (Guth, Garfield, and Rudowitz 2020). Not only did utilization increase for many types of healthcare (Guth, Garfield, and Rudowitz 2020), but research indicates that the use of services known to be particularly beneficial for health, including screenings and treatment for cancers (Eguia et al. 2018; Sabik et al. 2018) and prescription drugs for chronic conditions like diabetes and heart disease (Ghosh, Simon, and Sommers 2019), also increased. The results are generally consistent with research on the Oregon Medicaid lottery that found the program increased the use of many types of care, including preventive services, in addition to diagnosis of and medication use for diabetes (Finkelstein et al. 2012; Baicker et al. 2013; Finkelstein et al. 2016).

While changes in health can be difficult to measure with available data, evidence indicates that access to health insurance does impact health for certain groups. One of the Oregon lottery analyses found significant improvements in self-reported health measures among those gaining Medicaid coverage (Finkelstein et al. 2012), a similar finding to that of many ACA insurance expansion studies (Soni, Wherry, and Simon 2020). While studies of the Oregon lottery did not detect overall changes in physical health measures (Baicker et al. 2013), a recent re-analysis found that people with little prior healthcare use who gained Medicaid experienced an improvement in blood pressure (Inoue et al. 2024). Studies examining the impact of historic Medicaid expansions have documented large reductions in infant and child mortality (Currie and Gruber 1996a; Currie and Gruber 1996b; Goodman-Bacon 2018), findings echoed in recent research showing substantial declines in adult mortality as a result of the ACA Medicaid expansions or other state insurance expansions (Sommers, Baicker, and Epstein 2012; Sommers, Long, and Baicker 2014; Borgschulte and Vogler 2020; Miller, Johnson, and Wherry 2021; Wyse and Meyer 2023). A novel experimental study of a federal outreach program increasing insurance coverage primarily through the ACA Marketplace found that the intervention

reduced mortality among middle-aged adults (Goldin, Lurie, and McCubbin 2021). Finally, there is evidence that Medicare coverage reduces mortality among elderly patients hospitalized with serious illnesses (Card, Dobkin, and Maestas 2009).

Growing evidence also suggests that, in addition to having short-term effects on health outcomes, access to health insurance has the potential to improve long-term health trajectories. Using quasi-experimental research designs exploiting variation in childhood exposure to Medicaid across cohorts or geographic areas to identify long-term effects, researchers have found evidence of improved self-reported health at later ages (Currie, Decker, and Lin 2008), reduced chronic diseases and related hospitalizations (Boudreaux, Golberstein, and McAlpine 2016; Thompson 2017; Wherry et al. 2018; Miller and Wherry 2019), reductions in disability (Goodman-Bacon 2021), and reduced mortality later in life (Wherry and Meyer 2016; Sohn 2017; Brown, Kowalski, and Lurie 2020; Goodman-Bacon 2021).

Health insurance coverage can also impact the health of future generations of Americans. Evidence indicates that not only do children who gain Medicaid coverage grow into healthier adults, but they also have healthier children of their own (East et al. 2023).

Insurance Coverage, Labor Supply, and Beyond

Despite concerns that expanding subsidized options for non-employer-based health insurance could negatively affect labor supply, evidence of the effect is minimal. One review concludes that ACA insurance expansions did not have major impacts on employment, hours worked, or wages (Gruber and Sommers 2019). The findings are consistent with evidence from the Oregon lottery, where researchers found Medicaid had no effect on employment status or earnings (Baicker et al. 2014). Other evidence indicates that increased access to non-employer-based insurance under the ACA has led to an increase in self-employment among certain groups (Bailey 2017; Bailey and Dave 2018; Blume-Kohout 2023).

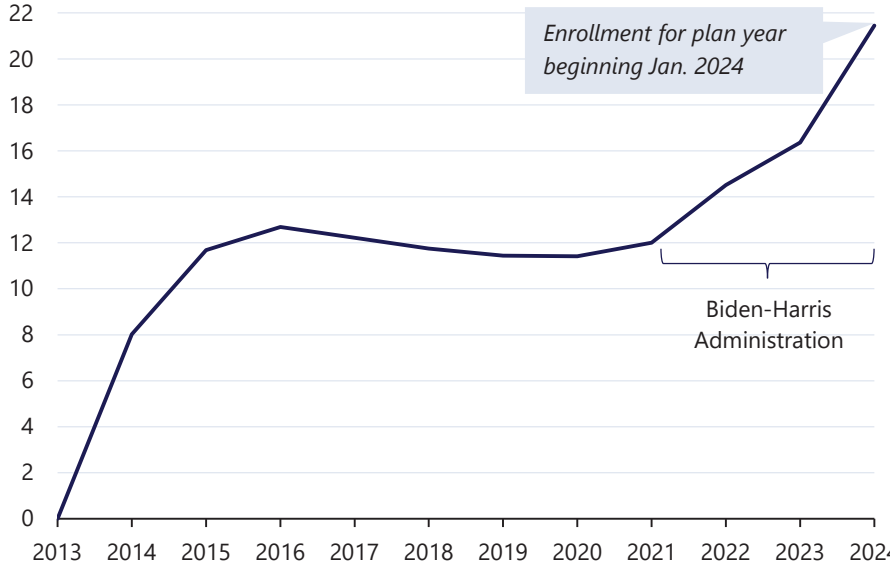
Over the long term, access to health insurance can have significant positive effects on labor market outcomes and economic wellbeing. Specifically, a growing body of evidence shows that childhood exposure to Medicaid can affect individuals' long-term trajectories and increase educational attainment and adult earnings, decrease use of public assistance programs, and reduce the likelihood of incarceration (Cohodes et al. 2016; Miller and Wherry 2019; Brown, Kowalski, and Lurie 2020; Goodman-Bacon 2021; Arenberg, Neller, and Stripling 2024). Further, providing Medicaid to children has been shown to repay its initial cost in the form of additional tax revenue and reduced government transfers once the children become adults (Hendren and Sprung-Keyser 2020; Goodman-Bacon 2021).

