



Access to Marketplace Plans with Low Premiums on the Federal Platform

Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan

Among the estimated 11 million uninsured non-elderly adults potentially eligible for Marketplace plans in HealthCare.gov states, 2 in 5 (42 percent) likely could find a plan for \$0 and more than half (57 percent) a plan for \$50 or less per month, after application of advance premium tax credits (APTC).

These numbers will increase beginning in April 2021 due to the American Rescue Plan.

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KEY POINTS

- Many uninsured and underinsured individuals can access plans with no premiums (“zero-premium plans”) or premiums for \$50 or less per month (“low-premium plans”) after application of advance payments of premium tax credits (APTCs).ⁱ These individuals may enroll in coverage under the Special Enrollment Period currently being made available on HealthCare.gov due to the COVID-19 pandemic.
- Among non-elderly uninsured adults potentially eligible for Marketplace plans in HealthCare.gov states, zero- and low-premium plans are most commonly available to lower-income individuals. For example, approximately 90 percent or more of eligible uninsured individuals with incomes between 100 and 150 percent of the federal poverty level (FPL) can currently find a plan for \$0, and all such individuals may find a plan for \$50 or less per month.
- By age group, more than half (52 percent) of eligible individuals ages 55-64 can find a zero-premium plan, and 62 percent could find a low-premium plan. Many eligible young uninsured adults (ages 18-24) can also find a zero-premium (44 percent) or low-premium (62 percent) plan.
- Half (50 percent) of eligible uninsured Hispanic / Latino adults can find a zero-premium plan and 64.5 percent can find a low-premium plan. Among eligible Black uninsured adults, 45 percent likely have available a zero-premium plan and 59 percent can find a low-premium plan.
- Among the nearly 8 million individuals *currently* enrolled in plans on the federal Marketplace, 15 percent are enrolled in a zero-premium plan after application of APTC (66 percent have access to a zero-premium plan), and 43 percent are enrolled in a low-premium (78 percent have access to such plans).
- Access to zero-premium and low-premium plans will increase when the subsidies newly enacted in the American Rescue Plan become available on April 1. ASPE will be providing updated analyses in the future.

ⁱ All references to premiums in this Issue Brief refer to premiums after application of APTCs, for those eligible to receive them.

INTRODUCTION

Approximately 30 million Americans remain uninsured, meaning that they do not have financial protection from the costs of obtaining health services and treatment, and many are eligible for Medicaid or Marketplace coverage.¹ Black, Latino, and Native American persons are more likely to be uninsured, and communities of color have been especially hard hit by both the COVID-19 pandemic and the economic downturn.² The Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and provided access to a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. This SEP will be available to consumers in the 36 states served by the federal Marketplace on the HealthCare.gov platform.^{3,ii,iii} Consumer access to the 2021 COVID-19 SEP on HealthCare.gov began on February 15, 2021 and will run through August 15, 2021.^{4,5} This SEP is an opportunity for uninsured and underinsured individuals living in the 36 states using HealthCare.gov to enroll in affordable coverage.⁶ Some of these individuals may have lost health insurance coverage or income during the COVID-19 pandemic. The SEP also allows individuals currently enrolled in a plan through HealthCare.gov to switch plans. Most of the fifteen states (including the District of Columbia) that run a State-Based Marketplace (SBM) have also made available a COVID-19 SEP with a similar timeframe.^{7,8}

Marketplace financial assistance, including advanced premium tax credit (APTC) payments, is essential to making health insurance available to individuals with no alternative for affordable coverage.⁹ APTCs are generally available to eligible individuals and families with household incomes between 100 and 400 percent of the federal poverty level (FPL) in states that have not expanded Medicaid under the ACA and between 138 and 400 percent FPL in states that have expanded Medicaid.¹⁰ For many individuals, particularly low-income individuals, APTCs on HealthCare.gov are large enough to substantially reduce premiums for consumers, in some cases to zero dollars. These credits are based on the premium of the benchmark plan (the second-lowest cost silver (SLCS) plan) available through HealthCare.gov in a person's area of residence. These zero-dollar and low-premium plans are more affordable so more people can enroll in health insurance. These plans can provide access to health care coverage and financial protection for millions of Americans who otherwise may be left uninsured and potentially liable for the full costs of their health care utilization.¹¹

Previous literature has identified affordability and unawareness of subsidy eligibility as common reasons individuals remain uninsured.^{12,13,14} Zero- and low-premium plans help to directly address this challenge, but many uninsured individuals may not realize they may be eligible to enroll in zero- or low-premium HealthCare.gov plans. Lower costs may also attract more younger and healthier individuals to enroll in Marketplace plans, which in turn can improve the risk pool and lower overall average costs for the broader Marketplace population.^{15,16,17}

This Issue Brief examines the availability of zero- and low-premium plans in states served by the federal Marketplace, HealthCare.gov, based on the premium subsidies available as of March 1, 2021, which does not yet include the enhanced subsidies created by the American Rescue Plan. Those subsidies will become available on HealthCare.gov on April 1, 2021, taking effect for covered enrollees as early as May 1, and are discussed in more detail later in this Issue Brief.

