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Innovative Options to Cut Health Insurance Costs by Expanding the Circle of Coverage

A Report for State Consumer Leaders
and Policymakers

Stan Dorn, J.D., Director of the National Center for Coverage Innovation
and Senior Fellow, Families USA



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Introduction

This report explores near-term state options for lowering insurance costs in the individual market by expanding the circle of coverage, focusing on policy approaches that are innovative, practical, and ready for adoption in 2019.

As new governors and legislators take office in 2019, states will have an opportunity to reexamine their approaches to pressing policy problems. One longstanding conundrum involves the individual market for health insurance. Although the Patient Protection and Affordable Care Act (ACA) made significant improvements to that troubled segment of the U.S. health insurance system, many families are still charged unaffordable premiums, deductibles, and other cost sharing.

The Trump administration and many of its state and national allies have embraced an approach that lowers nominal premiums for the young and healthy by undermining coverage and care for people with preexisting conditions and for older adults. The same basic approach comes in multiple forms—among them, short-term limited duration insurance (STLDI), Association Health Plans (AHPs), farm bureau plans, and health care sharing ministries. Each variation involves a two-tier insurance system:

- » In the upper tier, health plans remain legally obliged to offer comprehensive benefits without discrimination against people with preexisting conditions.

- » In the lower tier, insurance companies offer plans that recruit healthy consumers out of the ACA-protected market by operating under completely different rules. Those rules let insurance companies cut premiums for healthy people by (1) eliminating services, such as prescription drugs and maternity care, that many people need and (2) overtly or covertly preventing enrollment by consumers with preexisting conditions.

When enrollees in lower-tier plans develop health problems, their insurance companies often fail to cover necessary care, leaving consumers responsible for unaffordable—even catastrophic—medical costs. After the lower-tier plans take many healthy consumers out of the ACA-protected market, premiums escalate in that market, and carriers may simply stop offering any comprehensive plans. Those were the results that the nonpartisan Congressional Budget Office (CBO) projected and that numerous states observed long before the ACA's enactment.¹

There is a better way. States such as Massachusetts and California have lowered individual-market premiums by bringing young and healthy consumers into comprehensive coverage that provides full consumer protections. By reducing average risk levels, these states have lowered premium costs for the healthy and sick

alike.² Such states have also taken steps to manage the individual market intelligently, making it easier for consumers to navigate and giving insurers powerful incentives to keep premiums low.

In this paper, we explore seven specific strategies that states could pursue along these same general lines, both to enroll the eligible uninsured and to cut health insurance costs. As with any strategy that broadens coverage, the approaches discussed below would lower private insurance premiums by reducing uncompensated hospital care: Much evidence shows that a significant portion of the cost of such care is passed on to private insurers, which then raise premiums through a “hidden health care tax” imposed on those who receive health benefits at work or have other forms of private coverage.³ The policies discussed here offer an additional cost advantage: by bringing healthy consumers into the individual market, average costs—hence premiums—decline for those who buy insurance without help from an employer or the government.

This report has several limitations. First, it presents only a general overview of each policy approach, leaving many crucial policy details for later, more targeted issue briefs and technical assistance. Second, we focus primarily on helping uninsured consumers who qualify for individual-market coverage, leaving future reports to explore coverage innovations involving lower-income adults and children who are currently eligible for Medicaid and the Children’s Health Insurance Program (CHIP).⁴ Third, this analysis does not explore options for addressing two important causes of coverage gaps that merit extended treatment on their own: selected states’ refusal to implement the ACA’s Medicaid expansion, and denials of health coverage based on immigration status. Finally, this report illustrates the potential offered by several promising state coverage innovations, but it does not encompass all measures that could increase the number of people with individual insurance while improving risk pools.⁵ In future publications, we will both highlight additional coverage innovations and flesh out details for some of the policies that the next section of this report describes in general terms.

Strategies to Reduce the Number of Uninsured and Lower Insurance Premiums

Following are several innovative, practical options that states could use to lower unsubsidized premiums in the individual market by broadening the circle of coverage without weakening consumer protections for people with preexisting conditions, older adults, and others who need medical care. To decide among health policy priorities for action in 2019, state advocates and officials likely will need to consider potential limits on available resources, the income and age distribution of the state's uninsured residents, local market conditions, and how each state's evolving political landscape shapes the parameters of the possible.

