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The new $1.9T American Rescue Plan will substantially decrease the uninsured population in 2021 and 2022. Providers and Insurers will see financial improvements.

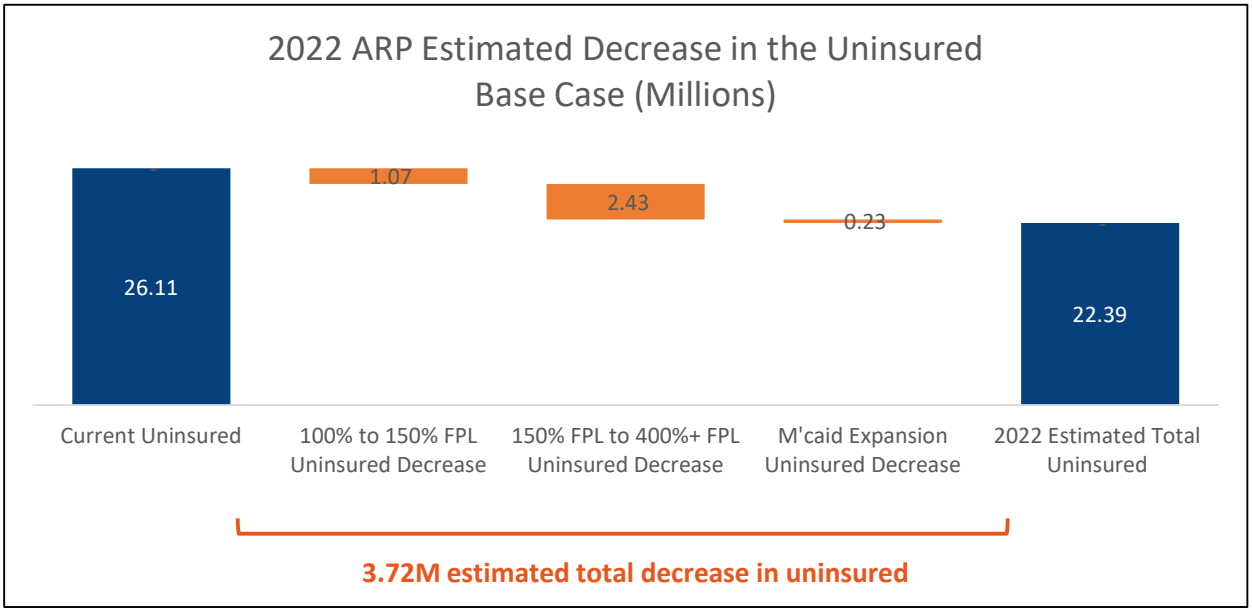
American Rescue Plan (ARP) Summary

The American Rescue Plan (ARP) was passed on March 11, 2021. This massive $1.9T piece of legislation represents further U.S. federal support for the impacts of COVID 19. The ARP provides support and investments in many areas of the U.S. economy. The focus of this paper will be on the healthcare related components of the law, especially its impact on materially decreasing the number of uninsured. On top of the health benefits to the newly insured, healthcare provider and insurers should see sizable revenue improvements.

This law has several irons in the fire that will contribute to decreases to the uninsured. Some of these include additional healthcare exchange insurance premium support across income levels, new incentives for the 12 states that have yet to expand their Medicaid populations to Affordable Care Act (ACA) levels, and additional support for households that should increase their disposable income. To note, most of the law's changes expire at the end of CY2022. Without additional legislation the significant decrease in the uninsured may be short lived.

Estimated Decrease in the Number of Uninsured Due to ARP

The Congressional Budget Office estimates as high as a 1.3M decrease in CY2022 in the 26M plus currently uninsured, and a cumulative 2.5M decrease through 2023.[1] ConsiderHealth believes this CBO estimate is quite low and expects a **3.7M** decrease in the uninsured in CY2022 alone. This estimated reduction in the uninsured would be a 1.1% drop in the total uninsured rate.[i2] Read on to see what is changing to decrease the uninsured and when households, care providers, and insurers can expect these changes.



Calendar Year	Estimated Decrease in Uninsured (M)
2021	1.63
2022	3.72
2023	0.70
2021 to 2023	*6.05*

[i] Current estimate of the uninsured 26.1M (8%). 2019 Annual Social and Economic Supplement survey (see endnote).

The drop in the uninsured will bring sizable revenues to the healthcare industry. Our base estimate is an additional $58B from 2021 to 2023. There should also be reductions to uncompensated care, as not all the newly insured's care utilization will be incremental.

What is the American Rescue Plan of 2021?

COVID has been an incredibly difficult time in human history. A sobering 586K lives lost in the U.S. (at the time of this publication) either directly or indirectly due to the pandemic.[3] The collective response to combat and hopefully soon beat this pandemic has required herculean efforts. In order to assist, the U.S. federal government has stepped in with some unprecedented spending. Over the course of 2020 and 2021, the federal government has passed $5.6T[4] in COVID relief. This COVID support is more than the U.S. government spent on everything in FY2019.[5]

The most recent COVID support bill is the American Rescue Plan (ARP) which was signed into law on March 11, 2021. This $1.9T law is only slightly smaller than the largest bill ever passed by the federal government (also COVID related). The ARP touches on many different areas of the economy, offering support to individuals, businesses, and state and local governments. The largest line-item expenditures include:

Chart 1. *ARP Major Line-Item Expenditures*

American Recovery Plan Support Area	Total Amount
One-time, $1.4K payments to eligible individuals and dependents	$413B
State and Local Government Support	$325B
Extended Unemployment Support	$242B
School Reopening Support	$129B
Other	***$800B***
Total	**~$1.9T**

The $800B other line in the ARP major expenditures table above has big league implications to the healthcare industry and specifically the number of uninsured individuals. This should improve provider's and insurer's financials significantly in 2021 and 2022 and potentially beyond.

Current Uninsured Landscape

As of the latest (2019) Annual Social and Economic Supplement of the Current Population Survey (ASEC), approximately 8% (26.1M) of the U.S. population is uninsured.[6,7] COVID 19 has changed household incomes in 2020, the number of uninsured likely has risen from this latest estimate. This paper will use the 2019 ASCE report as the basis for the current level of the uninsured. This is recognized as a paper limitation.

The ACA has been successful in reducing the uninsured rate in the U.S. The uninsured rate in 2010 pre-ACA was 15.5%[8] of the population and today is 8%, coming down by almost half.

Chart 2. *ARP Uninsured Reduction Main Contributors*

Contributor	ACA Impacts	ARP Enhancements
Health Insurance Exchange Support	**11.4M** currently enrolled[9]	✓
State Medicaid Expansion	**~12M** incrementally enrolled[10]	✓

The ARP will reduce the estimated 26.1M remaining uninsured primarily through:

1. **Increased Healthcare Exchange premium subsidies**, including new groups previously ineligible for federal premium support.
2. **Increase the number of ACA Medicaid expansion states.** The ARP includes an additional carrot to states that have yet to expand their Medicaid populations.
3. **Changes in tax policy** that should equate to more disposable income for lower income households.

ARP: Insurance Healthcare Exchange Premium Support

The ACA of 2010 expanded healthcare coverage in a few different ways. One was the transformative legislation created healthcare exchanges where individuals could purchase health insurance with a base level of benefits. The healthcare exchanges have not been without controversy, but currently 11.4 million people are insured through an exchange plan in the U.S.