Tables in the brief show zero- and low-premium plan availability for HealthCare.gov states overall, subset by demographic and other characteristics, and by state. The purpose of this Issue Brief is to expand understanding and awareness of the availability of low premium health plans, where they may be available, and to whom.

ⁱⁱ HealthCare.gov states examined include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

ⁱⁱⁱ States operating their own State-Based Marketplace (SBM) that do not use the HealthCare.gov platform are not included in the analysis: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington.

METHODOLOGY

We used the U.S. Census Bureau 1-Year 2019 American Community Survey Public Use Microsample File (ACS PUMS) to identify non-elderly adults (ages 18 to 64) uninsured at the time of the survey.^{iv} For each uninsured non-elderly adult, we calculated whether a 2021 HealthCare.gov plan, after application of APTCs, could have been purchased for \$0 (“zero-premium plan”) or for \$50 or less per month (“low-premium plans,” which by definition include plans with zero premiums). The analysis uses HealthCare.gov Qualified Health Plan (QHP) premium and service area data from the Centers for Medicare & Medicaid Services (CMS) for 2021 coverage.^{18,19}

The sample excludes individuals with household income (based on ACS health insurance unit, or HIU) less than 100% of the Federal Poverty Level (FPL) in Medicaid non-expansion states and less than 138% FPL in Medicaid expansion states, as they are generally not eligible for APTCs. There are some exceptions to this not accounted for in the analysis. For example, certain legal immigrants with incomes below these thresholds may be eligible for APTCs if they are not eligible for Medicaid. Additionally, we did not account for whether a person had an affordable offer of employer coverage, which also affects QHP subsidy eligibility.

We estimated the counts of uninsured non-elderly adults and the percentage of these individuals with access to zero-premium and low-premium plans. We used the Census person-level weights to account for the assignment of respondents to multiple counties (see the Appendix for more detail). These counts and percentages were calculated for HealthCare.gov states, by demographic and other characteristics, and at the national (HealthCare.gov states only) and state level.

In addition to examining the uninsured population, we also identified availability of the zero-premium and low-premium plans among the currently enrolled HealthCare.gov population as of March 1, 2021, which covers the first two weeks of the 2021 SEP (which started on February 15, 2021). This analysis used HealthCare.gov QHP data along with 2021 HealthCare.gov plan selection data from the CMS Multidimensional Insurance Data Analytics System (MIDAS), which includes plan selection premiums, APTC calculations, and household modified adjusted gross income (MAGI).²⁰ It is important to note that all enrollees for the current HealthCare.gov population are included in the analysis—including ages 0-17 and 65+ and those with unknown or <100 percent FPL income, who were excluded from the uninsured component of the analysis.

See the APPENDIX: DETAILED METHODOLOGY for further details of the study methodology, which was adapted from a prior ASPE analysis.²¹ We round all population counts to the nearest thousand for both the uninsured and HealthCare.gov enrollee analyses.

This analysis has several limitations. State-Based Marketplace data are not readily available for 2021 and our estimates therefore do not represent the full United States. Additionally, race and ethnicity data for HealthCare.gov enrollees were frequently missing (42 percent of enrollees) and therefore unusable for estimating descriptive statistics for this group. Lastly, the analysis of the uninsured does not account for immigration status or eligibility for most other forms of minimum essential coverage, which both affect eligibility for Marketplace subsidies.

^{iv} The uninsured estimates for this analysis may differ from those released by ASPE on March 12, 2021 and found here: <https://aspe.hhs.gov/pdf-report/estimates-of-the-qhp-eligible-uninsured>. The methodologies differ in several ways. For example, the uninsured component of this analysis does not account for undocumented immigration status, is restrict to uninsured ages 18-64, and excludes uninsured <=100% FPL.

ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY PLAN METAL TIER

Table 1 shows the availability of zero- and low-premium plans among Marketplace-eligible uninsured non-elderly adults and the 2021 HealthCare.gov enrollee population by plan metal tier.

Table 1. Zero- and Low-Premium Plan Availability and Selection in HealthCare.gov States by Metal Tier, 2021

	Uninsured QHP Eligible Non-Elderly Adults – Plan Availability ^{a,b}	2021 HealthCare.gov QHP Enrollees ^{b,c}	
		Availability	Selected Plans
Total Population*	11,103,000	7,968,000	
\$0 Premium Plan, %			
Any Metal Tier	42.5%	65.9%	14.5%
Bronze	42.5%	65.9%	10.5%
Silver	3.4%	7.1%	3.7%
Gold	3.4%	6.2%	0.3%
\$50 or Less Per Month Premium Plan, %			
Any Metal Tier	56.8%	78.1%	43.4%
Bronze	56.8%	78.1%	17.7%
Silver	21.9%	44.7%	25.1%
Gold	12.6%	21.8%	0.7%

a. Data Source: American Community Survey, 2019

b. Data Source: HealthCare.gov Marketplace Plan Files for Coverage in 2021

c. Data Source: CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

*Rounded to the nearest thousand

Note: Catastrophic plans and plan selections excluded from the analyses.

