



Building on Our Foundation: An Agenda for Stabilizing the ACA Marketplaces and Improving Coverage and Affordability

Over the course of 2017, the Affordable Care Act (ACA) endured unprecedented attacks ranging from attempts by congressional Republicans to repeal the law to Trump administrative actions that injected extreme uncertainty into the marketplaces. Despite these challenges, the marketplaces proved their resiliency and nearly twelve million consumers enrolled in marketplace plans across the country. However, 2018 and future years will be met with similar challenges. The Trump administration remains focused on promoting subpar insurance products and their commitment to promoting marketplace enrollment is uncertain. The federal individual mandate will no longer be enforced which will force premiums to rise and raise questions about both insurer and individuals' participation in the marketplaces.

Responding to these threats will take a concerted effort from both state and federal policymakers. While state policymakers focus on marketplace stabilization policies within their regulatory and legislative authority, federal policymakers should focus on complimentary structural improvements to the ACA aimed at shoring up weak points in our current system – namely, addressing the shortage of health insurers in many markets and improving the stability of the risk pools in the marketplaces. These improvements should directly address Americans' top health care priority: lowering the burden of health care costs – both premiums and cost-sharing – on families' budgets.

Much of the congressional debate over stabilizing the marketplaces – especially in the wake of the announcement that the Trump administration would stop payments to insurers offering plans with reduced cost-sharing – has centered on an appropriation for cost-sharing reductions (CSRs) and various structures of a reinsurance program. Depending on how they are structured these policy options may offer partial solutions to real problems, but as we look toward the 2019 plan year in the wake of recent changes, they will not be enough on their own and, with respect to CSR funding, could even make things worse in most states.

Because Congress was unable to pass a marketplace stabilization deal before the start of open enrollment for the 2018 plan year, states and insurers had to step up to mitigate the damages. Fortunately, [thirty states](#) utilized a workaround that would allow insurers to avoid financial loss while at the same time shielding most consumers from premium increases through increased premium tax credits. Because of this workaround, many consumers shopping for 2018 coverage were able to afford better coverage that required less out-of-pocket spending. However,

consumers ineligible for financial assistance had to either find cheaper options outside of the marketplace or shoulder the full premium increase of marketplace plans. Therefore, any congressional action to fund CSR payments must both address the affordability problem for consumers who are not currently eligible for financial assistance while ensuring that consumers who benefited from cheaper and more robust coverage in 2018 have similar options in future plan years. This is especially important in light of the elimination of the penalty for not purchasing affordable insurance. Without the penalty, the availability of free or very low premium insurance is critical to sustaining marketplace enrollment and a balanced risk pool. Further, short-term funding for CSRs (as opposed to a permanent appropriation) actually injects new uncertainty into the marketplaces and will require carriers and consumers to repeatedly petition Congress for continued funding.

Additionally, while reinsurance is one way to address affordability concerns – especially for consumers at the higher end of the income scale – it might not be enough to make coverage affordable in parts of the country where premiums are particularly high, often due to a lack of insurer or provider competition. While reinsurance will help insurers manage the risk of higher-cost enrollees, which should help bring down premiums to some degree, on its own it won't guarantee coverage will be available nationwide nor will it ensure a balanced risk pool with affordable premiums and out-of-pocket costs.

Below, we outline reform options that could address these real priorities.

Ensure that coverage is available nationwide. By design, the ACA depends on insurance carriers voluntarily participating in state marketplaces. The expectation being that with the support of premium stabilization programs and financial assistance for the majority of enrollees the new markets would be attractive to private insurance carriers. While many states, such as California and New York, have robust participation in their state marketplaces, other states like Tennessee and Alabama have consistently struggled to attract and retain carriers. While some states might work to address this issue on a state-by-state basis, the following policy proposals would help ensure that coverage is available nationwide on a more sustainable basis year-to-year.

- **Public option or “fallback” option.** Creating a national public option would ensure at least one plan option in every marketplace. There are a variety of ways this could be achieved. One promising design is to mirror Medicare, which would help ensure affordable premiums. The public-option plan can rein in costs through effective bargaining leverage and administrative savings. The Congressional Budget Office estimates that its premiums would be [7 to 8 percent lower](#) on average than premiums for private plans in the marketplaces.