In almost every state, one urgent priority is protecting people against plans, including those embraced by the Trump administration, that destabilize markets and harm families by operating free of core consumer protections.

Some states have already banned or limited these substandard forms of coverage—STLDI, AHPs, health care sharing ministries, and indemnity plans—unless they abide by all of the ACA's consumer safeguards.⁶ Among other things, such safeguards bar discrimination against people with preexisting conditions, require minimum benefits, limit premium variation based on age and sex, assure solvency, forbid discriminatory and deceptive marketing, and mandate that at least a specified percentage of insurance premiums are used to pay health care claims.

In addition to protecting their markets from attack, state policymakers can achieve important forward progress using the following seven strategies.

1 Move toward implementing a Medicaid buy-in policy that lets consumers with incomes too high for Medicaid enroll in substantially more affordable insurance.

The buy-in approach that many state leaders prefer would offer consumers with incomes too high for Medicaid the opportunity to use premium tax credits (PTCs) to obtain Medicaid-type coverage. With a waiver under ACA Section 1332, such coverage might substantially lower enrollee premiums and deductibles compared to what people now must pay in the exchange. Unfortunately, any policy—including a Medicaid buy-in approach—that greatly increases enrollment is likely to violate Section 1332's deficit neutrality requirement, which forbids waivers that increase total federal spending.⁷

Colin Baillio of Health Action New Mexico has developed a strategy to overcome this challenge by taking multiple steps during the next few years to increase enrollment into marketplace coverage funded by PTCs. As a result, the federal cost baseline to which a buy-in waiver will be compared will have such high participation levels that only modest additional enrollment would result from a waiver. This could make it easier for future federal officials to approve a buy-in proposal that offsets the cost of additional enrollees by lowering average federal costs per PTC beneficiary. The latter cost offset could come from both the buy-in policy itself and by other measures added to the waiver proposal, such as traditional reinsurance (the final option described below).⁸

2 Supplement federal financial assistance with extra help for paying premiums and lowering deductibles and other cost sharing.

Unaffordability is the most significant factor inhibiting eligible consumers' enrollment into private coverage, according to much research.⁹ Federal PTCs and cost-sharing reductions (CSRs) have helped, but costs remain a significant obstacle. With financing strategies like those described below, a few states use their own resources to supplement federal subsidies, making coverage more affordable for consumers with incomes up to 300 percent of the federal poverty level (FPL). In Massachusetts, for example, those additional subsidies play a major role in helping the state obtain some of the country's lowest marketplace premiums, even while the state's overall health care costs are among the highest in the nation.¹⁰ Massachusetts's additional affordability aid eliminates deductibles for consumers with incomes up to 300 percent of FPL, eliminates premiums for those up to 150 percent of FPL, and reduces premiums for consumers between 150 and 300 percent of FPL below levels charged in the exchange. These steps lower unsubsidized premiums in two ways:

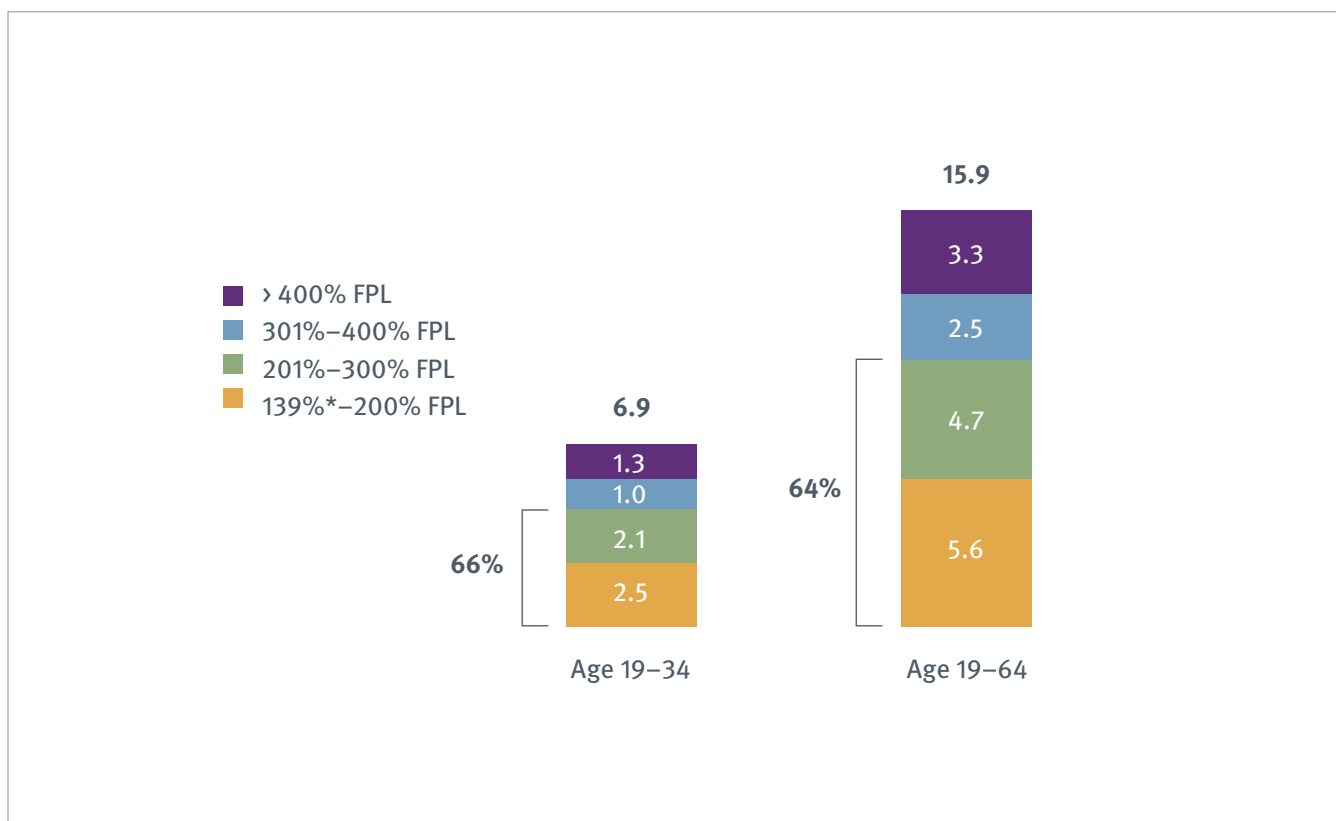
- » They improve the risk pool by expanding the circle of coverage to include numerous young and healthy adults. Altogether, 76 percent of potentially eligible adults enroll in Massachusetts's individual market—more than in any other state, and far more than the 51 percent of potentially eligible adults who receive individual coverage nationally.¹¹

- » With substantially reduced consumer premium payments, and a larger and more stable pool of enrollees attracted by much less costly coverage, a plan that charges even a small amount above the lowest available price can lose significant business. This gives insurers incentives to offer inexpensive coverage. The state shares the resulting savings with other consumers and with employers by offering low-cost plans through the exchange to people at all income levels and to small businesses.¹²

State policymakers could also provide additional financial assistance to higher-income consumers, including those who do not currently qualify for PTCs and so are exposed to very high costs. It is nevertheless easy to understand why Massachusetts focused supplemental affordability aid on consumers with incomes at or below 300 percent of FPL. Nationally, such consumers comprise 64 percent of all uninsured adults who potentially qualify for marketplace coverage, including 66 percent of such adults who are under age 35, whose participation has a particularly favorable effect on risk pools (Figure 1).

Massachusetts used Medicaid waivers under Social Security Act Section 1115 to claim federal funds that covered part of the cost of supplemental aid, but the federal government may not grant similar waivers to new states. Depending on the local political landscape, states without access to Section 1115 dollars might consider using general-fund resources for this purpose; raising tobacco taxes, as Massachusetts does to help

Figure 1. Uninsured adults under age 65 who are potentially eligible for individual-market coverage, by age and income as a percentage of FPL: 2016 (millions)



Source: Families USA analysis of American Community Survey (ACS) data for 2016. Note: Potentially eligible individuals were either uninsured or received individual coverage. ACS data did not allow the identification or exclusion of those who were ineligible for premium tax credits (PTCs) because of immigration status or unaccepted coverage offers from employers. It also was not possible to identify or include lawfully resident families who qualify for PTCs with incomes below 139 percent of FPL because their immigration status precluded federal Medicaid funding for non-emergency services.

* The lower income threshold for this band is either 101 or 139 percent of FPL, depending on whether the applicable state had expanded adult Medicaid eligibility by 2016.

fund supplemental affordability aid; or taxing nonprofit insurers and hospitals that have accumulated large surpluses, augmented by windfalls from recent federal tax cuts.