Uninsured QHP Eligible Non-Elderly Adults

The analysis included 11.1 million uninsured non-elderly adults in HealthCare.gov states potentially eligible for Marketplace coverage (with or without APTCs) based on their income.^v Among this population, approximately 2 in 5 (42.5 percent) may be able to access a zero-premium plan in the Marketplace during the SEP and more than half (56.8 percent) can find a plan for \$50 or less per month. Most of these plans are in the bronze metal tier. Low-premium plans of \$50 or less per month (which include plans with zero-dollar premiums) are more common than zero-premium plans in all three tiers. Low-premium silver and gold plans, available to 21.9 percent and 12.6 percent of uninsured non-elderly adults respectively, are substantially more available than zero-dollar premium silver and gold plans, each of which are available to only 3.4 percent of the uninsured.

2021 HealthCare.gov Enrollees

A majority of current 2021 HealthCare.gov enrollees have access to zero-premium and low-premium plans: 65.9 percent have access to a zero-premium plan and 78.1 percent have access to a low-premium plan. While less than 10 percent of enrollees have access to a zero-premium silver plan (7.1 percent) or a zero-premium gold plan (6.2 percent), 44.7 percent have access to a low-premium silver plan and 21.8 percent have access to a low-premium gold plan. Among current 2021 HealthCare.gov enrollees, 14.5 percent are enrolled in a zero-premium plan and 43.4 percent in a low-premium plan. More HealthCare.gov participants are enrolled in a zero-premium bronze plan (10.5 percent) than a zero-premium silver plan (3.7 percent) or a zero-premium gold plan (0.3 percent). More consumers enrolled in low-premium silver plans (25.1 percent) than low-premium bronze (17.7 percent) or gold (0.7 percent) plans, in part likely due to greater AV for silver than bronze plans and cost-sharing reductions (CSRs) often resulting in higher AV in silver than gold plans.^{vi}

^v All results referring to “uninsured adults” in this brief are uninsured, non-elderly adults who are QHP-Eligible in HealthCare.gov states.

^{vi} The actuarial value (AV) of a health plan is the average percentage of total costs of in-network essential health benefits (EHB) covered by the health plan. The AV available to all QHP eligible individuals ranges from 60% for bronze plans, 70% for silver, 80% for gold, and 90% for platinum. For certain-

ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY DEMOGRAPHIC CHARACTERISTICS

Table 2 shows zero- and low-premium plan availability among the uninsured non-elderly adult population and current enrollees in the HealthCare.gov states by demographic characteristics.

Table 2. Zero- and Low-Premium Plan Availability in HealthCare.gov States by Demographics, 2021

	Uninsured QHP Eligible Non-Elderly Adults – Plan Availability ^{a,b}			2021 HealthCare.gov QHP Enrollees ^{b,c}		
	Total Population*	\$0 Available - Any Metal, %	\$50 or Less Per Month Available - Any Metal, %	Total Population*	\$0 Available - Any Metal, %	\$50 or Less Per Month Available - Any Metal, %
Total Population*	11,103,000	42.5%	56.8%	7,968,000	65.9%	78.1%
Rural Status [†]						
Rural	1,921,000	46.7%	60.6%	1,193,000	65.2%	78.8%
Urban	9,182,000	41.6%	56.0%	6,774,000	66.0%	78.0%
Age						
0-17	Excluded	N/A	N/A	758,000	52.8%	74.1%
18-24	1,333,000	44.2%	62.2%	704,000	73.4%	86.6%
25-34	3,058,000	36.7%	53.4%	1,257,000	58.4%	72.1%
35-44	2,721,000	41.6%	55.8%	1,302,000	61.8%	74.0%
45-54	2,290,000	42.8%	55.7%	1,593,000	69.5%	79.6%
55-64	1,701,000	52.3%	62.0%	2,239,000	70.9%	80.6%
65+	Excluded	N/A	N/A	115,000	88.7%	94.3%
Income/FPL						
<100% [‡]	Excluded	N/A	N/A	104,000	43.4%	53.9%
100-138%	1,290,000	99.9%	100.0%	2,663,000	98.4%	99.5%
>138-150%	611,000	90.1%	100.0%	702,000	88.7%	98.9%
>150-200%	2,370,000	75.2%	97.7%	1,520,000	74.9%	94.3%
>200-250%	1,990,000	36.9%	66.8%	1,036,000	51.8%	77.4%
>250-300%	1,269,000	18.2%	39.3%	637,000	28.5%	55.6%
>300-350%	901,000	9.5%	19.5%	415,000	16.6%	36.3%
>350-400%	617,000	6.9%	14.1%	287,000	13.4%	28.4%
>400% [‡]	2,055,000	0.0%	0.0%	115,000	0.0%	0.0%
Unknown [‡]	N/A	N/A	N/A	489,000	0.0%	0.0%
Race/Ethnicity [§]						
Hispanic and Latino	3,788,000	50.2%	64.5%	#	#	#
White Non-Latino	5,157,000	36.3%	50.7%	#	#	#
Black Non-Latino	1,504,000	45.1%	59.3%	#	#	#
Asian/Native-Hawaiian/Pacific Isl.	296,000	35.3%	51.1%	#	#	#
American Indian / Alaska Native	150,000	45.3%	59.2%	#	#	#
Multi-racial or Other	208,000	42.7%	58.1%	#	#	#

