The following appendices are part of a Commonwealth Fund issue brief, Michael Simpson, Andrew Green, and Jessica S. Banthin, *How Policies to Expand Insurance Coverage Affect Household Health Care Spending* (Commonwealth Fund, Jan. 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/policies-expand-insurance-coverage-affect-household-spending.

APPENDICES

Appendix 1. Detailed Health Reform Policies

This paper considers five incremental reforms that would build upon the baseline of Inflation Reduction Act (IRA) subsidies. The first three policies have been included in proposed legislation; the fourth and fifth policies we regard as logical next steps to further improve interstate equity, improve affordability, and expand coverage. The reforms are as follows:

1. **Marketplace expansion to fill the gap.** The first policy reform would fill the Medicaid gap by making marketplace coverage available to people with incomes too low to be eligible for marketplace premium subsidies in the 12 states that have not expanded Medicaid. The policy would provide most people with incomes above traditional Medicaid eligibility levels and below 100 percent of the federal poverty level (FPL) with access to marketplace subsidies. For people with incomes below 138 percent of FPL in nonexpansion states, the reform would also eliminate the employer coverage firewall, which makes people ineligible for marketplace subsidies if they have an affordable offer of employer coverage. This policy would be fully federally financed and accompanied by an increase in the federal Medicaid matching rate from 90 percent to 93 percent for the expansion population in the 38 states that, along with the District of Columbia, have expanded Medicaid. This change to the matching rate, included in the draft Build Back Better Act, would partially address funding inequities between expansion and nonexpansion states.
2. **8.5 percent employer-sponsored insurance affordability threshold.** The second policy reform would lower the threshold above which employer coverage is deemed unaffordable to 8.5 percent of income. Under the Affordable Care Act (ACA), a family who has an affordable offer for health insurance from an employer is ineligible for a subsidy to purchase insurance in the marketplace. By lowering the threshold for this firewall, the policy would make it possible for more employees and their families to access marketplace coverage. The IRA premium subsidies cap premiums at 8.5 percent of income; thus, the firewall threshold would be reduced to be consistent with this level.
3. **$10 billion reinsurance fund.** The third policy reform would make a $10 billion reinsurance plan available to all states. We assume states that currently spend toward reinsurance would continue to do so.
4. **Full federal funding of Medicaid expansion.** The fourth policy reform would increase the federal Medicaid matching rate in expansion states to 100 percent. Having the federal government fully finance marketplace coverage for the Medicaid gap population in nonexpansion states, as in the aforementioned reform, would create inequities between states; without this policy, the federal government would only pay 93 percent of the costs of covering the Medicaid expansion population in expansion states while paying all of those costs in nonexpansion states. This policy would remove all states' financial burdens for this group.
5. **Enhanced marketplace subsidies.** The final policy reform would expand cost-sharing reductions (CSRs) that increase the generosity of subsidized marketplace plans for people with low incomes. The percentage of covered costs paid by insurance, or the actuarial value (AV) of a plan, for people with incomes below 200 percent of FPL would rise to 95 percent. AVs would increase substantially for people with incomes between 200 percent and 300 percent of FPL (to 90 percent) and for people between 300 percent and 400 percent of FPL (to 85 percent). In addition to enhanced CSRs, the AV for those with incomes above 400 percent of FPL would increase from 70 percent (silver) to 80 percent (gold), because the benchmark premium on which ACA subsidies are based would be tied to the second-lowest-cost gold plan in each region.

We analyze the coverage and federal cost implications of each of these proposals in steps, starting from a baseline of IRA premium subsidies. In the first step, we examine the changes in coverage and costs relative to the IRA subsidies baseline resulting from filling the Medicaid gap in nonexpansion states. That reform and its results become the new starting policy that the second reform is compared with, a process that is repeated for each subsequent reform.

Appendix 2. Detailed Description of Financial Burden Methods

Two measures of household health care financial burden are presented. The measures compare how household spending on health care, including health insurance premiums and out-of-pocket spending, would change under reforms to the ACA, including and beyond those proposed in the Build Back Better Act (BBBA). These measures were described in earlier work and suggested as a standard way that the effects of policy on households could be shown.

1. The distribution of household health spending by quintile of spending (shown as a per-person average within the family), comparing the distribution under a baseline of the premium subsidies under the Inflation Reduction Act to the distribution that would occur under reforms.
2. The distribution of household health spending relative to income by quintile, comparing the distribution under the IRA subsidies baseline to the distribution that would occur under reforms.