States could also explore targeted provider donations as a win-win financing strategy. This approach builds on successful hospital initiatives in several localities

to pay the small portion of low-income consumers' premium costs that PTCs do not cover. In each locality, hospitals' resulting uncompensated care savings far exceeded their premium contributions.¹³ Both hospitals and consumers could benefit if these programs were scaled up to serve all eligible residents of a state, reducing or eliminating premium costs for the lowest-income uninsured who qualify for PTCs.

3 Implement the ACA’s Basic Health Program (BHP) option, through which consumers with incomes below 200 percent of FPL receive state-contracted coverage, rather than marketplace insurance.

When New York used BHP to greatly lower premiums and end deductibles for people with incomes between 138 percent and 200 percent of FPL, enrollment skyrocketed for the affected income group, from 166,000 covered in 2015 to 436,000 in 2018 (Figure 2).

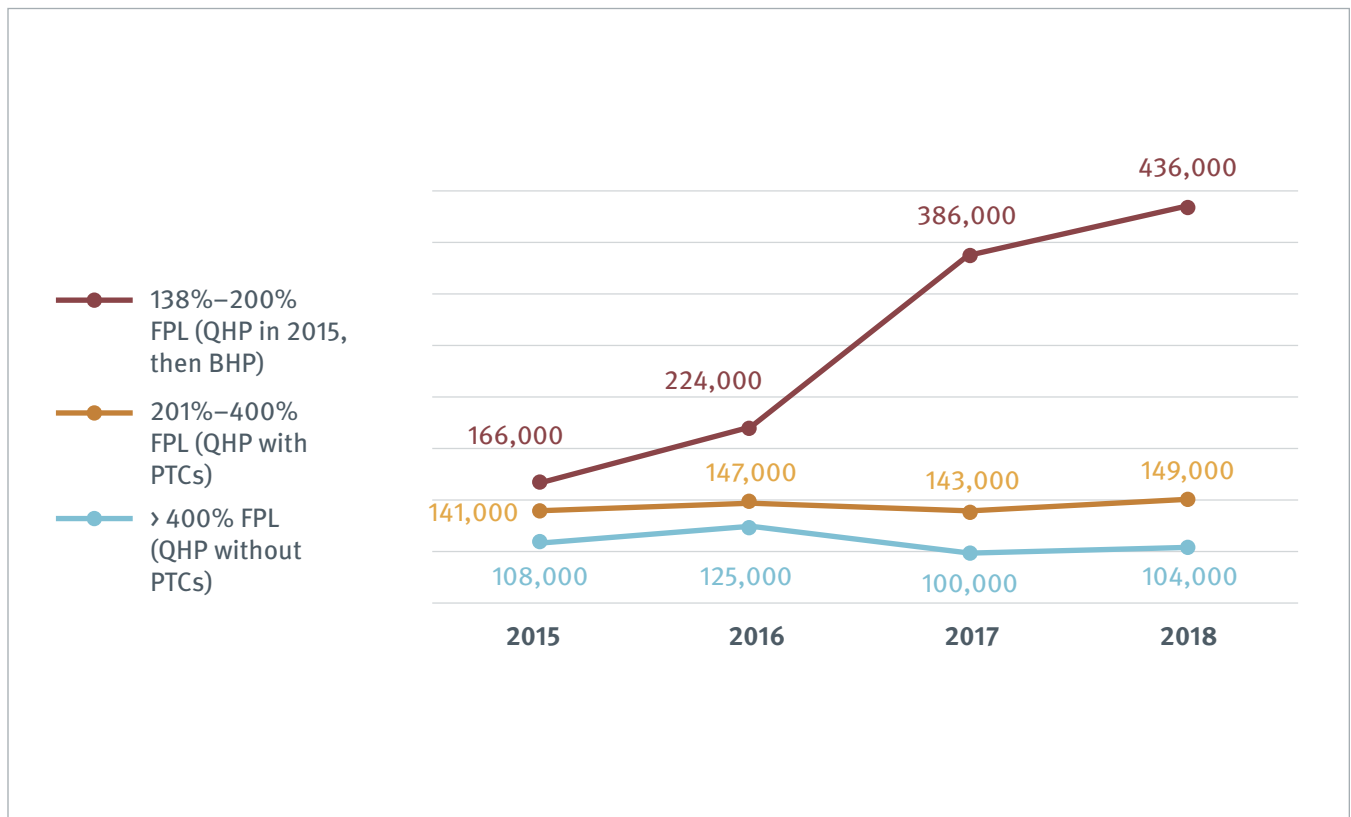
New York’s BHP offers substantially more affordable coverage than was provided by marketplace plans with PTCs and CSRs. BHP plans have no deductibles; premiums are not charged to people with incomes

at or below 150 percent of FPL; and BHP consumers between 150 percent and 200 percent of FPL pay premiums of \$20 per month, far below the \$63 to \$132 charged in other states to PTC beneficiaries in this income range.¹⁴