a. Data Source: American Community Survey, 2019

b. Data Source: HealthCare.gov Marketplace Plan Files for Coverage in 2021

c. Data Source: CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

Note: Catastrophic plans and plan selections excluded from the analyses

*Rounded to the nearest thousand

[†]Rural vs urban defined at the county level in the Marketplace files

[§]Race and ethnicity based on American Community Survey categories

#Excluded because of high % missing/unknown in HealthCare.gov data (42%)

eligible individuals (generally household income 100%-250% FPL) silver cost-sharing reduction (CSR) plans are available which enhance AV from 70% to 73%, 87%, or 94% depending on income. AV is allowed to vary within a de minimis range by -4/+2 percentage points and expanded bronze plans that pay for at least one major service other than preventive services before the deductible or meet the requirements of high deductible health plans can vary by -4/+5 percentage points (45 CFR 156.140(c)). Catastrophic plans are excluded from all analyses.

ⁱ Consumers who do not request financial assistance when applying for coverage do not enter their household income information. A small number of consumers that do request financial assistance have missing household incomes due to a tax filing status that makes them APTC-ineligible or data anomalies. Lawfully present individuals with a household income less than 100% FPL who were denied Medicaid due to their immigration status can be APTC eligible (26 CFR 1.36B-2(b)(5)).

Uninsured QHP Eligible Non-Elderly Adults

Zero- and low-premium plans availability was slightly higher for uninsured non-elderly adults in rural counties (46.7 percent and 60.6 percent, respectively) compared to those in urban counties (41.6 percent and 56.0 percent, respectively). These plans were most commonly available to people with lower incomes; for example, approximately 90.1 percent of those with incomes between 138 and 150 percent of FPL could find a plan for zero premium, and all could find a plan for \$50 or less per month.

Older (but non-elderly) uninsured adults were more likely to be able to find a low-cost plan, with approximately 1 in 2 (52.3 percent) of those ages 55-64 likely having a zero-premium plan available and more than 3 in 5 (62.0 percent) a plan for \$50 or less per month, which is partially a factor of the “age curves” used to calculate benchmark and other Marketplace premiums. Unsubsidized premiums increase with age but APTCs remain fixed as a percentage of income; therefore, older adults typically qualify for larger subsidies, which they can then use to buy lower-premium or even zero-premium plans.

Half (50.2 percent) of Hispanic or Latino uninsured adults have a zero-premium option and 64.5 percent could find a plan for \$50 or less per month. Among Black Non-Latino uninsured adults, 45.1 percent have a zero-premium plan available and 59.3 percent have a plan available for \$50 or less per. Finally, over 2 million uninsured non-elderly adults residing in HealthCare.gov states were above 400 percent of FPL and were not eligible for subsidies, though people in this income range are now potentially eligible for APTCs with the recent enactment of the American Rescue Plan.

2021 HealthCare.gov Enrollees

Access to zero-premium plans for those currently enrolled in HealthCare.gov states does not differ much between rural (65.2 percent) and urban areas (66.0 percent), and access to low-premium plans is also similar in rural areas (78.8 percent) and urban areas (78.0 percent).

Access to zero- and low-premium plans among current enrollees is highest for adults ages 18-24 (73.4 percent and 86.6 percent, respectively) and ages 55-64 (70.9 percent and 80.6 percent, respectively). This pattern for older adults relates to the higher amounts of APTC available to older adults, and the high rates for the youngest adults corresponds to their generally lower incomes qualifying each of these groups for higher amounts of APTC.

Current HealthCare.gov enrollees with the lowest incomes where APTCs are applicable (100-200 percent of FPL) had the greatest access to zero-premium plans (approximately 75 percent or higher) and the greatest access to low-premium plans (94 percent or higher).

Availability of zero-premium plans generally decreased at higher incomes, going from 98.4 percent among those with incomes between 100 and 138 percent FPL to 13.4 percent for those with incomes between 350 and 400 percent FPL (the exception being enrollees with income less than 100 percent FPL, who are often not eligible for APTCs and among whom only 43.4 percent have access to a zero-premium plan).^{vii} Availability of low-premium plans followed a similar pattern by income.

^{vii} Per the ACA, most individuals with incomes under 100 percent FPL are not eligible for premium tax credits. Medicaid expansion was made optional for states by Supreme Court case *Sebelius v. National Federation of Independent Business*. The exception is for individuals that are not eligible for Medicaid because of immigration status; these individuals can have incomes less than 100 percent FPL or less than 138 percent FPL (non-expansion vs. expansion) and qualify for APTC (premium subsidies).

ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY STATE

Table 3 presents state-level zero- and low-premium plan availability in HealthCare.gov states.