As an alternative to a public option structure, Congress could consider a “fallback” approach [modeled after the Medicare Part D program](#). HHS could contract with a “fallback” insurer – while taking on full risk – to provide coverage in areas with fewer than two insurers in the marketplace. Researchers suggest that [one option](#) to handle the claims and the provider network is the Federal Employees Health Benefit (FEHB) national service plan, which is operated by Blue Cross Blue Shield.

- **Use “linkage” to create requirements or incentives to participate in the marketplace.** As an alternative, or in addition to, creating a public option or a “fallback” option plan, Congress could require insurers selling other lines of federally subsidized insurance in a state, such as Medicare Advantage plans or the Federal Employees Health Benefit (FEHB) national service plan, to also sell at least one bronze and silver qualified health plan in the marketplace within the same geographic area. (If a requirement to participate in the marketplace was tied to plans selling plans subsidized through the federal tax code it would essentially sweep in all carriers). An alternative to a direct linkage would be to offer some material incentive (e.g. higher payments) tied to other federal programs for plans that participate in the marketplace.

Improve the stability of the marketplace risk pool. Much like the factors contributing to a lack of insurance carrier competition in the ACA marketplaces, there are also a number of factors that have contributed to an unstable risk pool in certain states’ marketplaces. While there are different policy solutions to address carrier participation and the stability of the risk pool, the two issues go hand-in-hand: the more stable the risk pool, the more likely insurance carriers are to participate in the marketplace. In order to achieve stability, the risk pool must have healthy individuals to help spread the risk and cost of sicker individuals. The following policy proposals aim to attract healthier individuals to the marketplace to stabilize and counteract policy decisions, such as cuts to marketing and enrollment assister budgets, which have undermined the stability of states’ marketplaces.

- **Robust enrollment support.** Continuing to fund a robust enrollment assistance infrastructure will be critical not only to maintaining the significant coverage gains made under the ACA, but also in continuing to reach the remaining uninsured, both of which will be integral factors to ensuring the stability of the marketplaces going forward. Despite the fact that this year’s open enrollment period was cut in half, funding for enrollment assisters was cut by 40 percent and the federal advertising budget saw a 90 percent cut in funding, sign-ups in federally-facilitated marketplaces came close to last year’s benchmark and many state-based marketplaces are expected to meet or exceed last year’s enrollment numbers. While this was a success in many ways, [preliminary reporting](#) from assisters in the field indicates that they had to cut back on the counties they served and outreach to specific populations as well as on performing critical educational services to ensure they hit their enrollment benchmarks. Over time, this means that without additional funding assisters will likely be unable to target uninsured populations, and as their consumer reach declines it’s likely the uninsured rate will continue to rise.
- **Enhanced tax credit for younger people.** Another way to help improve and maintain the stability of the risk pool, as well as potentially improve the affordability of marketplace plans, is to increase the amount of advance premium tax credits (APTCs) available to younger individuals (e.g. under 30). Under the ACA, individuals at 100 percent of the federal poverty level (FPL) are expected to contribute around 2 percent of income, while individuals at 400 percent FPL are expected to contribute 9.69 percent, regardless of their age. To incentivize enrollment among younger, healthier individuals, the “expected contribution” of this population could be reduced so they receive a greater amount of APTCs than they would under the current ACA formula. Because premiums

for this population are relatively inexpensive, the cost of enhanced premium support would be relatively low while the benefits of attracting more young enrollees would accrue to older enrollees as well.¹

- **Medicare buy-in with APTC.** While increasing marketplace enrollment among the young adult population is one way to improve the stability of the marketplaces, an alternative option is to reduce enrollment among the older adult population by requiring individuals between ages 60-65, who are not yet eligible for Medicare but who are APTC-eligible, to use their APTCs to buy-into Medicare. Moving older adults out of the marketplace risk pools and into Medicare has the potential to improve the risk pool for both programs, as this population tends to have higher claims experience in the marketplace but would be healthier than the typical Medicare enrollee.