Fully 61 percent of New York’s BHP members are under age 45, highlighting the program’s potential to improve risk pools and lower premiums for unsubsidized consumers in the individual market. To realize that potential, states would need to implement the federal option to include BHP members in the individual market risk pool. No BHP state has yet taken that step.

Minnesota, the other state that has implemented BHP, also achieved positive results, but its BHP program did

Figure 2. Enrollment through New York’s marketplace, by income level: 2015–2018



Source: New York State of Health (Open Enrollment Reports, 2015–2018). Note: A QHP is a qualified health plan offered in the New York marketplace.

not involve the kind of natural experiment that New Yorkers witnessed. Minnesota used BHP to refinance an existing state program with coverage that was already much more affordable than what the ACA made available in the marketplace, so no major change in coverage systems took place. The program is widely viewed as a success, as reflected in the governor's proposals to expand BHP by offering it as an option to all state residents.¹⁵

States receive federal funding for BHP that equals 95 percent of the PTCs and CSRs for which BHP members would have qualified had they received exchange coverage. New York and Minnesota supplement these federal dollars. However, because BHP replaced previous coverage for which these states received less generous federal funding, both of them realized net budget gains.¹⁶

States that want to improve affordability for lower-income consumers may face a choice between implementing BHP and providing supplemental affordability aid for marketplace coverage, as described under Option 2. In such states, officials could compare any net state costs required to supplement federal BHP payments with the net cost of using state dollars to supplement federal PTCs and CSRs.

