

Impact of the American Rescue Plan Act on the Massachusetts Health Care System

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INTRODUCTION AND OVERVIEW

On March 11, 2021, President Biden signed into law the American Rescue Plan Act (ARPA) of 2021 (H.R. 1319), a wide-ranging law that will pump \$1.9 trillion into the American economy through funding to individuals, government agencies, community organizations, schools, and other entities. Some monies will go to existing programs and organizations that suffered financial losses during the pandemic or experienced a pandemic-induced surge in demand; other funds must be used to assist new people or organizations and to start new programs. ARPA includes many health-related provisions, including addressing access to and affordability of health insurance; supporting, replenishing, and expanding the health care workforce (in response to losses due to retirement, burnout, etc.); enhancing availability of mental health services and substance use treatments (referred to throughout this brief as behavioral health services); and more. ARPA also directs significant funding toward COVID-19 vaccination outreach, testing, and support for health care providers responding to the pandemic.

Like so many aspects of the health care system, many ARPA provisions interact, approaching the same goal from multiple angles or encouraging care in a more convenient or appropriate setting. For example, the law aims to improve access to behavioral health services, which it facilitates through funding school-based services, enhanced community health center behavioral health programs, mobile crisis intervention services, and other programs and services. Increased availability of school-based services could expand access to care for children *and* shift some pediatric care from other provider settings into schools. Mobile crisis intervention services are intended to reduce the use of hospital emergency departments and of police response to mental health and substance use emergencies by providing an alternative, more appropriate approach to some crises.

The health care workforce is a population of focus given that health care workers have been on the frontlines throughout the pandemic. ARPA provisions aim to give health care professionals better access to mental health care services, address burnout, improve salaries, augment a depleted workforce, and address gaps identified during the pandemic.

This issue brief reviews some of the key components of ARPA that will affect health care in Massachusetts. There is particular focus on provisions related to MassHealth, the Commonwealth's Medicaid program and Children's Health Insurance Program, and to the Health Connector, the Commonwealth's health insurance marketplace. Areas where ARPA provisions may improve racial, gender, or economic equity in health and health care are also noted. One conclusion from the research conducted to inform this brief is that Massachusetts had broad and robust services in place prior to the onset of the pandemic and the passage of ARPA. Many Massachusetts programs and providers were severely tested by the demands of COVID-19 and could surely benefit from their budgets and workforces being bolstered. Fortunately, much basic infrastructure was and is in place, which ARPA will no doubt strengthen.

PROVISIONS AFFECTING MASSHEALTH AND ITS MEMBERS

MassHealth provides health coverage for over two million residents—including children, older people with limited means, people with disabilities, and individuals and families with low incomes. ARPA includes a number of sections directed toward state Medicaid programs, allowing options for additional services and financial incentives to provide or expand them. It also includes additional funding for health care providers that serve large numbers of patients with low incomes.

12-MONTH POSTPARTUM MEDICAID COVERAGE

ARPA offers states the option of extending postpartum Medicaid coverage to one year (from the current 60 days postpartum) to enrolled people whose household income would otherwise be too high to qualify for ongoing Medicaid coverage. Extended coverage has the potential to benefit birthing parents—and indirectly, their infants—by continuing their connection to the health care system begun or strengthened during pregnancy and delivery. An ongoing connection, especially during the all-important first year after birth, is generally considered beneficial to the parent-infant pair in many ways, both measurable and not. While insurance alone cannot ensure that a member will seek care, coverage removes a significant barrier to doing so. In addition, a 2019 study reported that a significant proportion of pregnancy-related deaths (11.7 percent) occurred 43–365 days postpartum, and 62 percent of such late postpartum deaths were deemed “preventable.”¹ This makes the argument for extending postpartum coverage especially compelling.

Extending the postpartum coverage period can:

- Facilitate the potential identification and treatment of postpartum depression, a potentially serious condition, the prevalence of which is highest among Black, non-Hispanic mothers.²
- Facilitate the delivery of women-centered preventive services such as screening for high blood pressure; high cholesterol; breast, cervical, and colorectal cancers; gonorrhea and chlamydia; diabetes; HIV and human papilloma virus; substance use and misuse; obesity; and intimate partner violence.³
- Encourage and facilitate a delay in a subsequent pregnancy. Research has shown that pregnancies that start just a short interval (less than six months) after a previous birth are associated with delayed prenatal care and adverse birth outcomes, including preterm birth, neonatal morbidity, and low birthweight.⁴ Given this, it is important to identify ways to facilitate delays in subsequent pregnancies and to avoid unintended pregnancies shortly after a birthing parent has delivered a child. Unintended pregnancy is associated with inadequate prenatal care, substance use during pregnancy, and low birth weight.⁵ Massachusetts Behavioral Risk Factor Surveillance System data indicate that from 2012 to 2014, 21 percent of women 18 to 44 years of age had an unintended pregnancy and that in 2014, Black non-Hispanic and Hispanic people were 2.3 and 1.7 times, respectively, more likely than White non-Hispanic people to have an unintended pregnancy resulting in a live birth.⁶ Insurance coverage of any type does not automatically lead to effective use of birth control, but coverage does provide access to clinicians who can counsel people about healthy pregnancy spacing and prescribe reliable contraception.
- Prevent or treat causes of maternal mortality, which disproportionately affect people of color. From 2000 to 2007, Black non-Hispanic people were twice as likely to die from pregnancy-related complications compared to White non-Hispanic people.⁷ Maternal mortality, although rare in Massachusetts, is increasingly

MassHealth Financing

The MassHealth program is financed jointly by the federal government and the Commonwealth of Massachusetts. For every dollar of MassHealth spending, the Commonwealth receives at least 50 cents in federal reimbursement (called the *Federal Medical Assistance Percentage* or FMAP). Certain types of spending receive a higher reimbursement rate. To give a sense of magnitude, in fiscal year 2019 Massachusetts received \$10 billion in federal payments for MassHealth and related programs.