Expanding Access to Marketplace Coverage

The ACA Marketplace has seen record-breaking enrollment during the Biden-Harris Administration (CEA 2024). As seen in figure 4-2, 21.4 million people signed up for Marketplace coverage during open enrollment for the 2024 plan year, nearly double the number of enrollments for 2020. Created in 2014, the ACA Marketplace has allowed nearly 50 million people to gain health insurance coverage over the last decade, meaning nearly one out of every seven people living in the United States has benefited from Marketplace coverage (Treasury 2024a). In addition, the Marketplace is a source of coverage for self-employed workers and small business owners; in 2022, these groups represented 28 percent of Marketplace enrollees (Treasury 2024b). The surge in Marketplace enrollment under this Administration reflects policy efforts to increase the affordability of Marketplace coverage and remove barriers to enrollment by intensifying outreach and simplifying ways to sign up for coverage. During the four years prior, enrollment had stagnated.

Figure 4-2. Marketplace Enrollment at the End of Open Enrollment

Number of individuals who selected a marketplace plan (millions)



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Sources: Centers for Medicare & Medicaid Services; Department of Health and Human Services.
Note: Data for each year denote plan selections during the open enrollment period for that plan year.

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The ACA Marketplace has been successful in providing health insurance options for people without access to other affordable coverage. In the program's first year, 8.0 million people enrolled in private coverage through the Marketplace during the annual open enrollment period. The number jumped to 11.7 million in 2015 and grew further to 12.7 million in 2016 (see figure 4-2). The majority of people who enrolled in the Marketplace received financial assistance in these years: In 2016, 83 percent of enrollees qualified for premium tax credits to help with the purchase of Marketplace coverage (ASPE 2016). Research shows that previously uninsured adults who gained access to subsidized Marketplace coverage experienced a decrease in barriers to medical care and increased their use of outpatient services and prescription drugs (Goldman et al. 2018). The premium subsidies, along with additional cost-sharing reductions provided by the ACA, were associated with a 17 percent reduction in out-of-pocket spending and 30 percent reduced likelihood of catastrophic health expenditures for low-income individuals (Liu et al. 2021).

Following the initial Marketplace enrollment growth, fewer people enrolled between 2017 and 2020, possibly related to efforts under the Trump Administration to undermine the ACA. In 2018, one in three non-elderly people who were uninsured were eligible for free or subsidized coverage in the ACA Marketplace (Cox and McDermott 2020), suggesting that many people may be unaware of the option or unable to access it. Enrollment through the ACA Marketplace is typically limited to an annual open enrollment period, with the exception of certain qualifying life events. Designed to prevent people from signing up only when they need expensive healthcare, open enrollment periods can limit coverage opportunities for other individuals, particularly if they are not well advertised or understood. Changes during the Trump Administration to shorten the annual open enrollment period from 12 to 6 weeks and cut funding for marketing and enrollment assistance likely exacerbated barriers (Lueck 2021; Pollitz and Amin 2021). In addition, the individual mandate component of the ACA was removed in 2019, likely having an effect on Marketplace enrollment (Fiedler 2020).

Finally, Marketplace insurance affordability remained an issue for families despite government subsidies to help purchase coverage. Prior to the Biden-Harris Administration, families with incomes below 400 percent of the federal poverty level (FPL) still faced expected premium contributions of between 2 percent and 10 percent of their income on a sliding scale, while families above 400 percent FPL had no cap on the percent of their income they may need to spend on premiums, a significant burden for people in their 50s and 60s (Banthin et al. 2024; Banthin, Skopec, and Simpson 2024).

Expansion in Premium Tax Credits

The Biden-Harris Administration implemented several important policies to expand access to ACA Marketplace coverage and address affordability issues, leading to unprecedented growth in Marketplace enrollment. One major initiative expanded federal financial assistance to purchase Marketplace insurance. Initially, individuals with incomes between 100 percent and 400 percent FPL and no other source of affordable coverage were eligible for premium tax credits toward the purchase of Marketplace coverage. The American Rescue Plan Act of 2021 (ARPA) increased the credit amount for those who already qualified for assistance. It also expanded eligibility to people with incomes above 400 percent FPL for the first time, implementing a cap on expected maximum premium contributions of 8.5 percent of income for these households (Congress 2021). The changes lowered premiums net of the premium tax credit (i.e., net premiums) for most individuals and families, helping more people to enroll in coverage (Ortaliza et al. 2024). While originally slated for two years of availability, the expanded premium tax credits were extended through 2025 under the Inflation Reduction Act of 2022 (IRA) (Congress 2022a).

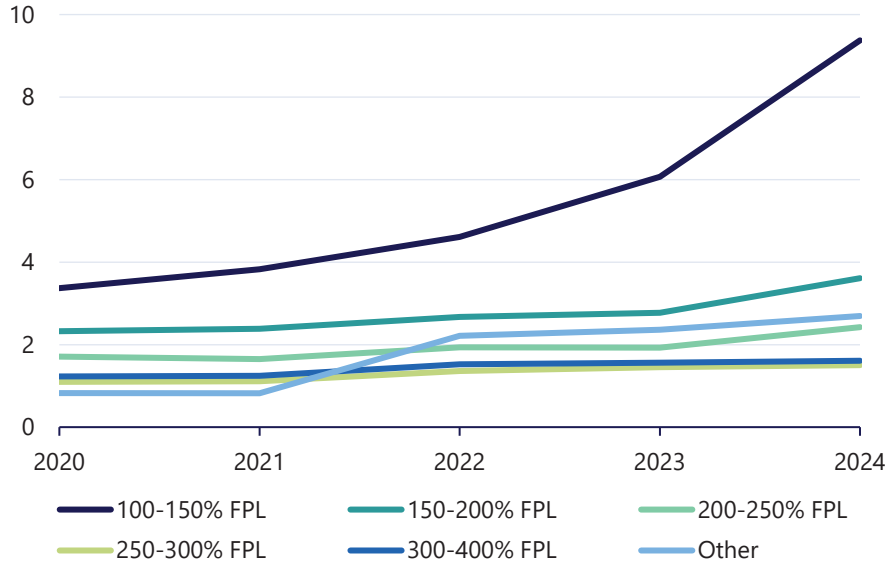
The expanded premium tax credits reduced net premiums for millions of Americans, saving them an average of over $800 annually (CMS 2023a). Individuals and families with incomes just above the Medicaid eligibility threshold (i.e., between 138 percent and 150 percent FPL), or residing in states not implementing the ACA Medicaid expansions and having incomes between 100 percent and 138 percent FPL, saw their maximum required premium contribution decrease to 0 percent of income under the expanded premium tax credits, down from roughly 2 percent to 4 percent of income (Banthin et al. 2024). As shown in figure 4-3, Marketplace enrollment nearly doubled for households with incomes between 100 percent and 150 percent FPL between 2020 and 2023. A noticeable, though less pronounced, increase is evident for the "other" group, which includes enrollees with household incomes above 400 percent FPL.