The ACA included caps for how much healthcare insurance premiums could be of a household's income. For qualifying households, once the cap was met the federal government would provide subsidies for the remainder of the total insurance premium. These caps made insurance much more affordable for low and middle-income households. The caps were based on a sliding scale of the Federal Poverty Level (FPL). More support for lower income households and less support for higher income households, up to a point of no premium support. The FPL for 2021 is included below for reference.

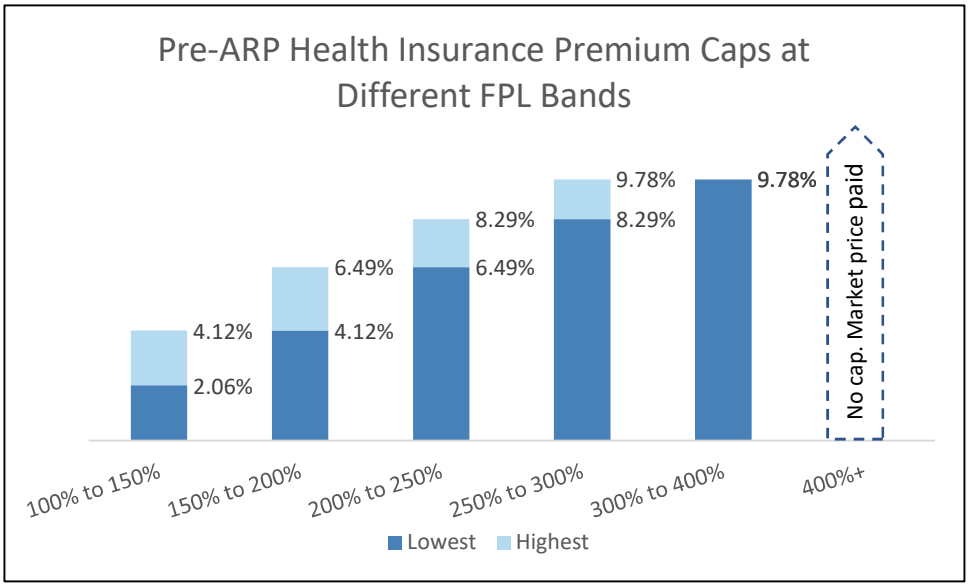
Chart 3. *Federal Poverty Levels 2021*

Federal Poverty Levels 2021[11]			
# in Household	**100% of FPL**	**138% of FPL**	**400% of FPL**
1	$12,880	$17,774	$51,520
2	$17,420	$24,040	$69,680
3	$21,960	$30,305	$87,840
4	$26,500	$36,570	$106,000

For states that expanded their Medicaid population, Households making between 138% to 400% of the FPL (100% to 400% in non-expansion states) were expected to pay no more than the percentages in the table below for healthcare. The federal subsidy for these households was based on the difference between the ACA premium cap percentage of income and the cost of the benchmark silver plan in their area.[ii]

[ii] Benchmark Silver Plan - The second lowest-cost silver plan in the exchange in each area, in the individual/family insurance market or the plan the state uses to define essential health benefits.

Chart 4. *Exchange Premium Caps by Income Level Pre ARP*[12]



For example, households making 150% of the FPL were expected to pay 4.12% toward their health insurance. Those at 200% of the FPL were expected to pay a maximum of 6.49%.

What Changes for Insurance Premium Support Under the American Rescue Plan?

A. **Fully Subsidized Premiums for Households Making 100% to 150% of FPL.** The federal government will fully pay premiums in 2021 and 2022 for those making 100% to 150% of the FPL.

B. **Enhanced Subsidized Premiums for Households Over 150% FPL.** Households making more than 150% of the FPL will see enhanced federal subsidies. Further, those making above 400% of the FPL now may receive some federal premium subsidy support where previously subsidies ended at 400% of the FPL.

C. **Enhanced Unemployed Subsidy.** Qualifying people who are unemployed will have full premium support, either through expanded COBRA or exchange plans for 2021 only.

Details for What Changes Related to Premium Support

A. Full Subsidized Premiums for households between 100% to 150% of the FPL

Free healthcare. You heard that right. If a household makes less than 150% of the FPL in CY2021 or CY2022 they will be eligible for full federal premium support. Prior to the ARP, households in this income band, that were not covered by their state Medicaid plan, would have been expected to pay between 2.06% to 4.12% of their income towards healthcare premiums. While the expected contribution was not much, there is not a lot of extra money to go around for a family of 3 making ~$33,000 a year (150% of FPL). Some households simply couldn't afford the ~$1K+ annual premium household contribution and thus did without insurance.

Chart 5. *Example Premium Support At 150% of the Federal Poverty Level 2020 vs 2021*

	CY2020	CY2021 & CY2022
Household Income	$32,940	$32,940
Household Size	3.00	3.00
Income Percent of FPL	150%	150%
Max Annual Insurance Premium / Income	4.12%	0.00%
Max Annual Health Insurance Premium	**$1,357**	**$0**

Chart 6. *100% to 150% FPL Uninsured Population 2019* [13,14]

Low FPL	High FPL	People in Income Band	% Uninsured	# Uninsured	Estimate Exchange Eligible Uninsured
100%	150%	25,675,000	14.1%	**3,637,000**	**2,665,000**

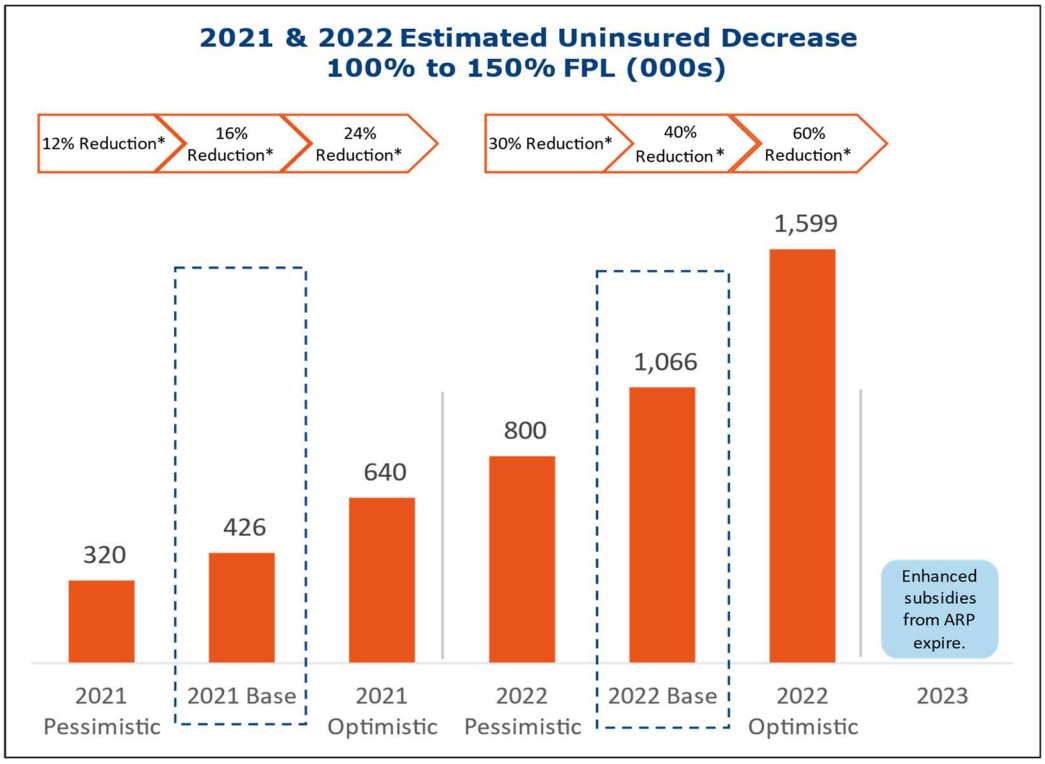
There is an estimated 3.64M uninsured people that make between 100% to 150% of the FPL. However, some of these people are ineligible to obtain exchange insurance as they are undocumented immigrants not otherwise eligible for Medicaid under special state specific provisions. We estimate 2.67M of the 3.64M uninsured would be exchange eligible.