Source: Blue Cross Blue Shield of Massachusetts Foundation, “MassHealth: The Basics,” 2020.

associated with an indication of substance use disorder (SUD).⁸ In Massachusetts, the biennial proportion of pregnancy-associated deaths with any indication of substance use increased from 13.3 percent in 2005 and 2006 to 35.4 percent in 2013 and 2014 and is likely higher now.⁹ While a pregnant person who had regular prenatal care during their pregnancy would likely have been screened and treated for any identified SUD, it would be imperative for the birthing person (and their family) to have uninterrupted access to treatment through delivery and beyond, optimally with one consistent provider. Extended Medicaid coverage can help a person continue to receive SUD treatment after pregnancy from the same MassHealth provider they saw while pregnant.

- Improve the health of the newborn. Poor maternal health and mental health is associated with adverse child health outcomes, with implications for neonatal survival, birth weight, cognitive development, child behavior, school performance, and future costs for health care and social services.¹⁰ Research has shown that when a baby is covered by health insurance, their health is better, and they are more apt to be taken for regular checkups, preventive care, and other necessary services when their parents are also covered.¹¹

ARPA offers states the option to extend postpartum coverage through 2027.

Separately, however, Massachusetts has submitted a request to amend its Medicaid 1115 demonstration waiver to the Centers for Medicare and Medicaid Services (CMS). The amendment would make extended coverage permanent and begin the extended coverage immediately upon approval, rather than on April 1, 2022, as ARPA stipulates. Massachusetts also proposes to extend 12-month postpartum coverage to all people at or below 200 percent of the federal poverty level (FPL), regardless of immigration status.¹² Federal law bars federal Medicaid funding for certain immigrants, including those who are legally residing in the country fewer than five years and those who are undocumented. Massachusetts may choose to cover such people for the proposed postpartum extension with state-only dollars, forgoing the federal match, if the state waiver request is approved but federal match for this specific immigrant population is denied.

The Affordable Care Act gives states the option of expanding their Medicaid programs to include most residents with low incomes (below 138 percent of the FPL). These Medicaid expansion states (there are currently 39, including the District of Columbia), by covering more people under Medicaid, have lower numbers of uninsured residents than they would without the expansion.

Equity considerations. Extended postpartum Medicaid coverage can bring substantial (if sometimes difficult-to-measure) benefits to those eligible for the extension; a recent article in the *Journal of the American Medical Association* reporting on postpartum uninsured rates across states before the pandemic (Massachusetts had the lowest such rate of the 50 states) highlighted populations that are particularly disadvantaged. The article reported that individuals who are Hispanic or Indigenous, unmarried, age 35 years and older, and with less than a high school education face a greater risk of being uninsured after delivery than others. It cautions:

While the overall rates of uninsurance in Medicaid expansion states [see sidebar for more information on Medicaid expansion states] were considerably lower than in non-expansion states, the racial/ethnic disparities in postpartum uninsurance were still large in expansion states, reflecting structural inequities that persist even in states with more generous eligibility guidelines. This suggests that while extending Medicaid coverage postpartum may have some of the benefits described above, this alone will not be enough to address disparities in postpartum uninsurance by race and ethnicity, particularly if extensions do not provide options for pregnant and postpartum immigrants or attention to the specific needs of Indigenous people.¹³

ENHANCED FEDERAL FUNDING FOR MOBILE CRISIS INTERVENTION SERVICES

ARPA offers state Medicaid programs the option to provide coverage for community-based mobile crisis intervention services. These are short-term services provided by a team of qualified professionals to assess, treat, and stabilize individuals experiencing a behavioral health emergency. Such services are designed to improve care for people in crisis and to meet goals across several systems:

- To reduce the use of emergency medical services and hospital emergency departments in responding to non-life-threatening mental health and substance use crises, thereby facilitating a connection to community-based services for those experiencing a crisis.
- To reduce reliance on law enforcement in responding to behavioral crises, making the default response a health care rather than a public safety model; this would likely reduce the role of the justice system—and potential incarceration in such situations—and lower the risk of use of force that encounters between uniformed, armed police officers and people in crisis sometimes engender. Importantly, moving crisis response away from arrest and incarceration would address a serious equity issue. According to a 2020 report, “[Massachusetts] significantly outpaced national race and ethnicity disparity rates in incarceration, imprisoning Black people at a rate 7.9 times that of White people and Latinx people at 4.9 times that of White people.”¹⁴

ARPA provides incentive for states to introduce or expand mobile crisis services by offering an enhanced Federal Medical Assistance Percentage (FMAP) of 85 percent for three years of the service, beginning April 1, 2022. The services must be provided by multidisciplinary teams that include at least one behavioral health professional and are trained in trauma-informed care, de-escalation strategies, and harm reduction. The teams must be able to provide screening and assessment, stabilization and de-escalation, and coordination with health, social, and other services. The services must be available 24 hours per day, every day of the year.

