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Affordability Together: How Congress Can Cut Health Costs for People Who Buy Their Own Insurance

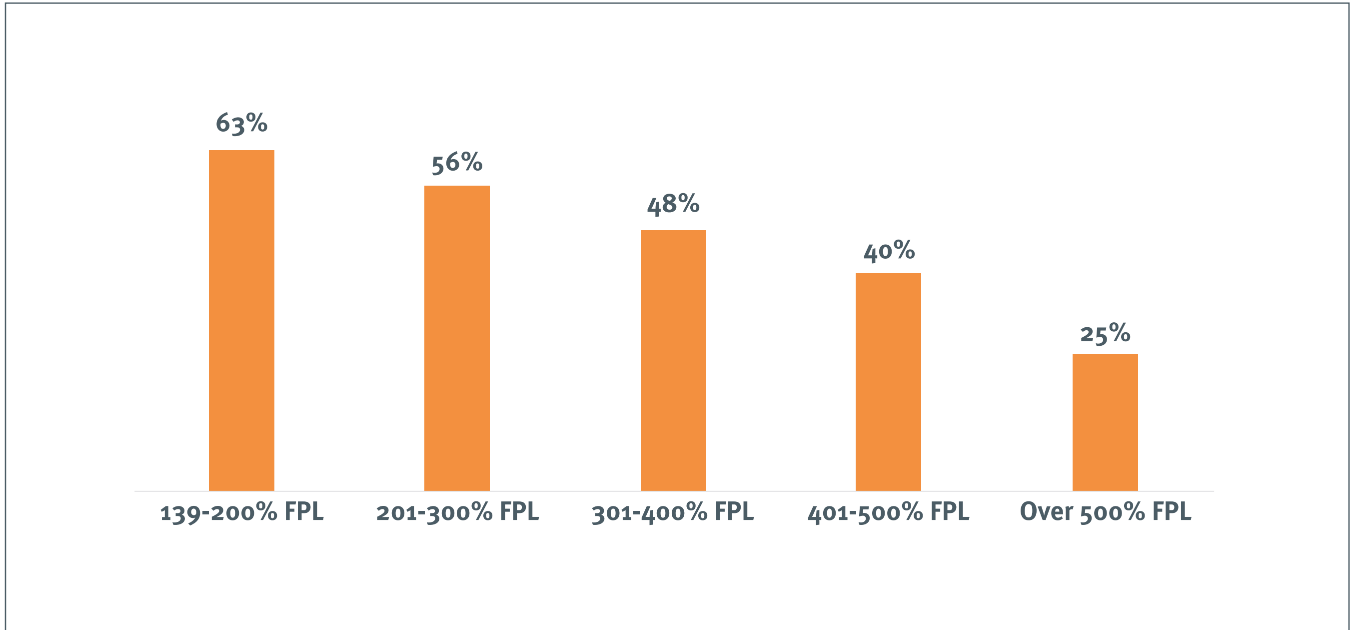
The Affordable Care Act (ACA) greatly improved the U.S. health insurance system, but our country's work is not complete. Although 20 million people gained insurance as a result of the ACA, 30 million still lack coverage. Nearly half (49 percent) of the remaining uninsured are eligible for individual market coverage, evenly divided between those who qualify for financial help and those who do not.[1] Despite the ACA's gains, health insurance and health care remain unaffordable for many of us.

Some observers rightly focus on high premiums charged to consumers in the individual market whose incomes exceed the eligibility threshold for premium tax credits (PTCs). That limit is 400 percent of the federal poverty level (FPL), or roughly $50,000 for an individual and $100,000 for a family of four. **But people at lower income levels also face serious affordability challenges**. The ACA's PTCs and cost-sharing reductions (CSRs) provide critically important assistance, but tight household budgets still place health care out of reach for many who qualify for help. Nearly two-thirds (63 percent) of financially eligible consumers with incomes below 200 percent of the FPL are uninsured rather than enrolled in the individual market (Figure 1). While 10 percent of individually insured adults with incomes between 300 and 500 percent of FPL cannot afford necessary medical visits or prescription drugs—far too many—that proportion rises to 16 percent for individually insured consumers below 300 percent of FPL, and is even higher among the uninsured (Figure 2).