Expand coverage/improve premium affordability. The ACA has cut the uninsurance rate almost in half, from 16 percent of the population in 2010, to 8.8 percent in 2016. However, Gallup and Sharecare’s [most recent poll](#) on the percentage of uninsured adults in the United States found that an additional 3.2 million Americans were uninsured in 2017. This is the largest single-year increase in the number of uninsured Americans since 2008. While there are many factors contributing to this drop in coverage last year, [evidence suggests](#) that lowering premiums would improve take-up rates. Of those who remain uninsured, [one in five](#) (5.3 million, or 19 percent) is already eligible for APTCs to purchase coverage through the marketplace. In addition, there is a strong demand among those who are already insured for lower premiums. Despite APTCs, [just over half](#) of all marketplace enrollees report finding it somewhat, very difficult, or impossible to afford their premiums. Below we outline some policy options that would expanding eligibility for subsidized coverage to an additional four million uninsured Americans, and improve affordability of coverage for millions more who are already covered.

- **Full federal funding for three years to any state that closes the coverage gap.** [2.5 million uninsured people](#) are trapped in a “coverage gap” because they live in one of the 19 states that have not yet expanded Medicaid under the Affordable Care Act. The incentive for states to expand Medicaid to cover these low-income adults has shrunk over time. States were offered full federal financing for all newly eligible Medicaid beneficiaries in 2014, 2015 and 2016. That enhanced federal match rate began falling in 2017, leveling out at 90 percent in 2020 and beyond. So under current law, states that expand coverage now or any time in the future will have to contribute a small portion of the costs of the newly eligible from day one. To give the remaining 19 states a stronger incentive to expand coverage, this proposal would reimburse each state for the full cost of covering newly eligible beneficiaries for the first three years after it closes the coverage gap – regardless of when it closes the gap. Moreover, [research shows](#) that marketplace premiums are approximately 7 percent lower in Medicaid expansion states than in states that have not yet expanded Medicaid, so the cost for the enhanced federal match would be partially offset as the cost of advanced premium tax credits would decrease with the premiums.

¹ For example, the American Health Care Act (AHCA) sought to increase financial assistance for younger adults [by reducing the expected contribution ranges](#) of individuals under 30 between 100-400 percent FPL to 2-4.3 percent.

- **Fix the “family glitch.”** People offered “affordable” employer-sponsored coverage are ineligible for APTCs under the Affordable Care Act. However, the way that “affordable” is defined by the IRS greatly disadvantages families over single adults and unfairly excludes millions of uninsured people from help affording premiums. Fixing this glitch would [reduce the uninsured population by up to 1.5 million people and lower premium costs for millions more](#).
- **Increase the advanced premium tax credit for people between 250 percent and 400 percent of the Federal Poverty Level.** APTCs for modest-income households – those between 250 and 400 percent of the Federal Poverty Level (FPL) – aren’t sufficient enough to lower health care costs to the Affordable Care Act’s own definition of “affordable.” The law exempts people from the individual responsibility requirement if they are unable to obtain health insurance for less than 8 percent of family income, yet APTCs only bring the premium cost of benchmark plans down to 8.10 percent of family income for people at 250 percent FPL and 9.56 percent for those at 400 percent. We propose boosting APTCs for people with modest incomes – between 250 and 400 percent FPL – so no one in this income range would have to spend more than 8 percent of their income on their premiums.
- **Extend APTCs to people earning over 400 percent FPL.** Under the current APTC schedule, there is a sudden drop at 400 percent FPL. While most people at that higher income level do not need help purchasing coverage, some, especially older adults who feel the full effect of the 3-to-1 age band and with income just above 400 percent FPL, may still be unable to afford their plans. To ensure everyone, regardless of income, has access to affordable coverage we recommend extending APTCs to anyone earning above 400 percent FPL who would have to spend more than 8.5 percent on the benchmark plan.
- **Expand small business tax credit.** Although the Affordable Care act [significantly lowered the uninsurance rate among adults working in small businesses](#), those working for small firms still make up a disproportionate share of those without coverage. The ACA offered a powerful incentive for small businesses to offer coverage to their employees: a tax credit of up to 50 percent of their premiums for small businesses with up to 25 employees. However, take-up of this tax credit has been much [lower than expected](#) – in 2014, only 181,000 employers claimed the credit, despite somewhere between 1.4-4 million businesses qualifying. We recommend increasing the maximum credit amount and simplifying the complex phase-out and eligibility rules to allow more small businesses to qualify for the full credit and to make it easier for small businesses to determine how much they are eligible for.