Massachusetts had been at work redesigning its behavioral health system before ARPA was passed. The “Roadmap for Behavioral Health Reform,” announced in February 2021, seeks to improve access to outpatient behavioral health care and “ensure the right treatment when and where people need it.”¹⁵ A component of the Roadmap is the creation of a community-based crisis response system that reduces reliance on hospital emergency departments. Central to this goal is the development of regional crisis systems, embedded within new Community Behavioral Health Centers, and a single, multilingual “front door” access system to connect people seeking care to all behavioral health services.¹⁶ The crisis services will build on services currently offered through MassHealth managed care organizations: the Emergency Services Program (ESP) for adults and Mobile Crisis Intervention (MCI) for children and youth up to age 20. These programs have been operating in their current form since 2009, with the goal of offering community-based alternatives to emergency departments. In state fiscal year (FY) 2019, there were 80,226 ESP service encounters across 21 providers and 26,755 MCI encounters.¹⁷

Massachusetts clearly shares the intention of the federal law to improve access to and continuity of mental health and substance use services. Because ARPA requires that the 85 percent enhanced FMAP be used to supplement rather than supplant existing services, the Commonwealth is assessing how it might apply the incentive to the improvements envisioned in the Roadmap.

Equity considerations. Broader access to crisis response services is an issue for the entire population but is of particular concern for people of color. Among all adults in the United States with a diagnosed need for behavioral health care, only 22 percent of Latinx people and 25 percent of Black people receive treatment, compared with 38 percent of White people.¹⁸ And opioid overdoses in Massachusetts continue to be a grave problem for all; in 2020 the opioid-related death rate for Hispanic males was 57.9 per 100,000 population, 55.1 for Black non-Hispanic males, and 46.4 for White non-Hispanic males. The opioid overdose death rate was significantly lower for females.

ENHANCED FEDERAL FUNDING FOR HOME AND COMMUNITY-BASED LONG-TERM SERVICES AND SUPPORTS

ARPA offers an opportunity for states to increase their usual FMAP by 10 percentage points for expenditures on Home and Community-Based Services (HCBS). States may claim the additional FMAP on services delivered from April 1, 2021, through March 31, 2022, that enhance, expand, or strengthen HCBS beyond what was available under the Medicaid program as of April 1, 2021.¹⁹ The additional federal funds claimed during this one-year period may be used for HCBS enhancements until March 31, 2024, to allow states to plan longer term strategies for sustaining promising and effective HCBS programs. Massachusetts anticipates it will receive approximately \$500 million in additional federal funds under this ARPA provision.²⁰

Services eligible for the additional funding include certain home health care, personal care services, case management, school-based services, rehabilitation services, and private duty nursing.²¹ HCBS are used by those MassHealth members who are older adults and by individuals who have physical, intellectual, or developmental disabilities. While financed by MassHealth, the services may be administered by another Massachusetts Executive Office of Health and Human Services (EOHHS) agency.²² These services allow many people to continue to live in their own homes rather than in more expensive and restrictive nursing facilities, to maintain employment, and to participate in their families and communities. Over 320,000 individuals receive HCBS and over three-quarters of MassHealth expenditures for long-term services and supports (LTSS) go toward HCBS.²³

CMS requires states to file spending plans to document how the funds are to be used. To inform its spending plan, Massachusetts issued a request for information (RFI) on April 16, 2021. The RFI asked respondents to suggest how MassHealth should make use of the enhanced funds in four broad topic areas:

1. Access to services and supports
2. Technology and infrastructure investments to strengthen HCBS
3. Initiatives to promote HCBS
4. HCBS workforce development, including recruitment and retention strategies

There were over 200 responses to the RFI, from service providers and associations, advocates, worker representatives, family members and caregivers, health plans, and others. The responses included recommendations in all four areas; the majority addressed either workforce (67 responses) or access to services (69 responses).²⁴

Massachusetts' resulting spending plan, announced on June 17, 2021, envisions three rounds of spending. Round 1 will implement \$100 million in payment enhancements to HCBS providers from July through December 2021. The payments are intended to strengthen and stabilize the workforce and will come with the requirement that at least 90 percent of the funds associated with these time-limited rate enhancements be targeted to the direct care workforce for things such as hiring and retention bonuses.²⁵ The workers to whom the funding would apply include those who provide these services:²⁶

- Home health services
- Durable medical equipment
- Continuous skilled nursing
- Personal care services
- Adult foster care/group adult foster care
- Program of All-Inclusive Care for the Elderly (PACE)
- HCBS waiver services²⁷
- Targeted case management
- Day habilitation services
- Rehabilitative services

Massachusetts announced Round 2 of its spending plan in July 2021. The plan proposes to invest about \$44 million in programs focused on diverting individuals from facilities and supporting transitions to HCBS. The investments include:²⁸

- Addition of 150 slots in the **Moving Forward Plan—Community Living (MFP-CL) waiver program**, over and above the MFP-CL waiver’s planned slot growth. The MFP-CL waiver supports individuals with disabilities to transition from facilities to their own or someone else’s home in the community.
- An **in-home crisis intervention program** for youth in crisis and their families, to support diversion from emergency departments and hospitals.
- Enhancements to the Commonwealth’s **pre-admission screening and resident review (PASRR)**, to ensure that people with serious mental illness receive services in the least restrictive setting possible.
- Short-term rate enhancements to **PACE** organizations, for infrastructure and capital improvements to support expansion into underserved areas; PACE is an interdisciplinary program for people 55 and older who are certified as eligible for nursing facility care, to allow them to live safely in their homes.
- Intensive hospital discharge **planning for MassHealth members without homes or with unstable housing**, to better connect members with community-based organizations and immediately establish their HCBS package.
- Development of an **online, person-centered self-service HCBS application** prototype.
- **Power wheelchair repair loaner program.**
- Creation of an **electronic directory of Continuous Skilled Nursing providers** for MassHealth members with complex care needs in the Community Case Management program.