CONSIDERHealth Estimated Uninsured Reduction and Takeaways: Full Premium Support 100% to 150% FPL

For the estimated exchange eligible, currently uninsured people, free insurance in 2021 and 2022 is a no brainer. We believe the only limitation to insuring these people will be a function of marketing the program. HHS has announced aggressive plans to market with insurance navigator funding. HHS is dedicating $80M dollars to do so which is more than 8x what was spent during regular open enrollment in 2020.[15] There is also a COVID driven special enrollment period open through August 2021. Further, insurers and providers will add additional marketing support as increases in the number of insured helps them. If households are aware there is little reason for them not to be insured in CY2021 and CY2022.

- **Base Case: Decrease in the Uninsured 100% to 150% FPL.** **426K** drop in CY2021, **1.07M** drop in CY2022.
- **Uninsured decrease weighted towards states that have yet to expand Medicaid.** Expansion states would already cover those making up to 138% of the FPL.

Chart 7. *100% to 150% of FPL - Estimated Decrease in Uninsured Due To ARP*



** Reduction is in estimated exchange eligible from 2019 uninsured estimate*

2021 Commentary 100% to 150% FPL

Our model assumes a ~16% reduction in the 100% to 150% exchange eligible uninsured in 2021. It will take some time for the enhanced subsidies to be fully known by those that could benefit.

Note. Unemployment and COBRA changes to the uninsured due to ARP are included in the estimated insured reductions for 2021.

2022 Commentary 100% to 150% FPL

The expected uninsured reduction for those eligible making 100% to 150% of the FPL jumps significantly for 2022 to a base case estimate of 40%. HHS has $80M to spend to advertise the exchanges coupled with insurers and providers adding visibility to individuals that could benefit. Further, those receiving free coverage will provide word of mouth advertising. By regular open enrollment for 2022 (Nov 2021) these seeds should be sprouting. Further, there is some discussion on automatic enrollment for certain eligible groups in this income band. This would be a game changer.

2023 Commentary 100% to 150% FPL

The additional federal premium subsidies expire at the end of 2022. There may be some residual reduction from those that acquired fully subsidized coverage in 2022 that continue to be insured but pay the higher premium responsibility in 2023. Our guess is most will not, thus for conservatism our estimate for the uninsured reduction in 2023 for this group is 0%.

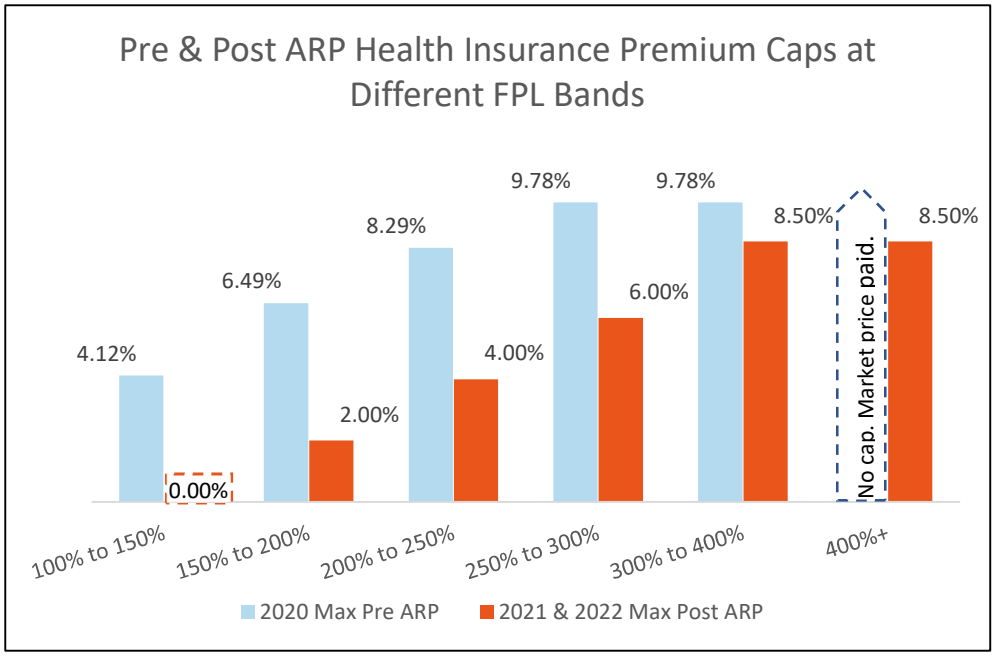
B. Enhanced Subsidized Premiums for Income Groups Over 150% of the FPL.

Currently, those that make more than 400% of the FPL receive no Federal premium support. The ARP will provide relief for middle income households in that even those that make over 400% of the FPL will have their exchange premiums capped at 8.5% of their earnings. This could be big savings for older people, not yet Medicare eligible, living in high-cost insurance markets. Benchmark plans for 60-year-old seniors can easily stretch to over $1K per month. At an 8.5% cap on premiums, this easily supports sizable subsidies for those making well over 400% of the FPL.

Further, for all income bands over 150% of the FPL, ARP premium caps are lower. These larger subsidies should entice some of those that have gone without coverage due to affordability to enroll in plan.

The below chart shows the changes in premium caps at various income levels

Chart 8. *Premium Caps at Different Income Levels Pre-ARP and Post (2021 & 2022)*



These reductions in the premium households are expected to pay are sizable. These reductions for those between 150% to 400% of the FPL range from 1.3% to ~4.3% of a household's total income. This will bring annual premiums down by several thousand dollars for an average family.