Many advocate restoring the ACA's original reinsurance program, which guarantees premium savings by substituting public reinsurance dollars for premiums in paying certain high-cost claims.[2] While helpful to many consumers, reinsurance is not the optimal use of taxpayer dollars in a world of finite public resources. Reinsurance does not help PTC beneficiaries, whose premium payments are largely determined by income.[3] In essence, reinsurance is an across-the-board premium subsidy for all individual market enrollees who are ineligible for PTCs.

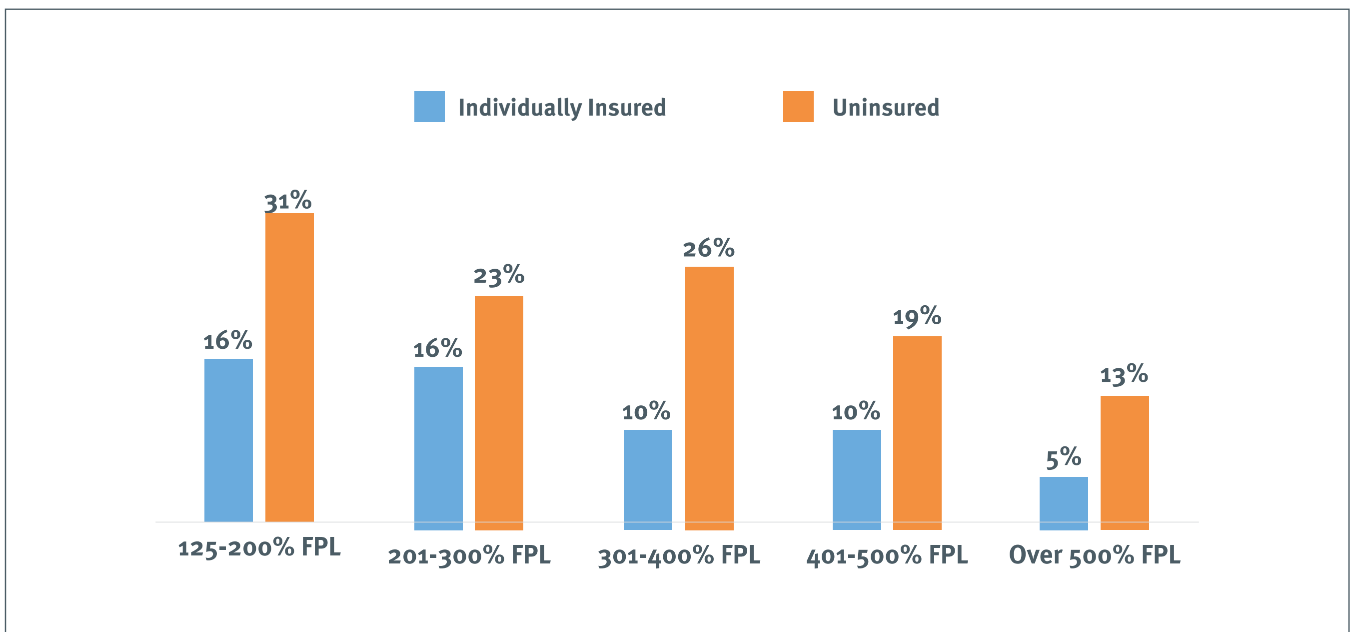
Lowering premiums through reinsurance helps many who are struggling, but most of the money goes to relatively affluent people who typically need less help. Fully 74 percent of individually insured consumers with incomes too high for PTCs earn more than 500 percent of FPL, placing them in the top 28 percent of the U.S. income distribution, with an average annual income of $198,000.[4] Compared to other groups, these higher-income adults are more likely to have insurance and less likely to go without care, as shown in the figures below. Congress should consider a two-part plan that targets funding more closely to need, offering greater relief to the families who are most likely to face unaffordable costs:

Figure 1. The percentage of adults under age 65 who were financially eligible for the individual market but who did not enroll and instead remained uninsured, by income as a percentage of federal poverty level (FPL): 2017



Source: Families USA analysis of American Community Survey data for 2017.