Round 3 of the spending plan will address larger scale system enhancements in the three broad areas of (1) access to and promotion of HCBS, (2) technology and infrastructure, and (3) workforce. In its initial plan, Massachusetts described plans to use some of the federal funds to promote awareness of HCBS, with a focus on initiatives that support planning and navigation of the HCBS system. Examples of potential initiatives include a centralized “front door” to HCBS, training programs for inpatient providers, investment in residential care coordinators, community supports for transitioning individuals out of facility-based settings, diversion from facility-based care, and enhanced community-based care models such as “hospital at home” and “rehab at home” and expanded family caregiver supports.²⁹

Massachusetts will use federal funds for further HCBS technology and infrastructure improvements. Envisioned potential initiatives include developing a comprehensive HCBS webpage to search for services, pre-screen for possible eligibility, and connect with providers; creating a data exchange infrastructure to improve coordination across EOHHS agencies that serve the same individuals; giving community-based organizations access to admission and discharge data to facilitate smooth transitions; and establishing a public dashboard to report who is using HCBS and the quality of the services they receive.³⁰

Further workforce investments may include pipeline programs to increase the pool of people coming into direct care professions, training programs (e.g., to promote language skills and career pathways), childcare and transportation supports for direct care workers, loan repayment incentives, and employer-workforce partnerships such as in-home clinical placements for nursing students.³¹

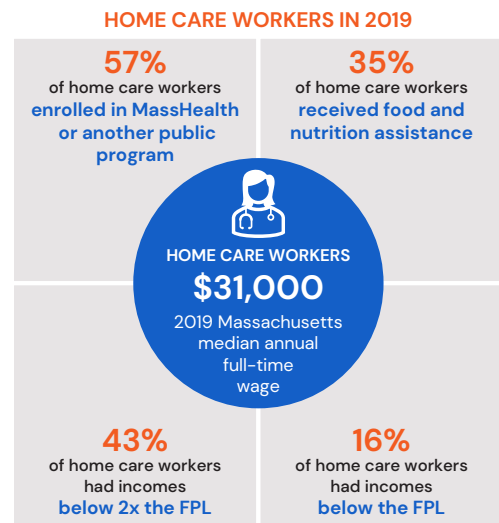
Further detail is available in the initial spending plan.³² EOHHS plans to refine its plans, with input from HCBS stakeholders, through the summer and fall of 2021.

Equity considerations. The Round 1 spending, which will put at least \$90 million into compensation for HCBS workers, is important for several reasons. First, increasing pay for home care occupations also addresses important gender and racial equity issues. Home care workers are overwhelmingly women and disproportionately people of color. In 2017, seven out of every eight home care workers nationally (88 percent) were women. Twenty-eight percent of women home care workers were Black, compared with 13 percent in the U.S. workforce overall, and 22 percent were Hispanic, compared with 16 percent in the entire workforce.³³ One recent report suggests that home health aides are among the top 10 occupations in the metro Boston area projected to add the most workers of color to the workforce from 2020 to 2030.³⁴

Second, this is a low-paid workforce: The median wage for home care workers in Massachusetts in 2019 was \$15.21 per hour, about \$31,000 per year for full-time work. Sixteen percent of home care workers had incomes below the FPL in 2019, and 43 percent were below two times the FPL, an annual salary of \$24,300 for an individual. More than half (57 percent) of home care workers had health insurance through MassHealth or another public source, and more than a third (35 percent) received food and nutrition assistance in 2019.³⁵ Additional wages will allow home care workers to pay for needed goods and services and therefore also provide a stimulus to local economies.

The demand for HCBS is high and is expected to grow. In the short term, as pandemic-related restrictions phase out and programs for people with disabilities reopen, there likely will not be enough home care workers to meet demand.³⁶ For the long term, as life expectancy increases, so will the demand for care. The need for personal care aides and home health aides in Massachusetts is projected to grow about 20 percent from 2018 to 2028.³⁷ Both of these trends suggest the need for higher pay to facilitate the growth of a qualified, stable workforce.

These ARPA-funded increases are time limited, however, and sustaining the higher level of wages is not guaranteed. This issue was on the minds of participants on a conference call about the use of ARPA funds for HCBS and behavioral health that EOHHS hosted on June 8, 2021. EOHHS acknowledged the challenge and stressed that its immediate focus was on supporting the HCBS workforce coming out of the pandemic.³⁸ The June spending plan states that investments in Rounds 2 and 3 will focus on using the one-time and time-limited funds to support initiatives with “long-term, structural impact.”³⁹



COMMUNITY HEALTH CENTER FUNDING

ARPA makes additional federal funding available to community health centers (CHC)⁴⁰ to “support and expand COVID-19 vaccination, testing, and treatment for vulnerable populations; deliver needed preventive and primary health care services to those at higher risk for COVID-19; and expand health centers’ operational capacity during the pandemic and beyond.”⁴¹ In Massachusetts, 36 health centers, plus the Massachusetts League of Community Health Centers, received \$147 million in ARPA awards.⁴² According to the law, the CHCs may use this funding to:

- Plan, prepare for, promote, distribute, administer, and track COVID-19 vaccines, and carry out other vaccine-related activities.
- Detect, diagnose, trace, and monitor COVID-19 infections and related activities necessary to mitigate the spread of COVID-19.
- Purchase equipment and supplies to conduct mobile testing or vaccinations for COVID-19, purchase and maintain mobile vehicles and equipment to conduct such testing or vaccinations, and hire and train

laboratory personnel and other staff to conduct such mobile testing or vaccinations, particularly in medically underserved areas.