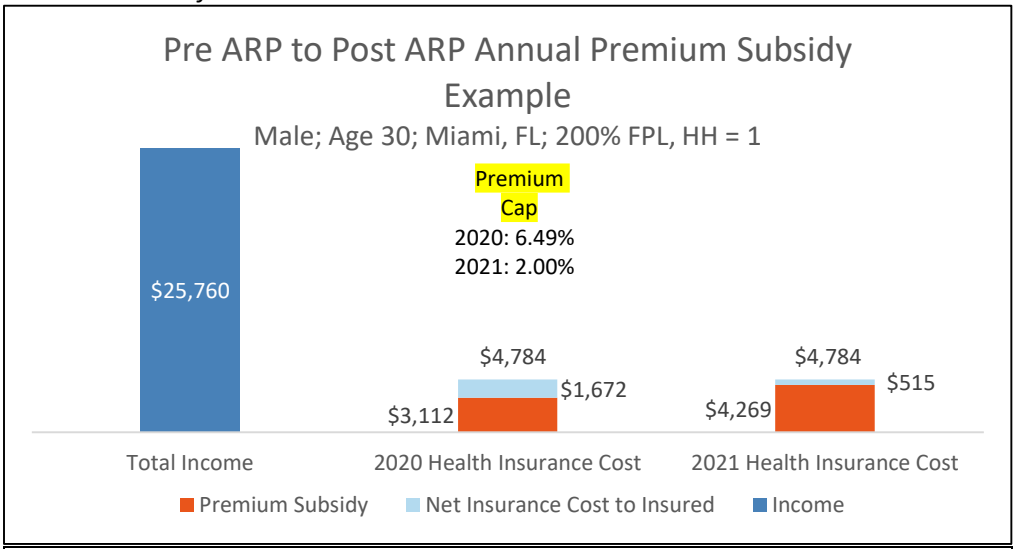
The savings for those making over 400% of the FPL are even larger. Pre ARP, affordability for middle income seniors not yet Medicare eligible, is challenging. A senior making 450% of the FPL prior to the ARP could spend over 20% of their income on healthcare insurance premiums.[iii] Now that will be capped at 8.5%.

[iii] 450% of FPL $57,960 single member household. Annual individual premiums for 60-year-old seniors are $12K per year or more in many markets.

Example Health Insurance Premium Savings

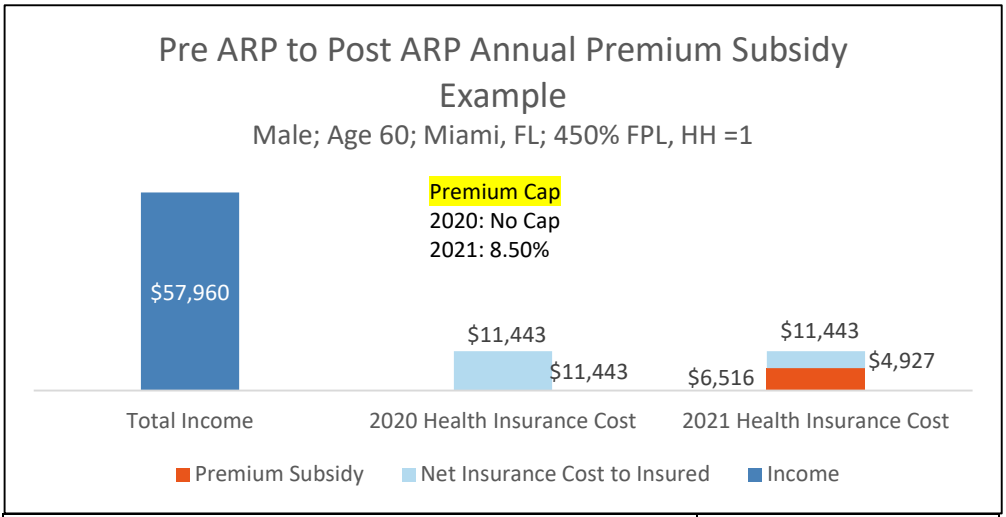
The below example shows a hypothetical premium reduction for a 30-year-old individual making 200% of the federal poverty level as well as a 60-year-old individual making 450% of the FPL using real premium market data from Miami, Florida.[16]

Chart 9. *ARP Premium Reduction Example 1: Male, Age 30, Miami, FL, Household Size 1, Income 200% of FPL*



Example Individual ARP Net Insurance Cost 2021 vs. 2020	($1,152)

Chart 10. *Premium Reduction Example 2: Male, Age 60, Miami, Florida, Household Size: 1, Income 450% of FPL*



Example Individual Net Insurance Cost 2021 vs. 2020	($6,516)

CONSIDERHealth Estimated Uninsured Reduction and Takeaways: Enhanced Premium Support 150% to 400%+ of the FPL

The below table shows the number of estimated exchange eligible in the 150% to 400%+ income bands. The estimated uninsured exchange eligible removes several million uninsured undocumented immigrants that would not be eligible for exchange health insurance.[17]

Chart 11. *Uninsured Population by Income Band*

Uninsured Makeup 2019 (#000s)

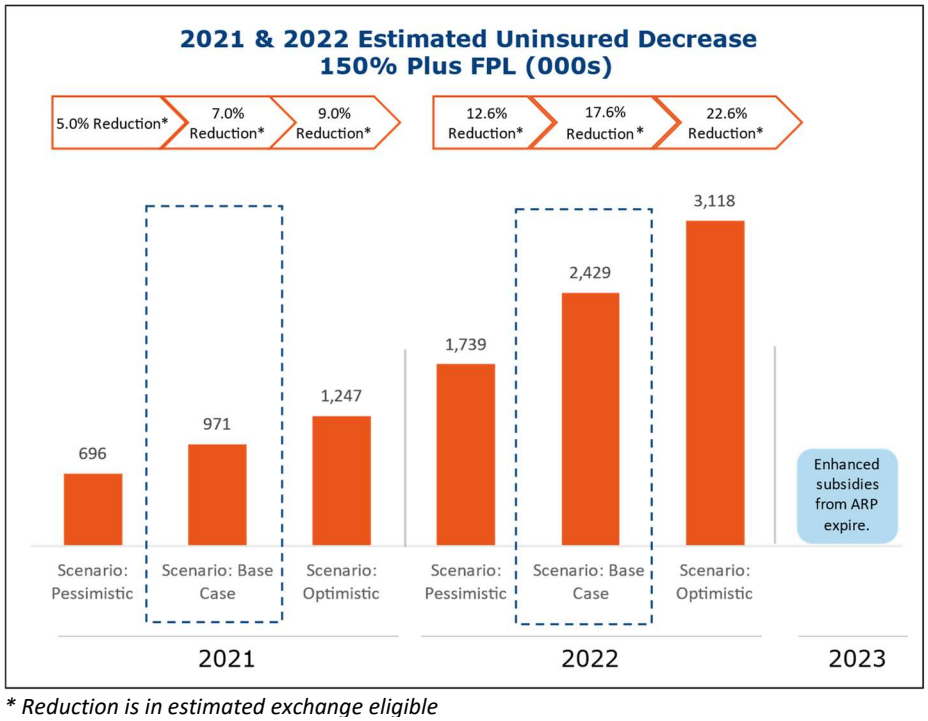
Low FPL	High FPL	Individuals in Income Band	% Uninsured	# Uninsured	Est Uninsured Exchange Eligible
0%	100%	33,879	16.0%	5,412	3,945
100%	150%	25,675	14.2%	3,637	2,665
150%	200%	25,675	14.2%	3,637	2,847
200%	300%	48,924	11.1%	5,407	4,581
300%	400%	43,078	8.3%	3,592	2,766
400%	X	146,818	3.0%	4,425	3,599
Total		324,048	8.1%	26,111	20,402

Subtotal 150% to 400%+	*264,495*	*6.3%*	*17,062*	*13,792*

Uninsured Change FPL 150% to 400% Plus

Our estimate of reductions in the uninsured from these increased payment subsidies to those making over 150% of the FPL under the base case scenario is 0.97M in 2021, 2.43M in 2022. For conservatism, we assume no reduction in 2023, as the ARP enhanced subsidies expire at the end of 2022.