Table 3. Zero- and Low-Premium Plan Availability in HealthCare.gov States, 2021

State	Uninsured QHP Eligible Non-Elderly Adults – Plan Availability ^{a,b}			2021 HealthCare.gov QHP Enrollees ^{b,c}		
	Total Population*	\$0 Available - Any Metal, %	\$50 or Less Per Month Available - Any Metal, %	Total Population*	\$0 Available - Any Metal, %	\$50 or Less Per Month Available - Any Metal, %
HealthCare.gov States	11,103,000	42.5%	56.8%	7,968,000	65.9%	78.1%
Alabama	229,000	67.7%	74.3%	163,000	84.2%	89.4%
Alaska	37,000	0.0%	60.4%	18,000	0.0%	70.1%
Arizona	389,000	24.7%	42.1%	149,000	37.7%	55.4%
Arkansas	124,000	22.9%	46.1%	63,000	34.1%	56.4%
Delaware	33,000	43.2%	53.7%	25,000	50.6%	64.7%
Florida	1,560,000	46.1%	58.0%	2,086,000	82.4%	89.0%
Georgia	737,000	46.0%	59.5%	508,000	71.0%	80.0%
Hawaii	22,000	0.0%	42.1%	21,000	0.0%	72.3%
Illinois	463,000	0.0%	37.5%	273,000	0.0%	55.4%
Indiana	267,000	16.0%	36.4%	130,000	25.2%	39.7%
Iowa	80,000	55.8%	61.8%	55,000	69.2%	76.9%
Kansas	144,000	49.7%	60.3%	84,000	56.7%	70.1%
Kentucky	137,000	39.8%	55.7%	72,000	49.6%	63.7%
Louisiana	193,000	39.6%	51.2%	78,000	59.3%	72.6%
Maine	58,000	0.0%	34.6%	55,000	0.0%	52.1%
Michigan	286,000	25.0%	42.7%	253,000	41.1%	59.7%
Mississippi	172,000	28.1%	48.0%	109,000	68.0%	82.8%
Missouri	254,000	45.9%	58.5%	205,000	67.7%	76.0%
Montana	50,000	40.5%	49.5%	42,000	47.5%	62.8%
Nebraska	66,000	64.4%	73.2%	84,000	84.7%	90.2%
New Hampshire	54,000	16.3%	29.1%	44,000	26.2%	38.2%
New Mexico	95,000	33.6%	48.4%	41,000	42.4%	55.0%
North Carolina	643,000	59.1%	69.0%	510,000	77.0%	84.9%
North Dakota	24,000	53.0%	55.5%	22,000	77.1%	83.9%
Ohio	384,000	23.2%	41.3%	191,000	32.2%	50.6%
Oklahoma	238,000	55.7%	64.7%	166,000	81.0%	88.1%
Oregon	166,000	0.0%	43.8%	132,000	0.0%	47.9%
South Carolina	285,000	53.7%	65.5%	222,000	72.6%	82.1%
South Dakota	45,000	63.8%	73.0%	30,000	67.7%	80.4%
Tennessee	369,000	50.7%	62.2%	203,000	63.2%	73.4%
Texas	2,730,000	52.8%	63.1%	1,262,000	78.4%	85.4%
Utah	135,000	52.9%	66.5%	200,000	75.9%	86.2%
Virginia	322,000	36.9%	54.0%	246,000	55.7%	70.1%
West Virginia	56,000	5.7%	27.3%	18,000	14.9%	35.6%
Wisconsin	212,000	40.5%	52.5%	181,000	48.7%	62.1%
Wyoming	42,000	67.4%	70.0%	26,000	86.1%	89.7%

a. Data Source: American Community Survey, 2019

b. Data Source: HealthCare.gov Marketplace Plan Files for Coverage in 2021

c. Data Source: CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

*Rounded to the nearest thousand

Note: Catastrophic plans and plan selections excluded from all analyses

Uninsured QHP Eligible Non-Elderly Adults

HealthCare.gov states varied widely in the availability of zero-premium plans to uninsured adults; in some states (Alaska, Hawaii, Illinois, Maine, and Oregon) they were non-existent, while such plans may be available to up to two-thirds of the uninsured in other states examined in the analysis. Similar variability was found for low-premium plans with state-level ranges from 27.3 percent to 74.3 percent. Some states may not have zero-premium plans available to anyone; for example, if all plans in the state cover some services not considered essential health benefits (EHBs), then premiums in that state cannot be reduced by APTCs to zero dollars. APTCs cannot be applied to non-EHB portions of the premium and therefore these plans will always have some amount of premium cost to the consumer.^{viii} However, due to the comprehensiveness of EHBs, non-EHB portions of premiums are typically relatively small.

Some of the state-to-state variability is due to the composition of the enrolled and uninsured population, especially the income distribution in each state. Part of this variability is also due to whether a state has expanded Medicaid; in states that have not expanded, a larger percentage of the HealthCare.gov enrolled and uninsured populations are likely to have incomes below 138 percent FPL.

2021 HealthCare.gov Enrollees

Access to zero- and low-premium plans varies considerably by state for HealthCare.gov enrollees, ranging from 0 to 86.1 percent for zero-premium plans and 35.6 to 90.2 percent for low-premium plans. Five states have no access to zero-premium plans (Alaska, Hawaii, Illinois, Maine and Oregon), the same states where the uninsured don't have access to zero-premium plans.