- Establish, expand, and sustain the health care workforce to prevent, prepare for, and respond to COVID-19, and to carry out other health care workforce-related activities.
- Modify, enhance, and expand health care services and infrastructure. *Note: this item is not explicitly tied to the COVID-19 response and therefore seems to present an opportunity for CHCs to apply some funding to general improvements.*
- Conduct community outreach and education activities related to COVID-19.

Equity considerations. Massachusetts' 52 CHCs served over 800,000 patients across 261 delivery sites in 2019. Most CHC patients have low incomes—84 percent have income below twice the FPL, and two-thirds are members of groups that are racially and ethnically marginalized. About half of CHC patients are MassHealth members.⁴³

People of color are disproportionately represented in CHCs' patient populations and those populations can benefit from concerted efforts to prevent, detect, and vaccinate against COVID-19. The rates of infection among Latinx and Black Massachusetts residents have been disproportionately high,⁴⁴ owing primarily to the disproportionate representation of these groups in higher risk occupations (such as food service workers) and living situations that offer less protection against the virus.⁴⁵ In addition, take-up of the vaccine by Black and Latinx residents has been slower than the population overall,⁴⁶ probably due to a combination of access barriers, insufficient outreach, and a hesitant approach to the vaccine within these communities, rooted in current and historical distrust of the health care system as a result of past harms and inequities in care. CHCs are in and of the communities they serve and are in a good position to help close these gaps through outreach, education, and service to their patients.

ADDITIONAL PROVISIONS: HEALTH INSURANCE, COVID-19, SERVICES, WORKFORCE, AND MORE

HEALTH INSURANCE

Health insurance is one of the most important factors influencing access to health care. Massachusetts already has the highest level of health insurance coverage in the country, though there are inequities in coverage along racial and ethnic lines.⁴⁷ In Massachusetts, as in the rest of the country, most non-elderly people get their health insurance through an employer—either their own or a family member's.⁴⁸ With the pandemic-related loss of millions of jobs, many lost their health insurance.⁴⁹ While the economy rebuilds and people gradually return to work, several provisions in ARPA make health insurance from other sources—specifically, health care marketplaces and post-employment continuation of employer coverage—more accessible and affordable.

Marketplaces

Health care marketplaces were created in 2010 by the Affordable Care Act (“Obamacare” or the ACA). Massachusetts' marketplace is called the Health Connector.⁵⁰ The Health Connector offers health insurance options to people who cannot afford or are not offered employer-sponsored coverage and are not eligible for programs such as MassHealth or Medicare. Individuals in lower income ranges qualify for premium subsidies to help them purchase health insurance through the Health Connector. ARPA makes Health Connector plans more affordable in several ways:

More generous subsidies (through 2022)

Under the ACA, an individual qualifies for a premium subsidy if the cost of a “benchmark” insurance plan in their area exceeds a certain percentage of their income. For people with low and moderate incomes, Massachusetts adds a supplemental subsidy to the federal subsidy, further reducing the percentage of income someone would be expected to pay.

ARPA further lowers the percentage of income people are expected to pay for insurance in 2021 and 2022 by increasing subsidies, thus making insurance more affordable. In Massachusetts, the result is that many people with income below 400 percent FPL purchasing insurance through the Health Connector will see lower premiums as a result of these subsidies. And the maximum percentage of income anyone purchasing through the Health Connector will have to pay is 8.5 percent for a benchmark plan; prior to ARPA, there were no subsidies available for individuals with income over 400 percent FPL.

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

TABLE 1. EXPECTED PREMIUM CONTRIBUTIONS BY INCOME PRE- AND POST-ARPA

Income Relative to FPL*	Lowest Cost Health Connector Premium, Pre-ARPA (% of Income)	Expected Premium Contribution for a Benchmark Plan (with Federal Subsidy) under ARPA (% of Income)	Expected Premium Contribution for a Benchmark Plan (in \$) for an Individual in Massachusetts under ARPA
Less than 133%	0%	0%	\$0
Less than or equal to 150%	0%	0%	\$0
Less than or equal to 200%	2.2%–2.9%	0%–2.0%	\$0–\$43
Less than or equal to 250%	3.4%–4.2%	2.0%–4.0%	\$43–\$107
Less than or equal to 300%	4.2%–5.0%	4.0%–6.0%	\$107–\$161
Less than or equal to 400%	9.83%	6.0%–8.5%	\$193–\$365
Over 400%	Not Eligible	8.5%	8.5% of income

*FPL = Federal Poverty Level = \$12,880 for an individual in 2021.

Source: Massachusetts Law Reform Institute, “What does the American Rescue Plan Act Mean for Affordable Health Coverage and Enhanced Medicaid services in Massachusetts?” March 2021.