Chart 12. *150% and Up Estimated Decrease in Uninsured ARP*



** Reduction is in estimated exchange eligible*

2021 Commentary – 150%+ of FPL

The model averages to a ~7.0% reduction in the exchange eligible uninsured of this income group in 2021. The 2021 reduction is made possible by the special enrollment period through August 2021. This reduction estimate is composed of two parts. Those making between 150% and 400% of the FPL and those making 400% plus of the FPL. We assume a 6% base case reduction in the 150% to 400% exchange eligible uninsured in 2021. For those that make over 400% of the FPL, the model assumes a 10% reduction. The higher reduction in the 400% plus income bracket is due to this group now being eligible for premium subsidies vs. before the ARP they were not.

Note. Unemployment and COBRA changes to the uninsured due to ARP changes are included in the estimated insured reductions for this group in 2021.

2022 Commentary – 150%+ of FPL

In 2022, the expected uninsured reduction compared to current estimates for this group jumps significantly to a base case estimate of 17.6%. This is comprised of a 15% reduction for those making 150% to 400% of the FPL from the 2019 estimated exchange eligible uninsured. For those making over 400% of the FPL the estimate is a 25% reduction in the uninsured. HHS has $80M to spend to advertise the exchanges coupled with insurers and providers adding visibility to individuals that could benefit from the enhanced premium subsidies. Further, those receiving free coverage will provide word of mouth advertising. By regular open enrollment for 2022 (November) these seeds should be sprouting. Further, there is some discussion on automatic enrollment for certain groups which would be a game changer.

2023 Commentary

The additional federal premium subsidies expire at the end of 2022. There may be some residual reduction from those that acquired fully subsidized coverage in 2022 that continue to be insured but pay the higher premium responsibility in 2023. Our guess is most will not and thus we are not estimating a continued drop in the uninsured in 2023 due to the ARP.

C. Enhanced Subsidized Premiums: COBRA and Unemployment

There are special COBRA and unemployment insurance benefits in place for 2021 only. The impact of these are factored into the uninsured estimates in 2021 in the 100% to 150% and 150% plus sections of this paper.

- **Unemployment Subsidy Change.** Full ACA healthcare exchange subsidy for those that are on unemployment for any period in 2021. Expires at the end of 2021.
- **COBRA Subsidy Change.** Federal full payment of COBRA premiums from April to Sept 2021

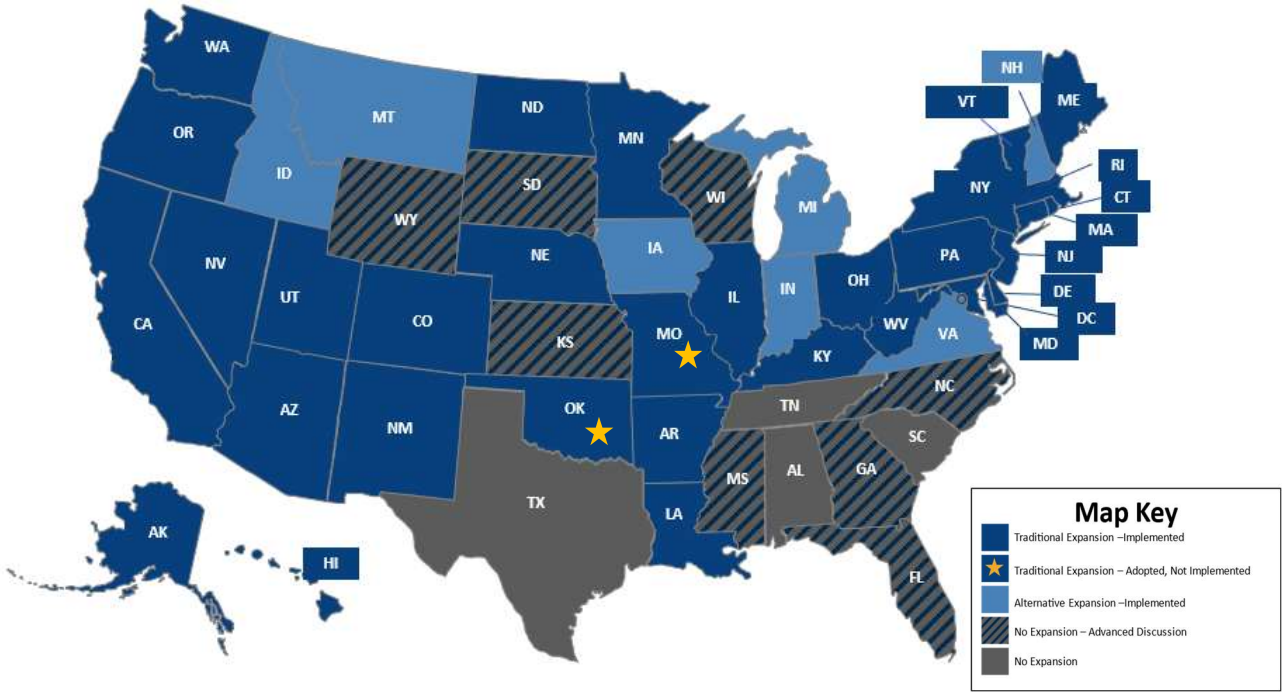
ARP - State Medicaid Expansion Enticements

The ARP provides an additional carrot to entice the remaining 12 states to expand their Medicaid eligibility up to the ACA outlined income levels. The carrot is in the form of additional federal matching funds for a state's established Medicaid population. This is on top of the enhanced FMAP for the state's incremental expansion population. The enhanced established Medicaid patient FMAP is only available for the first two years a state expands but should cover a state's expansion costs for at least 2 years.

Current Status of Medicaid Expansion by State

States have continued to expand their Medicaid populations over the past several years, with many doing so through ballot referendum. Time and again the public, whether residing in red state or blue state has shown an interest in expanding access to Medicaid.

Chart 13. *Current State Status of Medicaid Expansion*



Details for What Changes Related to State Medicaid Expansion Federal Support

A. For States that Newly Expand Eligibility, the ARP Increases Federal matching by 5% on a State's Current Medicaid Population For Two Years

Medicaid is funded partially by states and the federal government. State funding is "matched" by the federal government in the form of the Federal Medical Assistance Percentage (FMAP). Each state has a different FMAP percentage adjusted by the average per capita income of residents of that state. Less income equals a higher FMAP. For medical services, in FY21 this FMAP ranges from 56.2% in Washington to 84.0% in Mississippi.[18]

Under the ACA, the FMAP was enhanced to 90% for the newly eligible. Any Medicaid enrollees in a State's expansion group would have the federal government pay 90% of the medical services costs. Existing (current) Medicaid eligibility groups would continue to get an FMAP at the current matching (56% to 84%).

Under the ARP, for a period of two years, the federal government will increase the FMAP for a state's current Medicaid population. A state's current Medicaid population makes up an estimated ~80% of a state's total Medicaid population under expansion.[19] This may be what pushes states on the fence to expand.