^{viii} Non-essential health benefits are services beyond the ACA's ten categories of essential services. For example, Hawaii requires coverage of infertility services. For more details see: <https://www.cms.gov/ccio/resources/data-resources/ehb#ehb>

DISCUSSION

Access to Low-Cost Marketplace Coverage Among the Uninsured Population

During the first half of 2020, 30 million Americans were uninsured according to the National Health Interview Survey, and we estimate at least 11 million may be eligible for Marketplace coverage in HealthCare.gov states.¹ While the ACA coverage provisions led to a decrease in the number of uninsured non-elderly adults by 20 million between 2010 and 2016, the number of uninsured since 2016 has increased by approximately 2 million by the first half of 2020.^{1,22} The majority of the uninsured are currently eligible for coverage through Medicaid or the Marketplace with financial assistance. The Kaiser Family Foundation found 66 percent of uninsured nonelderly adults were eligible for Medicaid (including expansion), premium tax credits in the Marketplace, or other public insurance programs in 2019.²³ One of the most common reasons why the number of uninsured individuals remains high is their concern about the cost of health insurance coverage.²³

This Issue Brief analysis finds that more than half (56.8 percent) of uninsured non-elderly adults could find a zero- or low-premium plan through HealthCare.gov. Specifically, 42.5 percent may have access to a zero-premium plan and 56.8 percent may have access to a low-premium plan for \$50 or less per month. This suggests that many uninsured individuals be able to find affordable options for coverage but may be unaware they are eligible for coverage and/or financial assistance, may not know how to enroll in coverage, or may struggle with the complexity of insurance and/or the enrollment process.²⁴

The purpose of this Issue Brief is to bring awareness about the availability of zero- and low- premium plans to both the uninsured and underinsured populations as well as current Marketplace enrollees. However, it is important for consumers to understand that premiums are only one component of health coverage costs. While premiums represent the monthly cost to maintain coverage, there are other out of pocket cost-sharing expenses (i.e., deductibles, copays, and coinsurance) when receiving care. Some zero- or low-premium plans have higher consumer cost-sharing than higher premium plans, so consumers need to balance plan features when they select a plan.

Many of the zero- or low-premium plans are bronze plans with high deductibles (i.e., amount consumers need to spend out-of-pocket before the plan covers costs) and consumers need to be aware of out-of-pocket costs associated with different plan options.^{ix} The median QHP deductibles – without cost-sharing reductions – for individuals in HealthCare.gov states by metal tier in 2021 are approximately \$6,992 for bronze, \$4,879 for silver, and \$1,533 for gold.¹⁸ For those eligible for cost-sharing reductions (people with incomes between 100 and 250 percent FPL), these deductibles are typically substantially lower for silver plans.²⁵ For example in 2021, comparable median deductibles for silver plans with cost-sharing reductions were \$3,318 for 73 percent AV silver plans (available to those with income of 200 and 250 percent FPL), \$620 for 87 percent AV (available to those with income between 150 and 200 percent FPL), and \$74 for 94 percent AV (available to those with income between 100 and 150 percent FPL).¹⁸

Equity Impacts

This analysis finds access to zero- and low-premium plans varies across demographic groups. Historically, policies, laws, and practices served to limit health insurance coverage options for communities of color.^{26,27,28} The uninsured population disproportionately includes Black and Latino individuals, younger adults, individuals living in rural areas, and individuals with incomes between 100-400 percent of FPL.¹ The uninsured population is also more likely to defer or forgo needed health care, resulting in higher potential for poor health outcomes.^{29,30}

^{ix} Certain preventive services, such as an annual check-up and diagnostic screenings, are typically available before the deductible is met and with no cost-sharing, i.e. these services are accessible to a person before they have to pay toward their deductible.

Our analysis indicates that zero- and low-premium plans are available to approximately 40 percent or more of Black, Latino, and Native American adults who lack insurance and could qualify for APTCs, higher than some other racial and ethnic groups. Our findings suggest the ACA and access to coverage through the Marketplace can help address disparities in health insurance coverage in these populations.

Among the currently uninsured population in HealthCare.gov states examined in this analysis, access to both zero- and low-premium plans is slightly higher in rural areas, compared to urban areas. One factor in this pattern may be average income in rural areas being lower than urban areas and more individuals therefore qualify for larger subsidies.

The American Rescue Plan

The [American Rescue Plan](#) (ARP), signed into law on March 11, 2021, increases and expands eligibility for the ACA Marketplace premium subsidies for people enrolling in Marketplace health plans. Under the ARP, premium tax credits become more generous in several ways. For instance, among those with incomes less than 400 percent FPL who already are eligible for APTCs, the expected percentage of household income contribution toward benchmark premiums is lowered, including a reduction to 0 percent for those with household incomes between 100-150 percent of FPL. Those with incomes above 400 percent of FPL are now generally eligible for APTCs that cap their premium contribution at no more than 8.5 percent of their household income.

Advanced payments of premium tax credits under these ARP changes will be available on HealthCare.gov beginning April 1, 2021. The analysis in this Issue Brief does not account for the ARP changes to the Marketplace premium tax credit structure and therefore reflects the pre-ARP eligibility structure. The ARP will increase the availability of zero- and low-premium plans in the Marketplace for many consumers and uninsured individuals, and ASPE will publish additional analyses soon after this one examining the availability of these plans under the ARP.