4 Provide more public education and hands-on assistance to help consumers obtain and retain coverage.

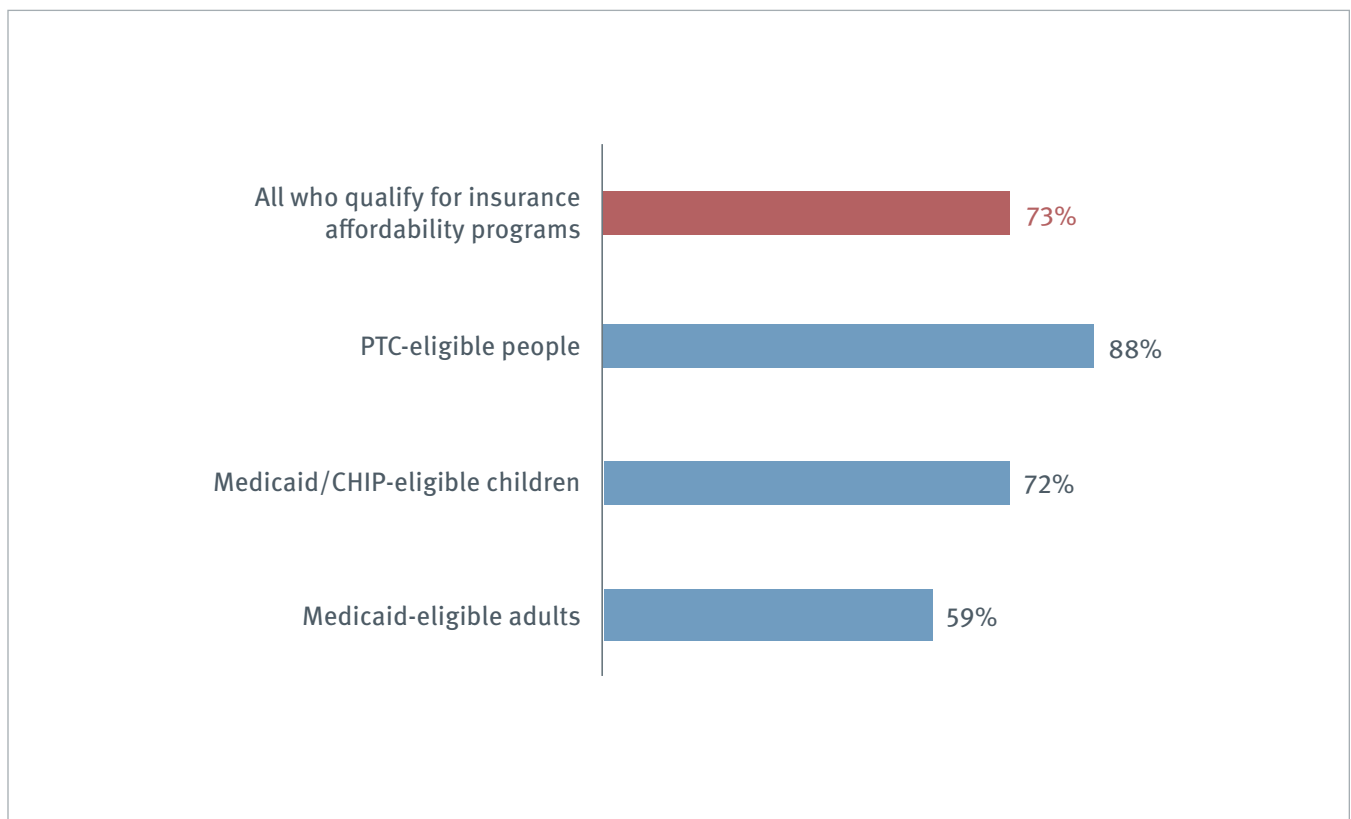
Much evidence shows that participation levels can increase dramatically when states provide public education about available coverage options and offer hands-on assistance with applications.¹⁷ Federal officials are nevertheless slashing funding for these essential functions in the federally facilitated marketplace,¹⁸ which is likely to reduce enrollment, especially among those who do not suffer from serious health problems that make obtaining health insurance a top priority. To prevent those results and to increase enrollment gains with resulting premium savings, states whose residents use the federally facilitated marketplace could furnish additional consumer assistance and targeted public education. Such efforts could be financed by charging fees to insurers serving the individual market or just to the marketplace carriers. Aiming for a win-win strategy that benefits both consumers and insurers, this funding approach helps plans gain customers. Moreover, unlike commissions for agents and brokers, insurance companies' payment of state-imposed fees for enrollment assistance and public education would not count against the Medical Loss Ratio requirements that limit insurers' administrative costs and profits to a specified percentage of premiums. Most states that operate their own exchanges already fund consumer assistance by charging fees to insurers that use the exchange; they could consider raising such fees if additional consumer assistance and public education are needed.

5 Use state income tax filing to give the eligible uninsured opportunities to seek coverage, including by making enrollment as automatic as possible.

States have many options for leveraging state income tax filing to facilitate enrollment in health insurance, taking advantage of very high tax filing rates among uninsured consumers who qualify for Medicaid, CHIP, and marketplace plans. Altogether, 73 percent of those who were uninsured before the ACA's passage and who became eligible for insurance affordability programs under the ACA live in tax-filing households, including 88 percent of such uninsured who qualify for PTCs (Figure 3).

To leverage tax filing for covering the uninsured, states could create special enrollment periods (SEPs) to allow marketplace sign-up at tax time, when consumers have left behind the financial anxieties of the November-December open enrollment period that coincides with holiday shopping.²⁰ Uninsured taxpayers could opt to have data from their state income tax returns shared with state health agencies, which would auto-enroll them into Medicaid or marketplace plans that are available at zero additional premium cost, beyond PTCs. **Nationally, the majority of PTC-eligible uninsured (54 percent), or 4.5 million people, qualify for marketplace plans with premiums that cost no more than the uninsured consumer's PTC.**²¹

Figure 3. The percentage of people in households who filed federal income tax returns among the pre-2014 uninsured who qualified for assistance under the ACA



Source: Urban Institute 2015.¹⁹ Note: "Insurance affordability programs" are Medicaid, CHIP, and PTCs.

Auto-enrollment may be especially powerful in states that take either or both of the following steps:

» **Supplement PTCs with additional premium subsidies.** Such supplementation would make zero-additional-premium plans available to more consumers, and more consumers would be enrolled automatically into plans above the bronze level.