Figure 4-3 also shows a large bump in enrollment in 2024 for the 100–150 percent FPL group, as well as smaller increases for the 150–200 percent and 200–250 percent FPL groups. The increase likely reflects, in part, the end of pandemic-era Medicaid coverage in 2023 and actions to assist those no longer eligible for Medicaid to transition to Marketplace coverage.

As shown in figure 4-4, expanded access to the Marketplace has particularly benefited people residing in the 10 states that have opted not to implement ACA Medicaid expansions. Marketplace enrollment in non-expansion states increased by 152 percent between 2020 and 2024, reaching a total enrollment of 11.3 million in the 10 states without ACA Medicaid expansions as of 2024. In contrast, Marketplace enrollment grew

Figure 4-3. Marketplace Enrollment by Household Income as a Percent of the Federal Poverty Level (FPL)

Millions of enrollees



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Sources: Centers for Medicare & Medicaid Services; CEA calculations.
Note: Data for each year denote plan selections during the open enrollment period for that year. Idaho, Nevada, and Vermont are excluded due to inconsistent availability of enrollee income information. "Other" category includes enrollees with household income less than 100 percent FPL and greater than 400 percent FPL, and those with no reported income because they did not request financial assistance.
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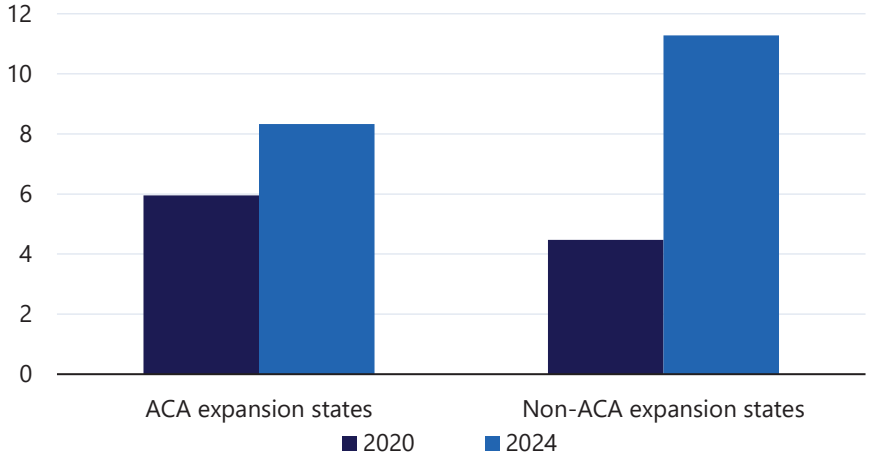
by 40 percent in expansion states over the same period, and total enrollment reached 8.3 million in 2024 across the 35 states, along with D.C., with ACA Medicaid expansions in place during the period.[1] The growth in Marketplace enrollment in non-expansion states likely reflects the relatively few alternative coverage sources available to low-income families in the states and, therefore, heightened need for coverage. However, subsidized Marketplace coverage is unavailable to individuals with incomes less than 100 percent FPL in the non-expansion states, creating a coverage gap.

In addition to increasing Marketplace enrollment, the expanded premium tax credits also made plans with relatively low cost-sharing (i.e., deductibles, copays, and coinsurance) more affordable. The Marketplace offers plans in different categories (Bronze, Silver, Gold, and Platinum)

[1] The five states adopting ACA Medicaid expansions after January 1, 2020 are excluded from this analysis.

Figure 4-4. Marketplace Enrollment by State ACA Medicaid Expansion Status

Millions of enrollees



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Sources: Centers for Medicare & Medicaid Services; CEA calculations.

Note: Data for each year denote plan selections during the open enrollment period for that year. States that adopted ACA Medicaid expansions after January 1, 2020 are excluded (Missouri, Nebraska, North Carolina, Oklahoma, and South Dakota).

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based on the plan versus enrollee share of the costs for covered services. As with most health insurance, Marketplace premiums tend to increase with the level of coverage of the plans (i.e., lower cost-sharing). While premium subsidies are calculated based on the cost of Silver plans, some consumers choose to use the increased subsidies to purchase plans with better levels of coverage. In addition, for people with incomes less than 250 percent FPL qualifying for additional cost-sharing reductions on Silver plans, the expanded premium tax credits decreased the cost of the plans, yielding either zero or low premiums (Congress 2021). Due in part to the change, the number of Marketplace enrollees receiving cost-sharing reductions increased from 5.3 million in early 2020 to 10.4 million by February 2024 (CMS 2020; CMS 2024a).

The Biden-Harris Administration has called on Congress to make the expanded premium tax credits, authorized by current law through 2025, a permanent policy change (White House 2024a). The Congressional Budget Office and Joint Committee on Taxation estimate that, on average each year, 3.4 million additional people will have health insurance from 2025 to 2034 if the premium tax credit expansion is made permanent (CBO 2024).

Beyond Tax Credits: Federal Actions Expanding Marketplace Enrollment

Additional federal actions have contributed to the historic Marketplace enrollment growth in recent years. To address the ongoing COVID-19 pandemic and allow people to access the expanded financial assistance made available in early 2021, a special open enrollment period was created from February 15 to August 15 in 2021, during which more than 2.8 million people signed up for ACA Marketplace coverage (Branham et al. 2022). In addition, the Biden-Harris Administration in 2021 reversed policy changes implemented under the Trump Administration, including extending the annual open enrollment period to 10 weeks and increasing funding for advertising and enrollment assistance (Treasury and HHS 2021; HHS 2022a).

Other changes expanded enrollment opportunities for low-income individuals and simplified the transition to Marketplace coverage during the end of pandemic-related Medicaid coverage. Starting in 2022, the administration created a special enrollment period for people with incomes under 150 percent FPL, allowing them to enroll in Marketplace coverage year round (HHS 2022b).[2] Originally specified to coincide only with the expanded premium tax credits, the special enrollment period was made permanent in 2024, meaning it will remain available even if the expanded subsidies expire in 2025 (Treasury and HHS 2024). To reduce the potential negative effects of the end of Medicaid's pandemic-related continuous coverage provision in 2023, the Biden-Harris Administration created a temporary special enrollment period for individuals and their families who lost Medicaid or Children's Health Insurance Program (CHIP) coverage (CMS 2024b). While the loss of Medicaid or CHIP coverage is a qualifying life event already allowing for Marketplace enrollment, the standard rules require that enrollment occur within 60 days of the loss. The special enrollment period relaxes the time constraint. The Administration also engaged in outreach efforts to help people make transitions from Medicaid to ACA Marketplace coverage (CMS 2023b).