The measures are shown for households with nongroup coverage under the health reform (all five reform provisions combined). Because the BBBA health insurance provisions and additional reforms are largely modifications to the ACA, the greatest effect of reforms are seen by people who have nongroup coverage under reform, including those who had nongroup coverage before reform, people who left employer-sponsored insurance (ESI) for nongroup, and those who were previously uninsured. Appendix 3 presents figures of spending for all households, including those with Medicaid and/or ESI. Because there are many more people with each of those coverages than with nongroup coverage and because the reforms presented have small if any effects outside the nongroup market, the changes in spending presented are quite small.

Both measures include premiums, out-of-pocket payments (payments toward deductibles, coinsurance, and copayments), and other spending on health not covered by insurance. Out-of-pocket spending by people who are uninsured is included, but uncompensated care provided to the uninsured is not included as part of financial burden, since households do not pay for it. We adjust household contributions to premiums for employer-sponsored insurance for the tax advantage of those payments.

Employer contributions to premiums are not included in either calculation of households' financial burden because we are unable to determine the effect employer contributions have on each individual workers' compensation. In addition, even if workers are aware of the amount of money contributed to their health insurance premiums by their employers, the true after-tax cost that results from the exclusion of employer contributions from income and payroll taxes is obscured by the complexity of its tax treatment. Further, employers, not workers, decide whether and how much to contribute to health insurance premiums.

The first measure shows spending as average spending per-person within the family unit to account for premium payments and cost-sharing requirements that cover more than one individual within a family, which allows us to include single and multiperson family units in the same distribution. This measure can be used to highlight the extent to which a policy change would lead to higher or lower levels of spending for people at different points in the spending distribution.

The second measure highlights the implications of a reform on a family's health care spending as a share of their household income. People would each be assigned to a fixed quintile of spending as a percentage of family income based on their place in the distribution prior to reforms. Specifically, total family unit level spending would then be divided by total family income. The resulting calculation would be assigned to each member of the family. In this way, individual and multiperson units can be included in the same distribution. For this metric, people are assigned to a fixed quintile of spending as a percentage of income based on their place in the distribution under the baseline. This contrasts with the metric showing spending in dollars, which allows people to move from one quintile to another when comparing a reform to the baseline. Fixing people in quintiles based on the ratio of current spending to income allows us to get a clear sense of how a reform would affect people with high spending relative to income today, while categorizing them by quintile of spending shows the household burdens in dollars in each quintile.

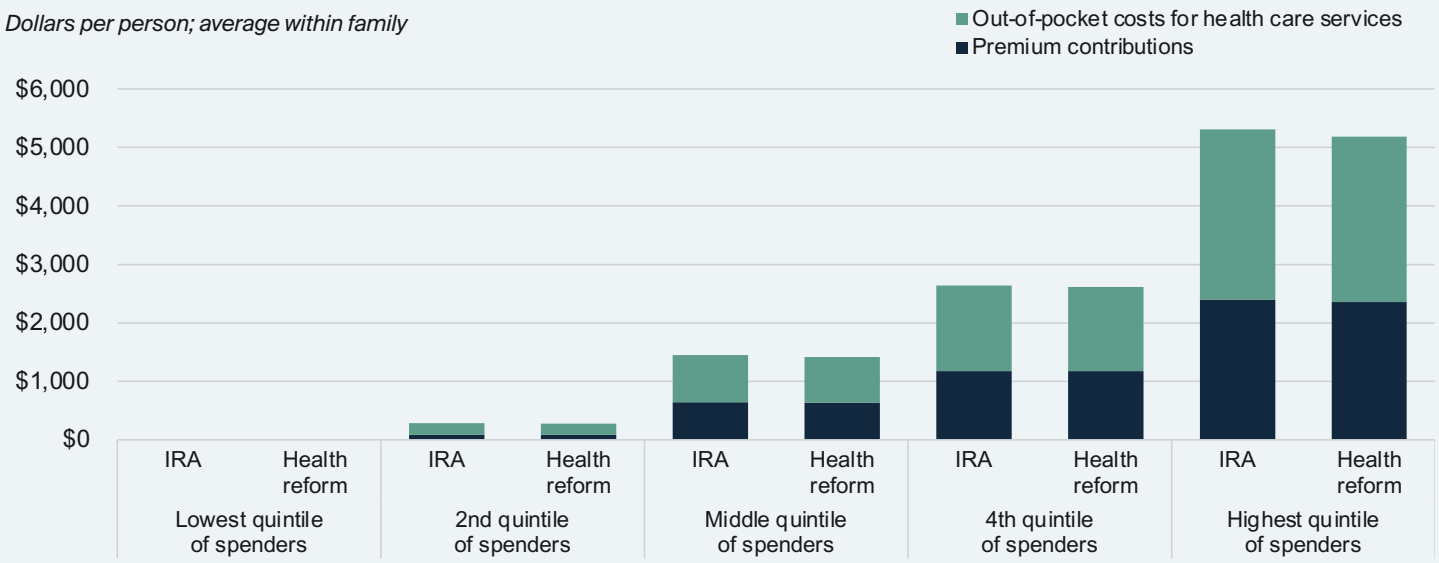
The first measure can be used to highlight the extent to which a policy change would lead to higher or lower levels of spending for people at different points in the spending distribution. For example, a large decrease in spending for people who currently spend the most would likely be considered more valuable than a large decrease in spending for those who spend very little. The second measure would allow policymakers to differentiate between a proposed reform that would reduce health spending for those currently devoting a high percentage of their income to health care from one that would largely affect families currently devoting a smaller portion. It could be of strong interest to those with a normative perspective on the appropriate level of health care spending as a share of income.