There are also unemployment provisions in the ARP allowing individuals who received unemployment compensation during any week of 2021 to be deemed to have an income not in excess of 133 percent FPL for the purpose of calculating eligibility for APTCs and cost-sharing reductions. The provision will not be implemented until summer. We do not address the provision in this brief; however, it is important to note the provision will further increase availability of zero- and low-premium plans.

CONCLUSION

There is evidence that zero-premium and low-premium plan availability encourages uninsured people to enroll in the Marketplace.^{31,32} Increasing consumer awareness of such plans is an important part of the strategy to increase health insurance coverage. The availability of the SEPs through HealthCare.gov during the COVID pandemic is another: during the first two weeks of the availability of the 2021 COVID-19 SEP through HealthCare.gov, 385,864 new consumers requested coverage on an application submitted on or after February 15.^{33,34}

The ARP includes provisions that build upon the ACA, including enhancing and expanding Marketplace subsidies. These changes will further improve the affordability of coverage for uninsured individuals as well as those already enrolled in Marketplace health plans, likely leading to more individuals enrolling in health insurance coverage in the coming months.

APPENDIX: DETAILED METHODOLOGY

A. Factors Applicable to Both the Uninsured and HealthCare.gov Enrollee Analyses

Qualified Health Plans

QHPs must offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs). QHPs can also offer benefits beyond EHBs, and QHPs report the premium percentage attributable to EHB. Most QHPs have an EHB percentage of 100%; however, plans that cover benefits beyond EHB have EHB percentages smaller than 100%, reflecting the fact that some premium pays for benefits beyond EHB. Premium tax credits cannot be applied to premium costs affiliated with non-EHB benefits.

Marketplace Health Insurance Premiums

We used plan year 2021 QHP premium and service area data similar to what is found in the HealthCare.gov state QHP landscape files.^x The data include plan premiums and the EHB percent of premium at the county-level. We assume plans cover all zip codes in a county. Alaska uses zip codes, rather than counties to define rating areas, and we assign each county to a single rating area based on the rating area that covers the most population using Census data.

B. Availability of Zero-Premium and Low-Premium Plans Among Currently Uninsured QHP Eligible

We used data from the 2019 American Community Survey (ACS) from IPUMS USA. IPUMS USA (originally, the "Integrated Public Use Microdata Series") is a website and database providing access to integrated, high-precision samples of the American population drawn from U.S. Census Bureau public use data, including the ACS.^{xi}

Number of QHP Eligible Uninsured Non-Elderly Adults

Using the ACS, we identified non-elderly adults (ages 18 to 64) who lack health insurance at the time of the survey and are likely QHP eligible, defined for the purpose of this analysis based on having an income at or above 100% Federal Poverty Level (FPL) in non-expansion states or above 138% FPL in Medicaid expansion states. For each uninsured adult, we calculated whether a 2021 Marketplace health insurance plan, net of APTC, could have been purchased for zero dollars or for \$50 or less per month. Note that the QHP eligible population includes both those eligible for APTCs, and those whose incomes are too high to qualify pre-ARP but are still eligible to enroll in a QHP without a subsidy.

The ACS queries respondents about whether they were covered by the following types of health insurance: (1) Insurance through a current or former employer or union, (2) Insurance purchased directly from an insurance company, (3) Medicare, (4) Medicaid, (5) TRICARE or other military health care, and/or (6) VA health care. Consistent with how the U.S. Census Bureau calculates the official rate of individuals without any source of health insurance coverage, we define individuals who were not covered by any of these six sources of coverage as uninsured.

We used the ACS to identify Health Insurance Units (HIUs). HIUs differ from households or families, as defined by the U.S. Census Bureau, in that they group together individuals who would likely be considered a "family

^x <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>

^{xi} <https://usa.ipums.org/usa/>

unit" in determining eligibility for either private or public coverage. HIUs are comprised of individuals living in the same household. Hereafter, we refer to HIUs as "families" or "family income" interchangeably. Family income is the sum of income of all family members.

We constructed income as a percentage of the FPL in order to identify QHP eligible individuals. FPL varies by family size. The 48 contiguous states and DC use the same FPL while Alaska and Hawaii each have their own FPL. Individuals in families with income as a percentage of FPL that is less than 100% in Medicaid non-expansion states and that is less than 138% in Medicaid expansion states are considered not to be QHP eligible for the purposes of this analysis and are excluded. We defined states as having expanded Medicaid if they did so by January 2021. Note, some uninsured individuals below these thresholds may be QHP eligible under certain circumstances but due to the complexity of information on immigration status needed to identify this in the ACS, we do not account for them in this analysis. We also did not model whether a person had an affordable offer of employer coverage, which also affects QHP subsidy eligibility.

We restricted the uninsured portion of the analysis to non-elderly adults (ages 18 to 64), with household incomes at or above 100% FPL, who are both uninsured and potentially QHP eligible.