Medicaid Eligibility Group	Pre ARP	Post ARP
FMAP – Pre ACA State Medicaid Eligibility	Range 56.2% to 84.0%	Pre ARP FMAP + 5% for 2 years
FMAP – Post ACA State Medicaid Eligibility	90% for 2020 and beyond	90% for 2020 and beyond

Note Children's Health Insurance Plan (CHIP) already enhanced FMAP does not change under ARP.

State Economics Considerations for Medicaid Expansion Under ARP

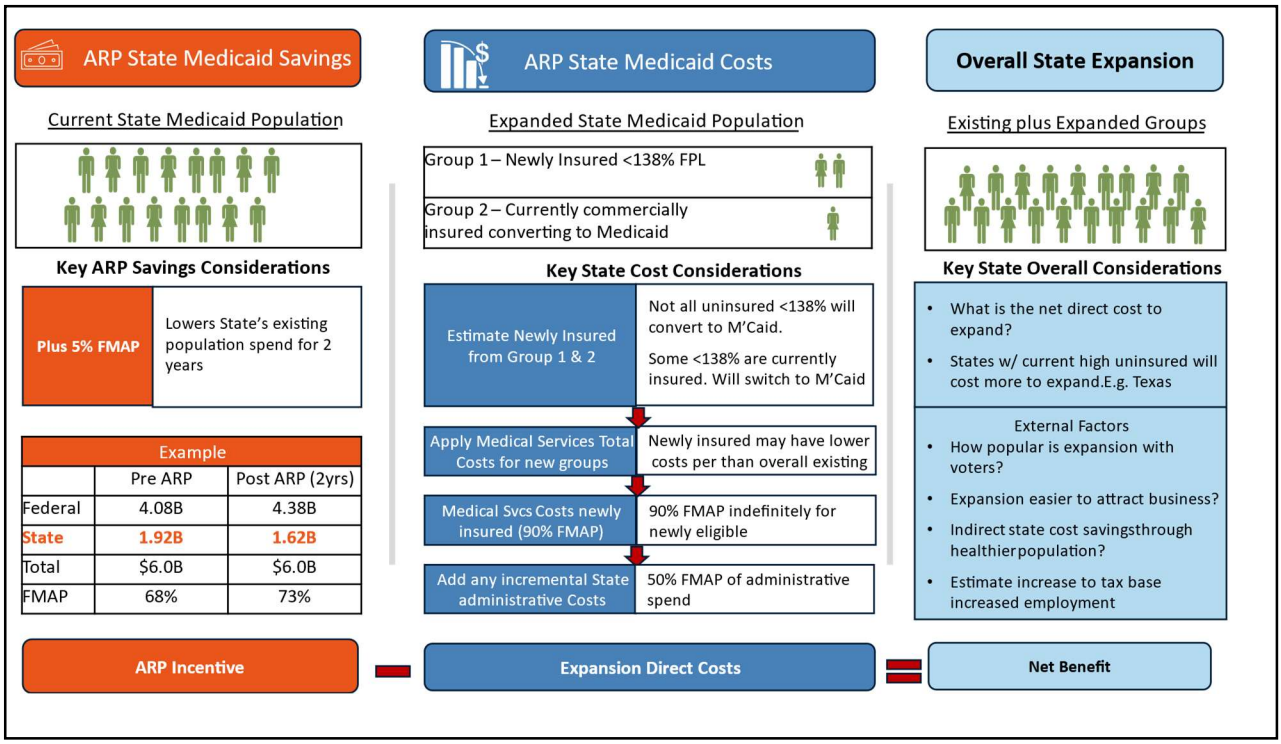
The summarized chart below shows how states will think about the Medicaid savings due to the ARP incentives balanced against the additional state costs upon expanding Medicaid eligibility.

The savings side is straight forward, with the additional 5% FMAP for two years. The cost side is more difficult to factor how many new Medicaid insured there will be and the cost of covering this new population. The number of new Medicaid insured will come from two groups. 1. Those currently uninsured now eligible for Medicaid. 2. Those that are currently commercially insured that would switch to Medicaid insurance. The total cost to cover the newly insured is complex too. There is evidence that costs per Medicaid expansion insured are less than costs per current insured. The established Medicaid population would include specialty groups like the aged, blind, and disabled which generally have much higher costs than the low-income Medicaid group.

In estimating the savings against the costs for the states that have yet to expand, the ARP incentive should be enough to pay for expansion for at least the first 2 years based on a KFF analysis[20] and supported by our own estimates. The upper bound of incentive funds covering expansion is about 5 years. The issue for states, especially those with a high number of uninsured is "where does the money come from to cover the expansion population when the ARP FMAP incentive ceases?" States like Texas will have potentially $1.5B to $2.0B dollars in annual incremental Medicaid costs if they were to expand.

Concerns of direct healthcare expansion costs will have to be weighed against external factors. Medicaid expansion has proved to be popular with voters. Further, some businesses, especially those with lower wage workers, factor in a state's Medicaid expansion into their decision on where to locate. Other state external considerations include the benefits of a healthier population and additional healthcare employment to meet the needs of the newly insured increasing the tax base.

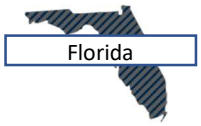
Chart 14. *State ARP Medicaid Expansion Considerations Outlined*



What States Are Most Likely to Expand?

With only 12 states left to expand their Medicaid populations (not including Oklahoma and Missouri which have adopted expansion but yet to implement) the goal of the ACA of near universal coverage for those under 138% of the poverty line has almost been realized. Of the remaining non expansion states, many of them are in advanced discussions to expand or have ballot referendums in upcoming elections. The ARP enhancement may be enough to encourage several of these remaining states to expand. Below is a quick status summary of states most likely to expand.

Chart 15. *States Most Likely to Expand Due to ARP Incentives*[21]

State	Status	Uninsured Below 138% FPL	Uninsured Below 100% FPL
	Expansion adopted now. Implementation by mid CY2021	233,298	167,300
	Expansion adopted now. Implementation by mid CY2021	224,718	162,200
	On 2022 ballot for referendum	855,752	570,600
	Partial expansion approved in Oct 20 to 100% of FPL. TBD if new ARP will entice state to fully expand to receive enhanced FMAP	494,984	344,200
	Previous expansion bill had bipartisan support but failed to pass. Discussions ongoing.	94,448	64,200
	On 2022 ballot for referendum	156,870	116,400
	Governor is pushing for expansion. Enhanced FMAP under ARP will soften cost concerns.	406,172	279,100
	Potentially will be on ballot referendum for 2022	30,034	20,800
	State already covers up to 100% of FPL. Governor pushing for full expansion but pushback from state legislators.	89,888	52,800
	House passed expansion bill in March 2021. Bill failed in Senate. Undetermined if ARP subsidies would influence.	17,190	9,400

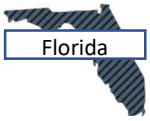
CONSIDERHealth Takeaways: Enhanced Support for State Medicaid Expansion

Uninsured Change Medicaid Expansion

We expect several states to be enticed by the additional federal matching funds available under the ARP. Although we don't expect legislation to be enacted swiftly.