More people eligible for subsidies (through 2022)

The ACA limited premium tax credits to people with income below four times the FPL (or \$51,500 annual income), regardless of whether available insurance was considered affordable relative to income. ARPA lifts this restriction, so that anyone for whom the benchmark premium exceeds 8.5 percent of income can receive a premium subsidy. In addition to benefitting higher income people, this particularly benefits older residents (not enrolled in Medicare) who purchase coverage through the Health Connector but did not previously qualify for subsidies. With the 8.5 percent cap now in place through the end of 2022, there are opportunities for significant premium savings, particularly for older people (since insurers can use age as a factor in rating premiums), purchasing insurance in the individual, unsubsidized market.⁵¹

Early impacts of these changes are apparent. In May 2021, Health Connector clients experienced average reductions of 31 percent in their premium contributions ranging from 7 to 55 percent, depending on income level and plan type.

TABLE 2. AVERAGE PREMIUM SAVINGS BY INCOME UNDER ARPA THROUGH THE HEALTH CONNECTOR

	ConnectorCare Program Type (0–300% FPL*)					300–400% FPL (“APTC-only”†)	
	Plan Type 1: 0–100% FPL	Plan Type 2A: 100.1–150% FPL	Plan Type 2B: 150.1–200% FPL	Plan Type 3A: 200.1–250% FPL	Plan Type 3B: 250.1–300% FPL	APTC-only in April	\$0 APTC in April—newly eligible in May
Number of April enrollees	15,100	32,400	59,900	51,800	35,000	17,800	3,600
April enrollee contribution	\$2.68	\$7.44	\$57.47	\$105.65	\$152.22	\$263.71	\$341.76
May enrollee contribution	\$2.48	\$5.79	\$25.71	\$74.75	\$133.77	\$198.51	\$257.19
\$ savings	\$0.19	\$1.66	\$31.76	\$30.90	\$18.44	\$65.20	\$84.57
% savings	-7%	-22%	-55%	-29%	-12%	-25%	-25%

*FPL = Federal Poverty Level = \$12,880 for an individual in 2021.

†APTC = Advanced Premium Tax Credit.

Source: Gasteier, Audrey Morse, “American Rescue Plan Implementation Update,” presentation to the Health Connector Board of Directors, May 13, 2021. “APTC” + Advanced Premium Tax Credit, i.e., federal subsidy with no additional state subsidy.

The Commonwealth will also benefit from this change. Because Massachusetts has been providing a supplemental subsidy to Health Connector clients, a significant impact of ARPA will be to reduce these state outlays. The Health Connector anticipates that it will save approximately \$81 million in the first year while the enhanced federal subsidies are in effect.⁵² This amount may increase if enrollment in ConnectorCare increases following the end of the public health emergency. State subsidies are paid from the Commonwealth Care Trust Fund, a dedicated fund used for this and other health care purposes.⁵³ The ARPA-related savings will result in unspent funds in the Trust Fund and are therefore presumably available for other related purposes.

No or low premium if received unemployment compensation (2021 only)

In addition to increasing premium tax credits and expanding the population eligible for them, ARPA also makes special provisions for people who have recently lost their jobs. Any individual who received unemployment compensation for at least one week in 2021 is considered to be in the lowest income tier for purposes of calculating a premium subsidy for the remainder of 2021. This means that those who were already purchasing coverage through the Health Connector and others who newly enroll following a layoff and unemployment claim may purchase health insurance coverage for a minimal amount, newly qualifying for ConnectorCare Plan Type 2A, with premium options as low as zero dollars.

As Table 2 above shows, many of the 215,000 people currently enrolled in insurance plans through the Health Connector will benefit, to a greater or lesser extent, from the ARPA enhancements. The increased subsidies may also attract more enrollees, particularly after the Maintenance of Effort (MOE)⁵⁴ provision—which effectively serves as a freeze on MassHealth disenrollments—is lifted. The MOE was put in place as part of the pandemic emergency response. And, while Massachusetts has the lowest percentage of uninsured residents in the nation, the levels of uninsurance among non-White and Hispanic populations are higher. In 2019, 2.8 percent of Asian and Asian American Massachusetts residents, 4.9 percent of Black residents, and 5.5 percent of Latinx residents did not have health insurance, compared with 2.4 percent of White residents.⁵⁵ The Health Connector estimates that thousands of uninsured people of color (13,000 Asian, 24,000 Black, and 46,000 Latinx) could be eligible for the enhanced premium subsidies for incomes under 400 percent FPL, or newly eligible for subsidies if their incomes exceed that level.⁵⁶ In addition to helping individuals and their families, increasing the level and stability of insurance coverage also benefits insurance carriers, which receive new premium revenue, and health care providers, particularly hospitals, which can receive payment for delivering care to patients that might otherwise be uncompensated.

ARPA also appropriates \$20 million to assist state-based marketplaces in implementing the changes required to operationalize the new subsidy schedule. The Health Connector submitted a grant request to cover approximately \$1 million of implementation costs for this purpose.

COBRA

COBRA⁵⁷ is a provision of federal law that allows employees leaving their jobs to continue coverage by their employer-sponsored plan for up to 18 months by paying 102 percent of the premium. This can be an attractive—albeit expensive—option for people who have received coverage through their employer and may not be eligible for a public program or subsidized insurance in an ACA marketplace. ARPA offered a full subsidy of premiums for COBRA continuation coverage through September 30, 2021. While this was a generous benefit, it was extremely time limited, and the extent to which it will be used is unclear. In Massachusetts, the Health Connector began a special enrollment period beginning on October 1, 2021, for people coming off COBRA coverage who are interested in enrolling in one of its plans.^s

ADDITIONAL SECTIONS

Several other sections of ARPA will have an impact on health and health care, primarily by adding funding to existing programs. There is a focus on behavioral health of the population at large and of health care providers, as well as on replenishing and building the health care workforce, with an emphasis on underserved areas and populations. Table 3 summarizes the most significant of these provisions. In most cases, the amount and use of the funds in Massachusetts have not been finalized or yet made public.