Assigning Counties to ACS PUMS Respondents

As the smallest geographic unit available in the ACS is a Public Use Microdata Area (PUMA), and since PUMAs can be made up of multiple counties, there is not a one-to-one correspondence between counties-level premiums and the geography of respondents. We use the Missouri Census Data Center's Geographic Correspondence Engine to map PUMAs to counties. Respondents living in PUMAs for which there is only one county are assigned to that county. Respondents living in PUMAs which are comprised of multiple counties are assigned to each of those counties but are weighted according to the county's relative population in the 2010 Census. County-level Marketplace premiums are then assigned to each ACS respondent based on their assigned county.

Calculation of Maximum Premium Tax Credits

The percent of household income that each respondent must pay to purchase a 2021 benchmark plan is determined by that respondent's income as a percentage of the FPL. The expected family contribution (EFC) towards premiums is that percentage multiplied by family income. We allocate the EFC among each uninsured person (age less than 65) in the family using the relevant age curve used for their state.³⁵⁻³⁶

Calculation of the Premium Tax Credit

We calculated the premium tax credit (PTC) for each respondent by subtracting the EFC from the EHB premium of the benchmark plan in that respondent's county. If this difference is less than zero, the PTC is set to zero. We also set the PTC to zero for respondents with income as a percentage of poverty that is greater than 400% or less than 138% (100% in states that did not expand Medicaid as of January 2021).

Calculation of the Lowest Cost Premium Net of APTC

For each metal level and county, we found two lowest cost plans based on the age 21 total premium: 1) the lowest cost plan among all plans, and 2) the lowest cost plan with an EHB percent of premium equal to 100%. For each respondent and metal level, we then adjusted the age 21 premiums according to the respondent's age and the relevant age factor for the respondent's state. We then found net premiums for each respondent by taking the difference between each plan's EHB premium and the respondent's PTC. If the PTC was greater than the relevant plan's EHB premium, we set the difference equal to \$0 and set the final net premium equal

to the non-EHB portion of the plan's premium (which is \$0 for plans with an EHB percent of premium equal to 100%). The final net lowest cost premium for each respondent and metal level was equal to the lesser of the two net premiums for the metal level.

Availability of Zero-Premium Plans and Low-Premium Plans

A respondent is determined to have a zero-premium plan available if the net lowest cost premium is \$0. A respondent is determined to have a low-premium plan available if the net lowest cost premium is \$50 or less per month. Catastrophic plans were excluded from the analysis.

Estimation of Counts

We estimate counts of uninsured non-elderly adults, percentages of uninsured non-elderly adults with access to a zero-premium plan, and percentages of non-elderly adults with access to a low-premium plan using the Census person-level weights to account for assignment of respondents to multiple counties. The counts and percentages were calculated for HealthCare.gov states in aggregate, by demographic characteristics, and at the state level.

C. Availability of Zero Premium and Low Premium Plans Among QHP Enrollees in HealthCare.gov States

We used data on 2021 Marketplace selections in HealthCare.gov states using active plan selections as of March 1, 2021. An active plan selection is one that is non-cancelled with an end date of December 31, 2021. After excluding catastrophic plan selections, we have a total of 7,968,000 consumers with plan selections. From these data, we use attested household income, county and state of residence, age, the individual- and policy-level gross premium, policy-level premium net of applied APTC (net premium), and maximum amount of APTC available to the household.

Note: For the HealthCare.gov enrollee analysis we include all plan selections, including all ages and income; this includes individuals excluded from the uninsured portion of the analysis described in section A of the appendix (i.e. individuals ages 0-17, ages 65+, and household income below 100% FPL are all excluded from the uninsured analysis, but are included in the HealthCare.gov enrollee analysis described here).

Calculation of the Lowest Cost Premium Net of Premium Tax Credits

We used the calculated maximum APTC amount for a given household to determine the final premiums after applying APTC. For each plan available to a household, we calculated the net premium as the difference between the plan's EHB premium for all household members and household's maximum available APTC. If the maximum APTC was greater than the relevant plan's EHB premium, we set the difference equal to \$0 and set the final net premium equal to the non-EHB portion of the plan's premium for all household members (which is \$0 for plans with an EHB percent of premium equal to 100%). We then found the lowest net premium for each household and metal level.

We distributed the net premium amount among household members based on each member's individual gross premium amount, which aligns with the relevant age curve except in cases of tobacco rating. When a policy included more than 3 children such that some children are not rated, we distributed the total child rate among all children younger than 21 years-old (e.g., if the policy included 4 children, each with a rate of \$100, the policy-level premium would be \$300 and each child's premium would be \$75). We included tobacco users and calculated plan premiums using tobacco rates when they exist.

We assume that families with multiple enrollment groups or policies maintain their selected grouping arrangement regardless of the selected plan. We also assume that all family members select the same plan and require that the plan be available to all household enrollment groups.

Calculation of Current Plan Selection Premiums Net of Premium Tax Credits

We took the calculated policy-level premium net of APTC and distributed it to policy members based on each member's individual gross premium amount, as described above. Consumers have the option to use less than their maximum available APTC; consumers may opt to do so if they expect their income to rise during the year and want to avoid paying back PTC when filing taxes. For current plan selection premiums, we used the consumer elected APTC amounts, rather than the maximum amount available.
aspe.hhs.gov/reports

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