Further, the Biden-Harris Administration revised a prior interpretation of family eligibility rules for premium tax credits, which often prevented the families of low-wage employees from receiving assistance. Previously, the so-called family glitch did not allow families to qualify for premium tax credits if the employed members had access to affordable individual coverage through their employer, even if the available family coverage option was unaffordable (Keith 2022). Beginning in 2023, the Administration revised the eligibility rules to fix the glitch (HHS 2022c).

[2] The change went into effect in 2022 for low-income individuals in states with Marketplaces on HealthCare.gov and was made optional for states operating Marketplaces on their own platforms.

Effective in November 2024, the Biden-Harris Administration extended eligibility for Marketplace plans to Deferred Action for Childhood Arrival (DACA) recipients, as well as eligibility for financial assistance if they meet the other qualifying criteria. The Centers for Medicare & Medicaid Services (CMS) estimate that this change could lead to 100,000 previously uninsured DACA recipients newly enrolling in health coverage (CMS 2024c).[3]

Finally, the Biden-Harris Administration took deliberate steps to further strengthen the Marketplace by protecting consumers from so-called junk health plans, which emerged following a rollback of federal regulations under the Trump Administration. Short-term, limited-duration insurance plans (STLDI), commonly known as junk plans, were designed to fill temporary gaps in coverage, but a 2018 regulation extended their duration from 90 days to almost a year, renewable for up to three years. Junk plans could use consumers' medical histories to raise their premiums or deny them coverage (Pollitz et al. 2018). The plans did not need to adhere to ACA plans' minimum coverage requirements and threatened to attract individuals with low health risks away from the Marketplace, thereby potentially impacting the Marketplace risk pool and leading to elevated premiums (Young 2020). In addition, a number of high-profile instances highlighted how consumers were misled into thinking they were purchasing comprehensive coverage, then were surprised by thousands of dollars in medical bills (Gantz 2019; Levey 2019; Avila 2019). In response, the Biden-Harris Administration limited STLDI plans to four months, capping the length of plans advertised as "short-term," and required plans to disclose their coverage limitations (White House 2024b). These changes went into effect for plans sold on or after September 1, 2024.

The changes during the Biden-Harris Administration have both expanded and strengthened the ACA Marketplace. The Administration's policies have not only increased enrollment, but they have also likely improved the risk pool by attracting young people, who tend to have lower health risks, on average, than older adults, to enroll in Marketplace coverage.[4] In addition, the growth in Marketplace enrollment is expected to bring stability to the private insurance market for individuals and families and encourage competition among insurers (Banthin et al. 2024). If made permanent, the changes could help keep premiums low, attract increasing numbers of enrollees, and contribute to the long-term success of the Marketplace.

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[3] This estimate includes new enrollment in a Basic Health Program, which DACA recipients were also allowed to enroll in starting in November 2024. Two states currently operate Basic Health Programs, which cover individuals with incomes between 133–200 percent FPL (CMS 2024d).

[4] The share of people under age 45 signing up for coverage under Marketplace open enrollment increased from 50.6 percent to 55.3 percent from 2020 to 2024, according to CEA calculations based on CMS Marketplace Open Enrollment Period public use files.

Protecting and Extending Medicaid Coverage

Despite the ACA's aim of improving access to affordable health insurance, coverage gaps still exist in states that did not expand Medicaid as intended under the law. While Medicaid is the nation's public health insurance program for low-income individuals, eligibility rules prior to the ACA were restrictive and generally excluded childless adults and many low-income parents (MACPAC 2021a). Since 2010, 40 states and D.C. expanded Medicaid to non-elderly adults with incomes up to 138 percent FPL; four states have expanded Medicaid since President Biden took office (KFF 2024a). In non-expansion states, most childless adults and low-income parents with incomes below 138 percent FPL remain ineligible for Medicaid.[5] Because of the way ACA changes were implemented, individuals in non-expansion states with incomes below 100 percent FPL do not qualify for subsidized Marketplace coverage (CRS 2021). This creates a gap in affordable coverage options. People in this coverage gap are primarily located in southern states and disproportionately Black and Hispanic (Drake et al. 2024).

Even for eligible individuals, Medicaid enrollment can be unstable. Research indicates that approximately 20 percent of people with Medicaid or Marketplace coverage are at risk of losing insurance coverage at some point over a two-year period, as compared to just 8.5 percent of those with employer-based coverage (Einav and Finkelstein 2023). In addition, about 8 percent of Medicaid and CHIP beneficiaries disenroll and re-enroll in the program within a year (MACPAC 2021b). While some of this churn results from changes in eligibility (e.g., short-term income fluctuations), it also likely reflects administrative or informational barriers related to state eligibility redeterminations. Not only does churn create administrative costs (Sugar et al. 2021), but disruptions in coverage may prevent people from receiving necessary healthcare and lead to prolonged uninsurance (Einav and Finkelstein 2023). While states were barred from disenrolling most people from Medicaid in exchange for enhanced federal funding during the COVID-19 public health emergency (PHE), the provision expired in March 2023, requiring states to redetermine eligibility for Medicaid recipients (CMS 2023c).

The Biden-Harris Administration therefore implemented a number of policies to strengthen Medicaid by facilitating expansions in eligibility, promoting continuity of coverage at the end of the COVID-19 PHE, offering 12-month continuous eligibility to certain vulnerable population groups like children and postpartum individuals, and reducing administrative barriers to enrollment.

[5] The median Medicaid income eligibility threshold for non-disabled parents in the non-expansion states for a family of three is 34 percent FPL (or $8,779) as of May 2024, while non-disabled adults without children only qualify for Medicaid in one of 10 states (KFF 2024b; Wisconsin DHS 2024).