In modeling the expected drop in the uninsured from Medicaid expansion, it was assumed that states that had not expanded their Medicaid populations would have similar remaining uninsured populations within the 138% FPL and below group as states that have traditionally expanded.[iv] Even under Medicaid expansion, there are some that still won't qualify or won't sign up for coverage even if they qualify. Impacts of those currently insured that could switch to Medicaid plans were not modeled as the new number of insured would not be reduced.

Chart 16. *Most likely states to expand Medicaid and expected uninsured decrease 2021 to 2023**

2021		2022		2023	
Expansion Implemented	Uninsured Decrease	Expansion Implemented	Uninsured Decrease	Expansion Implemented	Uninsured Decrease
	103,000		103,000		103,000
	126,000		126,000		126,000
					386,000
					68,000
					13,000
2	**229,000**	**2**	**229,000**	**5**	**697,000**

* Note – number may not sum due to rounding

[iv] The estimated uninsured rate for those that make under 138% of the FPL in traditional Medicaid expansion states is 11.2%. Thus, the estimate of uninsured reductions by state is the difference between the current estimated number of uninsured under 138% of the FPL and 11.2% of the total estimated population in a state that has income under 138% of the FPL.

2021 Commentary

Overall an expected 229K drop in the uninsured in 2021. The base model assumes only Missouri and Oklahoma expand in 2021 as they are already set to implement expansion in July 2021. These two states will qualify for the ARP 5% enhanced existing Medicaid population FMAP. The length of time to pass legislation to expand makes it unlikely any additional states expand in 2021.

2022 Commentary

Overall an expected 229K drop in the uninsured in 2022. Mid-term ballot referendums in Florida, Mississippi, and South Dakota are assumed all to be successful in expanding Medicaid. The modeling expansion implementation would not be until 2023.

2023 Commentary

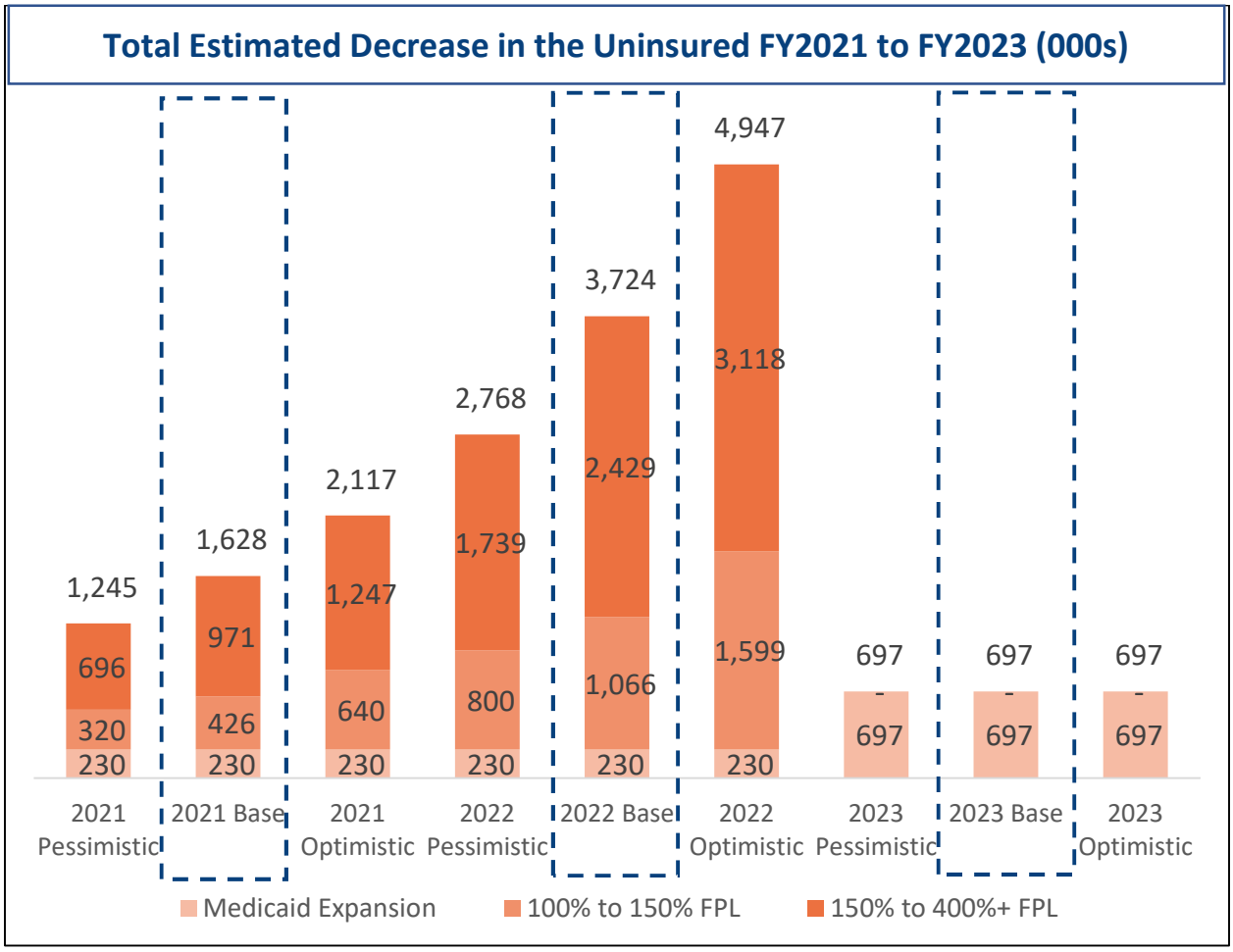
Florida, Mississippi, and South Dakota all implement their Medicaid expansion. Coupled with Oklahoma and Missouri the overall decrease in the uninsured is estimated at 697K.

Other Contributing Factors for Increases in the Insured

There are several other factors within the ARP that will contribute to households having additional disposable income the second half of 2021 through 2022. Many of these ARP provisions will temporarily change tax policy and allow for additional deductions. Further, as children go back to school, family's childcare and food costs should go down.

Other Contributing Factors for Decreases to the Uninsured			
	Child tax credit increase. $1K to 1.6K additional tax credit per child		Optionality for states to allow for 12-month post-partum Medicaid with Federal matching. Current expires after 6 months.
	Earned income tax credit expansion to young and old with no children.		$1.4K direct stimulus payment in March 2021 for qualifying individuals
	Schools and colleges reopening, reducing child-care costs		Target business support encouraging return to normal operations. Airlines, transit workers, teachers etc.