Figure 2. The percentage of adults under age 65 who needed but could not afford medical care or prescription drugs during the past 12 months, by coverage and income as a percentage of federal poverty level (FPL): 2016



Source: Families USA analysis of National Health Interview Survey data for 2016. Note: This graph shows people who went without either care or prescriptions.

1. Increase financial assistance for low-wage workers and moderate-income families. Illustrating this approach, Massachusetts supplements PTCs and CSRs to provide extra aid for consumers with incomes up to 300 percent of FPL. This helped the state achieve by far the country's highest participation levels in the individual market. **Enrolling low- and moderate-income uninsured families into affordable coverage greatly improves their lives while also cutting premiums for those who buy insurance without PTCs**. Nationally, 60 percent of uninsured young adults who are financially eligible for individual coverage have incomes below 300 percent of FPL.[5] With more of them joining Massachusetts' individual market, average risk levels have been low, and insurers received powerful incentives to capture market share by minimizing premiums. According to state officials,[6] increased financial assistance was the most important reason why, for the past three years, Massachusetts had the second-lowest benchmark premiums in the country—30 percent or more below the national average[7]—despite operating in the nation's second most expensive health care market.[8]

2. Raise or eliminate the artificial income cap on PTC eligibility. Today, if a 60-year-old buying average-price benchmark coverage has their income rise from 400 percent of FPL ($48,560) to 425 percent ($51,595), their monthly premium costs skyrocket from $399 to $1,016.[9] Even if robust reinsurance cut premiums 20 percent, they would still experience severe rate shock, with premiums jumping from $399 to $813. By contrast, if Congress lifts the current artificial cap on PTC eligibility, their costs would rise from $399 to $424. Our 60-year-old would save $592 each month, nearly three times the $203 they would save from robust reinsurance. Lifting the cap offers much more relief to the people who desperately need help without subsidizing relatively affluent consumers who require little if any public support.

By closely targeting new resources to need, Congress can make health insurance more affordable for everyone.[10]

Endnotes

[1] Blumberg, L., Holahan, J., Karpman, M., & Elmendorf, C. (2018). Characteristics of the remaining uninsured: An update. Washington, D.C.: Urban Institute. Available online at https://www.urban.org/research/publication/characteristics-remaining-uninsured-update/view/full_report.

[2] Now that national risk adjustment compensates plans for the claims of members whose costs exceed $1 million, and carriers understand the characteristics of the ACA-regulated market, the original reasons for the ACA's temporary reinsurance program seem much less compelling. That said, reinsurance compensates for high average risk levels in the individual market, lowering premiums to what would be charged for a healthier enrollee mix.

[3] Those who buy benchmark plans make payments based on income and are not affected by gross premiums. The many PTC beneficiaries who enroll in bronze plans—24 percent of those in the healthcare.gov marketplace for 2018—are likely to pay slightly more with reinsurance, but in some places may pay slightly less, depending on how reinsurance changes the gap between benchmark and bronze premiums. These consumers pay their income-based charges for benchmark coverage minus the difference between benchmark premiums and the lower premiums for their actual bronze coverage.

[4] Families USA analysis of 2017 American Community Survey (ACS) data.

[5] This result, limited to the uninsured with incomes above 138 percent of FPL, applies whether one defines "young adults" as those below age 35 or those below age 45. Families USA analysis of 2017 ACS data.

[6] Gasteier, AM, Brice, E, & Woltmann, M. (2018, September 4). Why Massachusetts Stands Out In Marketplace Premium Affordability [Blog post]. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180903.191590/full/.

[7] Kaiser Family Foundation. (2018). Change in average marketplace premiums by metal tier, 2017-2019. Available online at https://www.kff.org/health-reform/state-indicator/change-in-average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[8] Families USA analysis of data from Bureau of Economic Analysis, per capita personal consumption expenditures by state: Health care, 2015-17.

[9] Kaiser Family Foundation. (2018). Health insurance marketplace calculator. Retrieved January 14, 2019, from https://www.kff.org/interactive/subsidy-calculator/.

[10] In addition to lowering risk and slowing premium growth in the individual market, reducing the number of uninsured lowers private premiums by cutting hospital uncompensated care and resulting cost-shifting.

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