Expanding Medicaid Coverage

To close the Medicaid coverage gap, the ARPA offered additional federal matching funds to states that had yet to expand Medicaid eligibility. Specifically, it provided a two-year, 5 percentage point increase in federal contribution to non-expansion Medicaid costs for any states newly expanding their Medicaid program (CRS 2021). Missouri, North Carolina, Oklahoma, and South Dakota received the ARPA increase for Medicaid expansion. As a result, an estimated 1.1 million adults became newly eligible for Medicaid coverage.[6] Numerous studies show that previous ACA Medicaid expansions were linked to significant coverage gains, narrowed racial gaps in healthcare access, increased use of healthcare among low-income individuals, and improved health outcomes (Guth, Garfield, and Rudowitz 2020).

The ARPA also provided the option for states to extend postpartum Medicaid coverage, an important step toward reducing the United States' high rate of preventable maternal mortality, which disproportionately affects Black, American Indian, and Alaska Native women (Hill et al. 2024). One in three pregnancy-related deaths occurs between one week and one year postpartum (Petersen et al. 2019). Before 2021, most individuals eligible for Medicaid because of pregnancy received only 60 days of postpartum coverage. Eligibility after 60 days often depended on state eligibility rules for parents, which were less generous than eligibility rules for pregnant people, particularly in non-ACA expansion states (Ranji et al. 2022).[7] Prior to the policy change, more than 20 percent of individuals with pregnancy coverage through Medicaid, which covers 41 percent of all births (KFF 2024d), became uninsured between two and six months postpartum (Johnston et al. 2021). Two thirds of the people who lost Medicaid coverage during the early postpartum period remained uninsured nine to 10 months after giving birth (Eliason et al. 2023).

The new Medicaid postpartum extensions aim to promote insurance coverage during the year following childbirth and ensure consistent access to the care needed to improve maternal health. The ARPA temporarily allowed states to extend coverage to 12 months postpartum, and the option was made permanent by the Consolidated Appropriations Act, 2023 (Congress 2022b). To date, 46 states, D.C., and the U.S. Virgin Islands have adopted Medicaid postpartum coverage extensions, with two more states planning to implement extensions (KFF 2024e). It is estimated that, if all states implement the extensions, approximately 720,000 people annually

[6] The number of newly eligible adults was calculated by summing individual estimates for each state (Legal Services of Eastern Missouri 2021; Raphael and Rudowitz 2023; KFF n.d.; Kids Count South Dakota 2024).

[7] The median state eligibility threshold for pregnancy Medicaid coverage is 201 percent FPL. The median state eligibility threshold for parents is 138 percent FPL, while the median for non-expansion states is 34 percent FPL (KFF 2024c).

will gain access to Medicaid for a full year after giving birth (Gordon et al. 2021). The postpartum extensions were especially important for preventing disenrollment of eligible individuals as the COVID-19 continuous coverage provision ended in March 2023.

Evidence from the ACA Medicaid expansions in 2014, which led to increased postpartum insurance coverage in expansion states (Bellerose, Collin, and Daw 2022), indicates that insurance coverage during the postpartum period impacts postpartum healthcare use. Research finds increased use of postpartum outpatient care following state Medicaid expansion (Steenland et al. 2021), as well as increased postpartum use of effective birth control methods (Myerson, Crawford, and Wherry 2020; Eliason, Spishak-Thomas, and Steenland 2022) and fewer hospitalizations during the first 60 days after delivery (Steenland and Wherry 2023). Impacts on maternal health are difficult to measure, perhaps accounting for the literature's mixed findings, with no change observed in maternal morbidity (Chatterji et al. 2023) but evidence of a decline in maternal mortality (Eliason 2020).

An additional Biden-Harris Administration Medicaid policy targeted children. To strengthen Medicaid coverage for young people, the Consolidated Appropriations Act, 2023 mandated that states provide 12 months of continuous eligibility for children under the age of 19 enrolled in Medicaid and CHIP starting on January 1, 2024 (CMS 2024e).[8] States typically renew coverage for children once a year, but the policy prevents states from disenrolling children if they experience an otherwise-disqualifying change in circumstances before the renewal period (e.g., a fluctuation in household income, which is more common among low-income households; see Gennetian et al. 2019). Prior to the policy change, about half of states exercised the available option of providing 12-month continuous eligibility for children (Brooks and Whitener 2023). Rates of disenrollment before annual renewals and churn were lower for children in the states exercising the option than in others (MACPAC 2021b; Williams et al. 2022). While continuous coverage policies are understudied, research indicates they are associated with increased insurance coverage, decreased coverage gaps attributed to application problems, and a lower probability of being in fair or poor health (Brantley and Ku 2021). The Biden-Harris Administration has also approved several state requests to provide continuous eligibility for children in Medicaid and CHIP until age six (Georgetown CCF 2024).

Protecting Medicaid Coverage

The Biden-Harris Administration implemented multiple short-term policies to protect Americans' Medicaid coverage at the end of the COVID-19 PHE.

[8] CHIP provides health coverage through both Medicaid and separate state CHIP programs to children in families with incomes too high to otherwise qualify for Medicaid.

In 2023, enrollment in Medicaid and CHIP hit an all-time high of more than 94 million (KFF 2023), due largely to the continuous coverage Medicaid requirement (Dague and Ukert 2024). To receive an increase in Medicaid funding through the federal pandemic response under the Families First Coronavirus Response Act, states were required to maintain enrollment of nearly all Medicaid enrollees starting in March 2020 until after the end of the PHE (Congress 2020). States typically redetermine eligibility for Medicaid on an annual basis and disenroll anyone who is no longer eligible for coverage or who fails to submit paperwork. The continuous enrollment provision meant that anyone enrolled in Medicaid at the start of or during the COVID-19 PHE would maintain coverage without going through the renewal process or reporting a change in circumstances that would otherwise disqualify them for Medicaid coverage. The continuous coverage requirement was delinked from the PHE and ended on March 31, 2023, under the Consolidated Appropriations Act, 2023, which started the eligibility redetermination process, or so-called unwinding.

Given the tremendous growth in Medicaid enrollment between 2020 and 2023, states faced a complex process of resuming eligibility redeterminations. Not only did states face challenges related to the large volume of redeterminations, but they also encountered issues related to sufficient staffing and the capability of existing eligibility systems (GAO 2024). Further, disenrollment was expected to include people potentially still eligible for Medicaid but losing coverage for procedural reasons, such as if a state was unable to reach the enrollee for the necessary information to determine eligibility or if the individual did not complete the needed paperwork. The occurrences were expected to be more prevalent during the unwinding period, given the time elapsed since the last eligibility renewal for many enrollees.[9] Not only would erroneous disenrollment, which required restoring enrollment for eligible individuals, result in additional administrative costs, but the periods without coverage would likely hinder and delay access to necessary medical care (Sugar et al. 2021).