General recovery funds. In addition to allocating funding that increases targeted programs or incentivizes certain policy changes, ARPA allocates a large sum of money as “State and Local Fiscal Recovery Funds.”⁵⁸ ARPA appropriates about \$195 billion to help states recover from the economic impacts of the COVID-19 public health emergency; states have broad latitude in how they may use the funds. Massachusetts will receive about \$5.3 billion out of this appropriation, equivalent to 8.4 percent of its total state expenditures in FY2020.⁵⁹ How Massachusetts will use its allocation is now under discussion among the governor and members of the legislature, but it is likely that some of these funds will have some impact on the health of Massachusetts residents and the health care system, either directly or indirectly. One potential use, proposed by the governor, is to increase affordable housing, an important health-related social need. There may be further investments in caregiving services, health care workers, and health equity.⁶⁰ The disposition of these recovery funds will be determined through a political process, which, given the amount in question, will garner much attention and participation. The importance of health care to the Massachusetts economy, though, points to an outcome that will likely include further sizable health-related investments.

TABLE 3. ADDITIONAL HEALTH AND HEALTH CARE SECTIONS IN ARPA

	SUBJECT (SECTION)	POPULATION SERVED	PRIMARY USE OF FUNDS	NEW OR ADDITIONAL ARPA FUNDING (NATIONAL AMOUNT)
Increased Federal Funding for Services				
Behavioral Health—All Ages	Community mental health services block grants (Section 2701)	Adults with a serious mental illness and children with a serious emotional disturbance	Provides additional funding for block grants to states for community mental health services.	\$1.5 billion
	Block grants for prevention and treatment of substance use disorders (Section 2702)	People with substance use disorder	Provides additional funding for various grants to states and programs to prevent and treat substance use disorders.	\$1.5 billion
	Community-based local substance use disorder programs (Section 2706)	People with substance use disorder	Grants for overdose prevention programs, syringe services programs and other harm reduction measures. Grants made to states; local, tribal, and territorial governments; tribal organizations; nonprofit community-based organizations; and primary care and behavioral health organizations.	\$30 million
	Community-based funding for local behavioral health needs (Section 2707)	All residents with behavioral health needs	Grants to address community behavioral health needs worsened by the COVID-19 emergency. Grants made to state, local, tribal, and territorial governments, tribal organizations, nonprofit community-based entities, and primary care and behavioral health organizations.	\$50 million
	Expansion of Certified Community Behavioral Health Clinics (Section 2713)	All residents with behavioral health needs	Grants to expand Certified Community Behavioral Health Clinics (there are 14 CCBHCs in Massachusetts ⁶¹).	\$420 million
Behavioral Health—Children & Youth	National Child Traumatic Stress Network (Section 2708)	High risk or medically underserved populations that experience violence-related stress	Grants, contracts, and cooperative agreements to public and nonprofit private entities, and Indian tribes and tribal organizations , to prevent long term consequences of child trauma by providing early intervention services and treatments.	\$10 million
	Youth suicide prevention grants (Section 2710)	Children and youth, higher education students	Grants to states, tribal organizations, schools, private nonprofit organizations, and other entities for development and implementation of youth suicide early intervention and prevention strategies.	\$20 million
	Statewide or regional pediatric mental health care telehealth access (Section 2712)	Children with mental health needs	Grants to states, political subdivisions of states, and Indian tribes and tribal organizations to support the development and improvement of statewide or regional pediatric mental health care telehealth access programs.	\$80 million
Veterans	Veterans Community Care (Section 8002)	Veterans	Funding for health care providers for coordination of hospital care, medical services, and extended care services delivered to veterans.	\$4 billion
	State Veterans' Homes (Section 8004)	Veterans residing in state extended care facilities	Grants to states to support operational needs to residential facilities providing nursing and domiciliary care to veterans (Massachusetts operates two such facilities).	\$250 million