Appendix 3. Household Spending for All Nonelderly People

Distribution of Household Health Care Spending Under IRA and Proposed Health Reforms

Base: Nonelderly population, 2023

Dollars per person; average within family



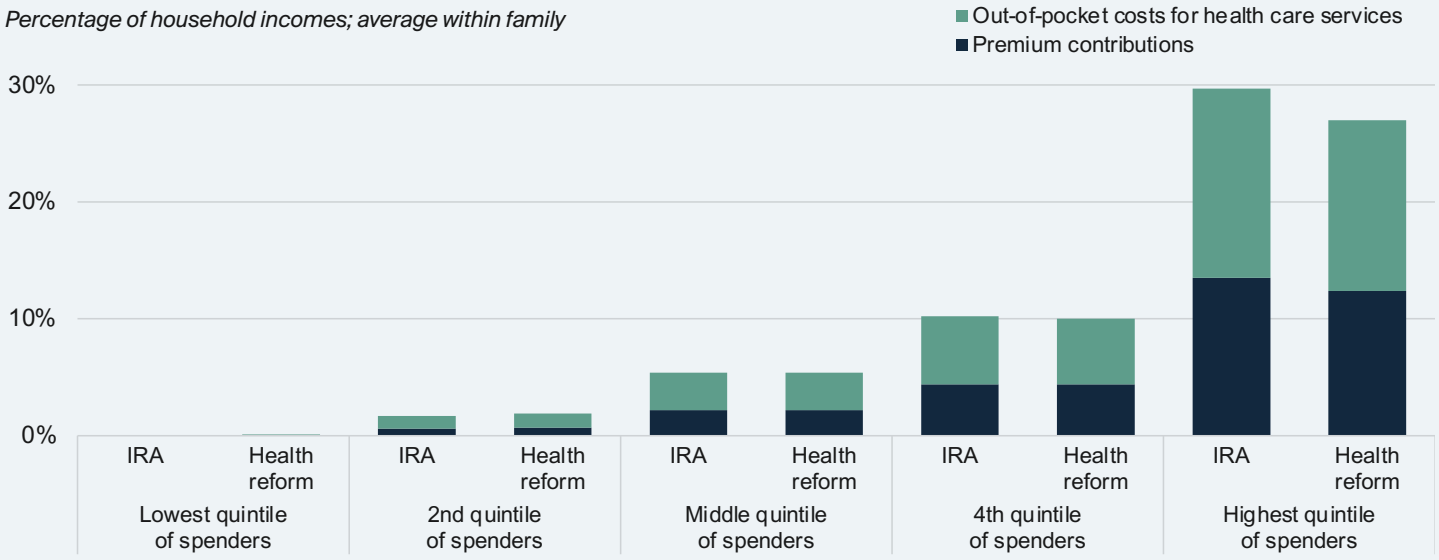
Notes: IRA = Inflation Reduction Act.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2022.

Distribution of Household Health Care Spending as a Percent of Income Under IRA and Proposed Health Reforms

Base: Nonelderly population, 2023

Percentage of household incomes; average within family



Notes: IRA = Inflation Reduction Act. Households with income below $100/month are excluded. Quintiles are computed under IRA policy and remain fixed.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2022.