The Biden-Harris Administration aimed to facilitate the redetermination process for states while preventing coverage loss among eligible beneficiaries. First, states were given 12 to 14 months to restore normal eligibility and enrollment, but were granted flexibility regarding when to begin the process and how to prioritize enrollee population groups (CMS 2023d; CMS 2023e). Second, CMS granted temporary waivers allowing flexibility for how state redeterminations could be processed (CMS 2023f). Some of the most common waiver types allowed states to use prior income or asset information to determine current enrollee eligibility. In addition, common waivers allowed states to use data from other reliable sources, such as the

[9] Some states continued to conduct eligibility redeterminations during the PHE but did not disenroll individuals, while other states discontinued redeterminations (GAO 2024).

U.S. Postal Service and managed care plans, to obtain updated enrollee contact information without requiring verification by the enrollee (GAO 2024). Other waivers allowed states to use financial information from means-tested benefits programs like the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families to renew eligibility, provide for assistance in renewal form completion and submission, or facilitate re-enrollment for eligible individuals disenrolled for procedural reasons (CMS 2023g). Finally, CMS gave states additional time to complete unwinding-related eligibility determinations to ensure that eligible individuals did not lose coverage in states unable to complete the process during the initial timeframe (CMS 2024f).

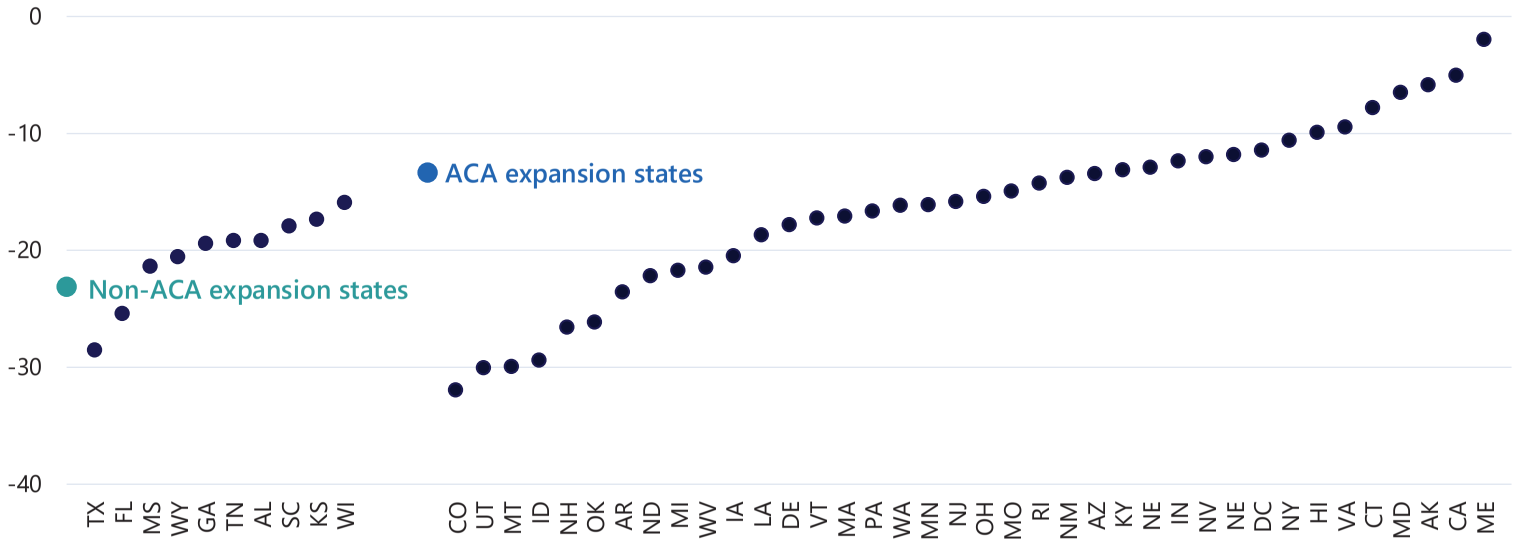
As of June 2024, monthly total Medicaid and CHIP enrollment had declined to 80 million (CMS 2024g), with nearly all states having completed the redetermination process (KFF 2024f). At the conclusion of the Medicaid unwinding, enrollment is expected to surpass pre-pandemic levels due to additional state Medicaid expansions since 2020, as well as enrollment gains during the pandemic among eligible people who signed up for and will retain coverage (Hale et al. 2024).

Nearly all states have experienced a decline in Medicaid enrollment since unwinding began. The only exception is North Carolina, which adopted a permanent Medicaid expansion during the time period (NCDHHS 2024). However, the magnitude of disenrollment shows noticeable variation depending on state policy choices; CMS notes that state uptake of the available flexibilities and adoption of Medicaid expansions had a significant impact on successful eligibility renewals (CMS 2023h). For example, figure 4-5 shows the percent change in Medicaid enrollment from March 2023 (the month prior to the start of unwinding) to June 2024 by state ACA Medicaid expansion status, excluding any states that expanded during this period. States without ACA Medicaid expansions saw the largest average decrease in total enrollment over the period, at 23.1 percent, compared to 13.4 percent in ACA expansion states. The difference is likely explained, at least in part, by variation in state eligibility rules. As described, some individuals who lost Medicaid coverage were able to transition to Marketplace coverage.

The attention to the redetermination process prompted some states to improve their approach to determining eligibility. During the unwinding, CMS and states worked in partnership to identify and resolve areas where states were not meeting federal eligibility redetermination requirements (GAO 2024). Many states took advantage of the temporary flexibilities approved by CMS, and a final rule issued in April 2024 made some of the flexibilities permanent, including allowing states to use available, reliable resources to update enrollee contact information (CMS 2024h). The agency is further reviewing other temporary flexibilities to determine which could be implemented on a long-standing basis (Brooks 2024), part of an ongoing

Figure 4-5. Change in Medicaid and CHIP Enrollment, March 2023 to June 2024

Percent change



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Sources: Center for Medicare & Medicaid Services; CEA calculations.