continued

	SUBJECT (SECTION)	POPULATION SERVED	PRIMARY USE OF FUNDS	NEW OR ADDITIONAL ARPA FUNDING (NATIONAL AMOUNT)
Increased Federal Funding for Services <i>(continued)</i>				
Native Americans	Indian Health Service (Section 11001)	American Indians/ Alaskan Natives	Directly funds the Indian Health Service (IHS) to address the impacts of the COVID-19 pandemic, including increasing mental health and substance use disorder prevention/treatment, improving health IT, addressing Native community sanitation issues, and replacing lost third-party medical billing reimbursements (e.g., private insurance, Medicaid, Medicare) to ensure IHS facilities can maintain operations.	\$6.1 billion (Only a very small portion of this funding would come to Massachusetts, which has one IHS clinic and a relatively small number of people eligible for IHS services.)
	Workforce			
Public Health	Public health workforce (Section 2501)	All residents	Hiring and training case investigators, contact tracers, social supports, Community Health Workers, etc. to “prevent, prepare for, and respond to” COVID-19. Also can be used for Personal Protective Equipment, data management and technology, and other necessary supplies. Grants to states, localities, territories.	\$7.66 billion
	Volunteer Medical Reserve Corps (Section 2502)	All residents	Medical Reserve Corps responds to public health emergencies. Funding to state, local, and tribal medical corps programs. Massachusetts’ chapter (Medical Reserve Corps of Massachusetts) is soliciting volunteers for COVID-19 response: 35 units in Massachusetts, coordinated by Massachusetts Department of Public Health.	\$100 million
Health Professionals & Paraprofessionals	National Health Service Corps (Section 2602)	Underserved communities	Scholarships and loan repayment to primary health care professionals to work in underserved settings. Massachusetts has 65 federally designated primary care Health Professional Shortage Areas, ⁶² including community health centers, low-income communities, and correctional facilities.	\$800 million
	Nurses Corps (Section 2603)	Underserved communities	Scholarships and loan repayment to nurses who agree to serve at least two years in areas with nursing shortages, or as faculty in a nursing school.	\$200 million
	Teaching health centers (Section 2604)	Community health centers and their communities	Payments to health centers to establish or expand graduate medical education (GME) residency training programs. Currently, one health center in Massachusetts—the Greater Lawrence Family Health Center—is a Teaching Health Center. ⁶³ Additional funding means other health centers have an opportunity to train physicians to work in a community primary care setting.	\$330 million
	Training to improve mental health of health care professionals (Section 2703)	Health care professionals	Grants or contracts to health profession schools, governments, and other public and nonprofit entities for training in evidence-informed strategies for reducing and addressing suicide, burnout, mental health conditions, and substance use disorders among health care professionals.	\$80 million

continued

	SUBJECT (SECTION)	POPULATION SERVED	PRIMARY USE OF FUNDS	NEW OR ADDITIONAL ARPA FUNDING (NATIONAL AMOUNT)
Workforce <i>(continued)</i>				
Health Professionals & Paraprofessionals <i>(continued)</i>	Mental health awareness campaign (Section 2704)	Health care professionals	CDC-led education and awareness campaign to encourage recognition of risk factors among health professionals and prevention of behavioral health conditions.	\$20 million
	Grants for providers to promote mental health among their health professional workforce (Section 2705)	Health care professionals in rural and medically underserved communities	Grants to provider associations and federally qualified health centers to establish, enhance, or expand evidence-informed programs or protocols to promote mental health among their providers, other personnel, and members.	\$40 million
	Behavioral health workforce education and training (Section 2711)	Students in behavioral health professional and paraprofessional training programs	Grants to institutions that place graduates in areas of high need , for behavioral health education and training that promotes understanding of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations	\$100 million
Temporary Increase in Federal Benefit				
Nutrition Assistance	Supplemental Nutrition Assistance Program (SNAP) (Section 1101)	All eligible residents	15 percent increase in monthly benefit to families through Sept. 30, 2021; state administrative expenses for management and oversight.	\$1.15 billion
	Increase in Women, Infants, and Children (WIC) benefit (Section 1105)	Women, infants, and children	Increase of up to \$35 in the cash-value voucher in the Special Supplemental Nutrition Program for WIC , through Sept. 30, 2021.	\$490 million

CONCLUSION

ARPA makes available an unprecedented amount of largely one-time or time-limited funds designed to accomplish many things, both broad and more specific to health and health care:

- Replenishing depleted state resources that were tapped to address urgent needs stemming from the COVID-19 pandemic.
- Jumpstarting stalled state economies by directing dollars to eligible state residents to help pay for necessities such as rent, utilities, food, and other items usually purchased locally.
- Increasing funding for and access to historically underfunded health services such as mental health care, substance use treatment, and public health monitoring, to meet the dramatic increase in demand during the pandemic and its aftermath.
- Supporting the physical and mental health of first responders, direct care providers, and others while also rebuilding the ranks of those workforces.
- Encouraging policy innovation in longstanding areas of concern such as postpartum care, behavioral health crisis care, community-based mental health, and substance use treatment.
- Beginning to address wage inadequacies in the direct care workforce and other essential health care workers.
- Improving the affordability of health insurance for people who need to purchase coverage on their own.

States, localities, and non-governmental organizations in line to receive ARPA funds are all acutely aware of the aid's temporary nature. While the hope is that some provisions may, in time, be made permanent, there certainly is no guarantee, so consideration of how to create long-lasting impact from a short-lived funding surge is warranted. Some questions policy and program planners might consider include:

- How will the impacts further goals of improving racial equity and access to services for all?
- How will the specific policy choices related to ARPA affect individuals most in need and areas where disparities and inequities are greatest, either directly or indirectly through institutions and organizations?
- How will behavioral health policy and funding advance the state's behavioral health delivery system goals specified in the Roadmap for Behavioral Health Reform? More specifically, will changes likely decrease the presence of those with serious mental illness and/or SUDs in the state's jails and prisons? Will the results likely reduce the racial disparities among those entering the state's jails and prisons?
- How will clients and patients of services benefiting from ARPA funds be likely to perceive or report improvements in care access and quality?
- How will initiatives help create a viable career path for lower-income workers entering health care professional and paraprofessional fields?
- How will the effects of a funding or policy change be measurable, either qualitatively (e.g., improved reported well-being or quality of life) or quantitatively (e.g., increases in HCBS workforce hiring and retention)?
- Do particular ARPA funding increases or policy changes have a path to sustainable funding by state, local, or commercial means if they are found to be effective?

While serving its short-term purpose of "rescue," ARPA also presents opportunities for lasting improvements in health care delivery, health status, and health equity. Policymakers and all who desire these improvements should seize ARPA's opportunities.

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