Putting it All Together. All ARP Uninsured Reductions



2021 to 2023 Commentary – All ARP Impacts

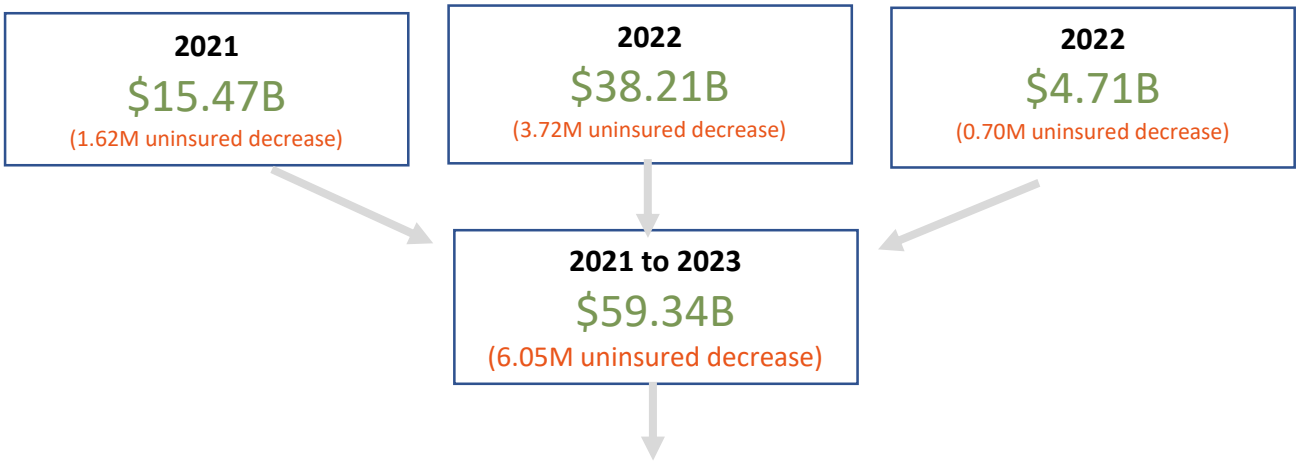
Taking all the aforementioned ARP driven estimated decreases in the uninsured yields a base case assumption there will be a **1.62M** drop in the uninsured in 2021, **3.72M** decrease in 2022, and **0.70M** decrease in 2023. These decreases are all based on the current 26.1M uninsured.

The additional exchange subsidies for those with incomes over 100% of the FPL in 2021 through 2022 will increase the high margin commercially insured. Medicaid expansion in states that expand will bring additional revenue albeit at the lower Medicaid rate. Further, uncompensated care should go down. Utilization from these newly insured will not all be incremental as emergent care needs. The expense for treating these patients that qualify for financial assistance will now be met with revenues to offset.

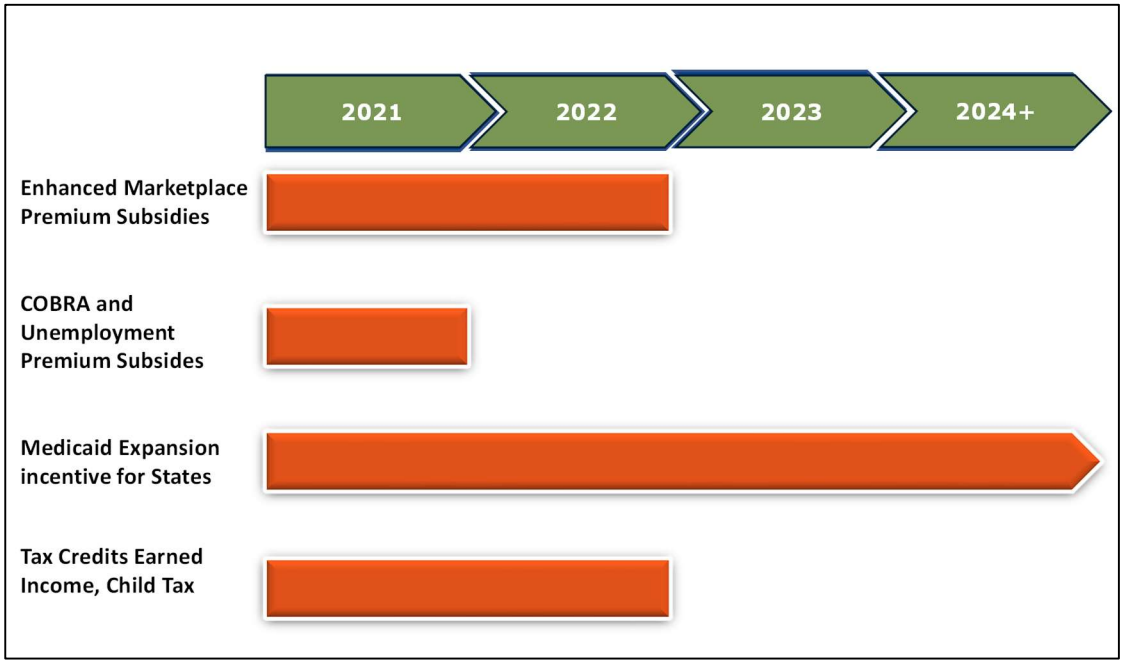
Financial Impact to Insurers and Providers

All the additional insured individuals will equal more revenues for the industry to be shared chiefly among insurers, providers, and pharmacies. We estimate the expected additional industry revenues to be:

Chart 17. *Base Care Estimated Additional Healthcare Industry Revenues from ARP*[22]



Timeline of ARP Impacts



CONSIDERHealth Takeaways: What Should Providers, Insurers and Other Industry Participants Do to Maximize Benefit?

Providers, pharmacies, and insurers have much to gain to participate in the estimated $58B in revenue generated from the newly insured through CY2023. To maximize benefit, these industry participants should address how big the newly insured market is for them and spend accordingly. This opportunity is definitely one of the times where it's a win for the patient, insurance company, and providers.

Providers, Pharmacies, Insurers, Others	
	**Based on a provider or insurer's geography, what is the potential market of insured expansion?** Additional 6M estimated reduction in uninsured from 2021 to 2023. What is the expectation for your specific market? E.g., expected Medicaid expansion state? What is uninsured makeup by FPL in your competitive market?
	**Invest marketing dollars to assist exchange subsidy awareness.** Awareness biggest hindrance in getting sizable numbers insured. Invest proportionate to addressable market
	**Engage with insurance brokers, insurance navigators, and assistors.** The more bodies helping those get coverage the better
	**Target frequent flyer uninsured populations.** One commercially insured inpatient case can generate $25K plus in revenue. Getting frequent flyers coverage can offset the cost of addressing this population's frequent care needs.
	**Lobby state for Medicaid expansion.** Highlight the enhanced ARP expansion benefits to legislators. Further, highlight the reduced number of states that have not expanded
	**Ensure additional demand for services can be met by workforce.** Have a plan to scale

Appendix

Chart 18. *FPL Estimated Uninsured Reduction by Year and Case Detail**

	Estimated Reduction in Exchange Eligible Uninsured 100%+ FPL*								
	2021			2022			2023		
FPL	Pessimistic	Base	Optimistic	Pessimistic	Base	Optimistic	Pessimistic	Base	Optimistic
100% to 150%	12.0%	16.0%	24.0%	30.0%	40.0%	60.0%	0.0%	0.0%	0.0%
150% to 400%	4.0%	6.0%	8.0%	10%	15%	20%	0.0%	0.0%	0.0%
400%+	8.0%	10.0%	12.0%	20%	25%	30%	0.0%	0.0%	0.0%

* Excludes Medicaid expansion reductions

ABOUT CONSIDERHealth

ConsiderHealth is a place to come read, learn, and share thoughts on the business of providing and consuming healthcare. ConsiderHealth's calling is to positively impact healthcare quality and payor and provider solvency. The organization does this by publishing detailed thought pieces covering new healthcare policy as well as current healthcare trends. ConsiderHealth is not afraid to have an opinion and will provide an honest account of our beliefs on what is working, what is not working, and how to improve healthcare delivery and consumption. For more information visit considerhealth.com.

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