Note: Enrollment is a count of the number of individuals enrolled in Medicaid/CHIP as of the last day of each month within the selected time frame. States with Medicaid expansions during this period are excluded (North Carolina, Oregon, and South Dakota). Green and light blue dots represent averages in ACA Medicaid expansion and non-Medicaid expansion states.

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effort to simplify eligibility requirements and streamline application processes for Medicaid and CHIP under the Biden-Harris Administration (CMS 2024i).

Strengthening Prescription Drug Coverage and Reducing Costs Under Medicare

Until the introduction of Medicare Part D in 2006, the Medicare program did not provide prescription drug coverage (Oliver, Lee, and Lipton 2004). The original Medicare program is made up of two parts: Part A and Part B, which cover hospital and outpatient care, respectively. Medicare Part C (i.e., Medicare Advantage) was enacted in 1997 as an alternative choice offering both Part A and B types of care through private insurance companies (CMS 2024j). Part D provides prescription drug benefits either through enrollment in a separate plan or as part of Medicare Advantage. Participation in Medicare Part D has grown over time; as of May 2024, more than 80 percent of the 67.5 million program enrollees held Part D coverage (CMS 2024k).

While Part D led to a substantial reduction in out-of-pocket spending for prescription drugs (Engelhardt and Gruber 2011), the benefit's design left many people vulnerable to high expenses. In particular, Medicare Part D had a coverage gap, or "donut hole," where Medicare paid 0 percent of costs for some people with a certain amount of drug expenditures (CMS n.d.). In addition, Part D enrollees had no out-of-pocket spending cap (Cubanski, Neuman, and Freed 2023). The coverage gap and lack of a spending cap are notable given the high price of prescription drugs in the United States compared to other countries; across all drugs, U.S. prices are nearly three times higher than those of other countries, and for brand name drugs, prices are more than four times higher (Mulcahy, Schwam, and Lovejoy 2024). These two features left beneficiaries taking expensive prescription drugs, or with many prescriptions, responsible for high out-of-pocket drug costs. Despite reforms under the ACA and Bipartisan Budget Act of 2018 to phase out the coverage gap, the number of Part D beneficiaries responsible for high out-of-pocket spending would likely grow over time due to rapidly rising drug costs (Trish, Xu, and Joyce 2018). For enrollees whose 2022 prescription drug spending reached the catastrophic coverage phase (the highest spending phase in Part D) and who did not qualify for subsidized coverage, average annual out-of-pocket spending was $3,093, more than 10 percent of the typical income for an enrollee. Average out-of-pocket spending was far higher for some serious health conditions (Sayed et al. 2024).

Increasing Financial Protection Against Prescription Drug Costs

The IRA, passed in August 2022, made several major changes to Medicare to reduce prescription drug expenses for beneficiaries and the Federal Government. First, the IRA limits out-of-pocket spending on insulin under Medicare Part B (effective July 2023) and Part D (effective January 2023) by removing any deductible for covered insulin products and capping co-payments at $35 per month per insulin prescription (Congress 2022a). In 2019, prior to the changes made by the IRA, estimates indicate the average Medicare beneficiary paid $63 per insulin prescription fill, with nearly 40 percent of beneficiaries paying more than $35 and roughly one quarter paying over $70 per fill (Sayed et al. 2023). Estimates suggest that the new insulin cap could, on average, save affected Medicare beneficiaries about $500 per year.

The IRA also expanded eligibility for subsidized prescription drug coverage under Medicare Part D. Prior to 2024, the Low-Income Subsidy (LIS) program provided two tiers of prescription drug coverage to individuals and families with little income and few assets. For individuals with incomes up to 135 percent FPL,[10] the program provided a full subsidy, covering Part D deductibles and premiums for certain plans and requiring minimal co-pays up to an out-of-pocket limit, followed by no cost sharing. For individuals with incomes between 135 percent and 150 percent FPL,[11] the LIS program provided a partial subsidy with less financial assistance than the full subsidy (CRS 2023b). In 2024, the IRA expanded the LIS program's full subsidy coverage of Medicare Part D prescription drugs to all individuals meeting the eligibility criteria for the partial subsidy.

Expanding the LIS program is expected to benefit approximately 460,000 people who now receive the full rather than partial subsidy, and could encourage about 3 million more people who are eligible for Part D to enroll (Feyman et al. 2024). Of note, LIS enrollees are not charged the typical Part D penalty for late program enrollment, a mechanism designed to limit adverse selection, removing any cost-related barriers to new Part D enrollment (CMS 2024l).

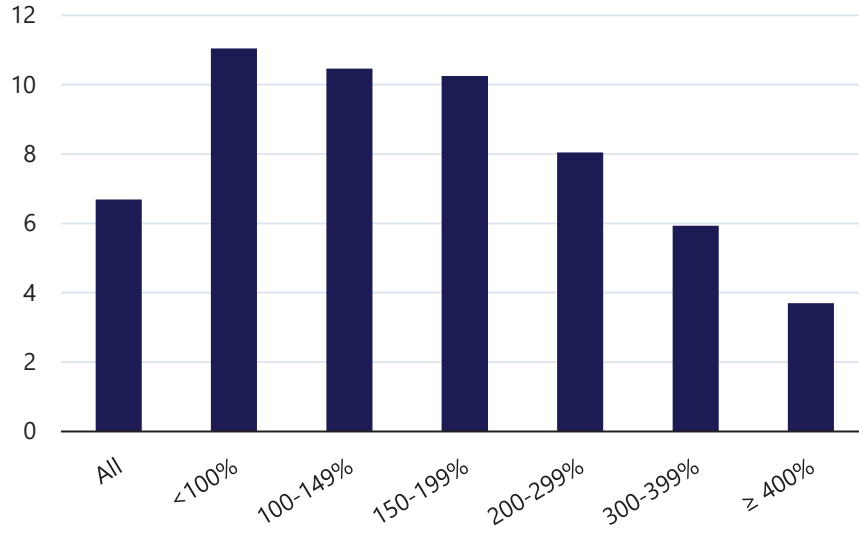
The LIS program expansion could help increase accessibility to drugs that were previously unaffordable for some elderly Americans, as well as remove cost-related barriers to medication adherence. As seen in figure 4-6, elderly people with incomes qualifying for the LIS program have higher rates of skipping medication due to cost than elderly adults with incomes at 200 percent FPL and greater. Research shows that medication adherence is

[10] In 2023, the program was available to individuals with incomes of less than 135 percent FPL and fewer than $9,090 in assets; for married couples, the asset threshold was $16,630. In addition, certain groups of Medicare beneficiaries automatically qualified for full LIS coverage.