Make cost-sharing more affordable. [Of those who are privately insured, 43 percent](#) still find their deductible difficult or impossible to afford. And research shows that unaffordable cost-sharing can have a detrimental impact on access to care. Those with high deductibles compared to their incomes were far more likely to forgo or delay recommended medical treatment or fail to fill a prescription than those with smaller or no deductibles. High deductibles also contribute to the burden of medical debt. Additionally, [lowering the cost of health care for individuals](#)

[consistently ranks as voters' top health care priority](#). Below, we recommend several policies aimed to lessen the burden of out-of-pocket costs on those with private insurance.

- **Expanding cost-sharing reductions to individuals with higher incomes.** [Cost-sharing reductions](#) (CSRs) are discounts that lower the amount individuals or families pay for deductibles, copayments and coinsurance if they have incomes up to 250percent FPL and purchase a silver plan on a health insurance marketplace. We recommend expanding CSR eligibility to include individuals between 250 percent and 300 percent FPL. Additionally, Congress could make the CSRs more generous for all currently eligible enrollees, as suggested by researchers at the [Urban Institute](#). Even if a premium is reasonable relative to income, the ACA's affordability standards do not take into account other out-of-pocket expenses like large deductibles and copayments. In the current environment, in which the cost of CSRs is generally recouped by insurers by increasing silver tier premiums, an expansion of eligibility for CSRs to 300 percent FPL would also provide some additional benefit to people with incomes up to 400 percent FPL because their APTCs would be higher relative to the price of both bronze and gold coverage.
- **New tax credit for people with chronic conditions.** The Affordable Care Act introduced [out-of-pocket \(OOP\) maximums](#), which cannot exceed \$6,850 for an individual or \$13,700 for a family plan. Implementing a tax credit for individuals who reach their out-of-pocket maximum in two consecutive years, and each consecutive year after, would help some of the sickest Americans access more affordable health care. For example, this credit could be a fixed amount for all eligible individuals equaling 50 percent of the OOP maximum for a given year. Alternatively, the credit could be administered to individuals on a sliding scale according to income. Additionally, for individuals who are treating a condition like cancer that spans multiple plan years, Congress could require that plans cover services related to this treatment pre-deductible until the treatment for the specific condition is finished.
- **Require coverage for up to three sick visits pre-deductible.** To control out-of-pocket costs and to ensure enrollees aren't deterred from seeking necessary care, we recommend offering more services without cost-sharing before the entire deductible is met for the year. Currently, the ACA requires [certain preventive services](#) to be covered at no cost-sharing to the enrollee. However, this can be [confusing to enrollees](#) because a visit to your primary care physician for a check-up can include a mix of free preventive services and diagnostic services that require cost-sharing. To simplify this, qualified health plans should give enrollees up to three free primary care office visits, not limited to preventive services, before meeting an annual deductible.
- **Prohibit surprise out-of-network balance billing in emergencies.** Nationally, [one third](#) of privately insured Americans have received a surprise medical bill. Surprise medical bills often [occur](#) in emergency care settings where patients have no ability to select emergency physicians. We recommend prohibiting surprise balance billing for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability or opportunity to choose a network provider. Note that depending on how disputes between out-of-network

providers and insurance plans would be settled, a ban on surprise out-of-network balance bills could, in addition to reducing out-of-pocket costs for consumers, make it easier for carriers to enter new regions and enhance marketplace competition.

- **Cap copays and ban coinsurance for prescription drugs.** Prescription drug prices have significantly increased in the past few years. In response to these price hikes, insurers have adopted strategies to shift drug costs to consumers through copays and coinsurance, which can cost consumers hundreds of dollars per drug per month. We recommend prohibiting the use of coinsurance and capping copayments for prescription drugs in qualified health plans.