[11] In 2023, the group included individuals with incomes between 135 percent and 150 percent FPL and fewer than $15,160 in assets; for married couples, the asset threshold was $30,240.

Figure 4-6. Share of People Age 65 and Older Skipping Medication Due to Cost, by Household Income

Percent



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Sources: Health and Retirement Survey; CEA calculations.
Note: Data include waves 2008 through 2018.
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related to out-of-pocket costs for prescription drugs, and mortality increases when people take fewer drugs as a result (Chandra, Flack, and Obermeyer 2024).

Finally, the IRA took important steps to introduce limits on out-of-pocket prescription drug spending for all Medicare Part D enrollees. Even after reforms to close the coverage gap, the standard benefit design exposed beneficiaries without LIS (approximately 72 percent of Medicare Part D beneficiaries) to unlimited prescription drug expenses (Sayed et al. 2024). The cost-sharing structure made beneficiaries responsible for 5 percent of all drug expenses surpassing a specified catastrophic coverage threshold (Cubanski and Neuman 2023). Nearly 1.5 million beneficiaries without LIS spent above the threshold in 2022 and paid an average of $3,093 in out-of-pocket drug costs (Sayed et al. 2024). According to one analysis, Part D enrollees requiring the most expensive drugs faced annual out-of-pocket spending ranging from about $11,000 to nearly $15,000 per year (Cubanski and Neuman 2023).

Under the IRA, the 5 percent coinsurance requirement for drug expenditures greater than the catastrophic coverage limit was removed in 2024. Starting in 2025, Part D enrollees' out-of-pocket drug costs will be capped at $2,000, with the amount updated each year using the rate of growth in per-capita Part D drug costs (CMS 2024m; CMS 2024n). The IRA also shifts more of the expenses for prescription drugs from Medicare onto drug manufacturers and Part D prescription drug plans. Finally, a premium stabilization mechanism in the IRA, which began in 2024 and continues through 2029, limits average premium increases for individuals enrolled in Part D (CMS 2024o). The Department of Health and Human Services estimates that the 2025 change, along with the other changes discussed, will lead to a roughly $7.4 billion reduction in annual out-of-pocket spending among enrollees with out-of-pocket savings, about 36 percent of Medicare Part D beneficiaries, amounting to almost 19 million individuals. This translates into an expected reduction in annual out-of-pocket spending of about $400 for these individuals (Sayed et al. 2024).

Negotiating Drug Prices to Bring Down Costs

The IRA also allows the Medicare program to negotiate certain pharmaceutical prices. Prior to the Act's passage, Medicare and the Federal Government were forbidden from negotiating directly with drug companies to lower costs (CRS 2022). The Federal Government was, therefore, unable to use its market power to buy and provide drugs at lower prices. According to CMS, Medicare is projected to account for an estimated 35 percent of all prescription drug expenditures in 2024, indicating the program represents a large share of the market (CMS 2024p).

Beginning in 2024, the IRA requires the Department of Health and Human Services to negotiate with drug companies for certain high-cost drugs. Under the IRA, drugs with high Medicare spending shares that meet certain criteria are eligible for price negotiation.[12] Initially, 10 drugs from Medicare Part D were subject to negotiation, but the number will increase each year and begin to include drugs from Medicare Part B, with a total of 60 drugs being price negotiable by 2029 (CBO 2023).

In August 2024, the Biden-Harris Administration announced the first set of prices, which will become effective in 2026, for all 10 drugs selected for the first round of negotiation (CMS 2024q). CMS estimates that if the negotiated prices had been in place in 2023, Medicare net prescription drug spending on the products would have been lowered by 22 percent (CMS 2024r). Moreover, the reduced prices are likely to help Medicare beneficiaries who previously paid cost-sharing on the drugs' list prices; in 2022,

[12] For more information on the criteria for drugs to be eligible for price negotiation, see CMS (2024s).

nearly 15 percent of all Medicare Part D beneficiaries used at least one of the drugs negotiated (ASPE 2023). In total, in 2026, CMS estimates beneficiaries will save $1.5 billion in reduced cost-sharing because of the negotiated prices (CMS 2024r).

The ability of the Federal Government to negotiate Medicare Part D drug prices is expected to improve the federal fiscal outlook. When the negotiated prices go into effect in 2026, it is estimated to save Medicare Part D about $6 billion (CMS 2024r). Between 2022 and 2031, the Congressional Budget Office estimates that the negotiated drug price provisions of the IRA will reduce the federal deficit by about $95 billion. Combined with a requirement that drug companies pay Medicare if the prices for certain drugs rise faster than inflation, the Medicare-related provisions of the IRA are expected to reduce the deficit by about $160 billion between 2022 and 2031 (CBO 2022).

The Next Steps in Strengthening Health Insurance and Lowering Costs

The Biden-Harris Administration has made major strides towards accomplishing its goal of expanding access to affordable health insurance and healthcare for all Americans. The nation's rate of health insurance coverage is at a record high, many Americans have seen significant savings on premiums, and Medicare beneficiaries will see reduced prescription drug costs for years to come due to policies implemented over the last four years. In addition to the policies discussed here, the Biden-Harris Administration has taken other important steps to strengthen private health insurance for Americans, including introducing new protections from surprise out-of-network medical bills and working to expand access to free, over-the-counter birth control. The Administration has also made it a priority to protect American families from the burden of medical debt with new policies that include its removal from consumer credit reports.

Future efforts to further expand and strengthen health insurance in the United States should build on the Administration's progress in closing the Medicaid coverage gap and expanding access to ACA Marketplace coverage by making the expanded premium tax credits permanent, simplifying enrollment in the programs, and easing transitions between different sources of insurance coverage. To further address rising healthcare costs in the United States, future government actions can build on the important first step of Medicare drug price negotiation started under the Biden-Harris Administration, as well as other efforts by the Administration to promote competition across healthcare markets. Expanding the Medicare drug price negotiation program, as proposed in the President's Fiscal Year 2025

Budget, and efforts to reduce prices more broadly will be critical to controlling the nation's healthcare spending.