» **Use their income tax systems to enforce the ACA's individual coverage requirements.**

When consumers pay a penalty for the previous year's coverage gaps, they could immediately learn from that experience and enroll in coverage that prevents future penalties. Maryland legislation proposes a less punitive approach that would let uninsured consumers convert their penalties into down payments that help buy health insurance.²² Nationally, 70 percent of the PTC-eligible uninsured (5.8 million people) are offered insurance that costs no more than their PTC plus ACA penalties for lacking insurance.²³ Enrolling consumers almost by default into such coverage, which would be effectively premium-free in a state implementing Maryland's proposal, could greatly reduce the number of PTC-eligible uninsured while improving the individual-market risk pool and lowering unsubsidized premiums.

One shortcoming of default or automatic enrollment into zero-additional-premium plans is that many default enrollees would receive high-deductible bronze coverage. To improve such enrollees' access to care, states could give them one final opportunity to "buy up" to high-value plans, borrowing tactics that are common for online sales. One factor that makes this strategy promising is the simplicity of consumer choice. Those with incomes below 200 percent of FPL would be offered a single, low-deductible silver plan with very high actuarial value; those above 200 percent of FPL would be offered a single gold option. Each buy-up option would provide greatly reduced deductibles and other cost sharing for the lowest possible monthly premium cost.

Under current federal law, enrollment cannot be fully automatic, even for essentially free coverage offered to consumers who have already asked to have their tax return data used to qualify for no- or low-cost insurance. Before enrollment, such consumers must consent to claim advance PTCs, which create (1) obligations to file year-end federal income tax returns and to inform the exchange about mid-year changes in household circumstances and (2) risks of reconciliation payments when year-end tax returns are filed. It is also important to design enrollment procedures so households with immigrant members provide informed and affirmative consent before any applications for coverage are submitted.²⁴

6 Enact state-based individual mandates while structuring them to strengthen both individual and group markets.

Federal tax legislation enacted in 2017 eliminated the federal government’s tax-based enforcement of the ACA’s requirement that people with access to affordable coverage must obtain insurance—the so-called individual mandate. Lawmakers took this step despite warnings from CBO that it would both increase the number of uninsured and boost individual market premiums by lowering the number of young and healthy adults who buy coverage.²⁵

States now have the option to fill this federal enforcement gap, which takes effect for the 2019 plan year. If all states enforced the ACA’s individual coverage requirement, the nonpartisan Urban Institute projects that individual market premiums would drop by 11.8 percent and that 3.9 million uninsured people would receive coverage in 2019, rising to 7.5 million in 2022.²⁶

Since 2006, Massachusetts has used state law to impose an individual responsibility to maintain coverage. New Jersey, the District of Columbia, Vermont, and Washington State enacted 2018 laws with personal responsibility requirements, providing state-level replacements for the federal government’s disappearing enforcement role.

In addition to limiting premium growth by incentivizing the participation of young and healthy adults, states with their own coverage requirements can achieve other important goals. One such goal is

described under Strategy 5—namely, leveraging the tax filing that accompanies mandate enforcement to increase enrollment of the eligible uninsured. Another goal is to use the state mandate law to set standards that employer-sponsored insurance (ESI) must meet for workers to avoid a state tax penalty. Although federal law bars states from directly regulating employee benefits, state individual mandate legislation could be structured to rein in ESI deductibles and other out-of-pocket costs, which have risen dramatically in recent years.²⁷

Under Massachusetts’s 2006 law, residents can avoid state tax penalties only if they enroll in coverage that meets the state’s definition of “minimum creditable coverage,” which excludes health insurance with very high deductibles. While state and federal employer mandates have required large and medium-sized companies to offer their workers coverage, many labor and health economists believe that employers’ main motivation for offering ESI is to recruit and retain valuable employees. Massachusetts’ approach to its individual mandate gives companies a strong incentive to meet their labor market goals by offering insurance that meets state mandate requirements. Illustrating the gains that may be possible under Massachusetts’s approach, deductibles and other cost-sharing for employer-sponsored insurance are now far lower than in the rest of the U.S.—73.2 percent of Massachusetts enrollees in private-sector ESI had a deductible in 2017, which averaged \$1,479 for worker-only coverage, compared to 87.5 percent and \$1,808 for the country as a whole.²⁸

7 Lower premiums by using public reinsurance dollars to pay individual market claims.

Reinsurance programs in Minnesota and Maryland, which immediately cut premiums by 20 percent and 30 percent, respectively, illustrate what this approach can accomplish. Reinsurance lowers costs only for people who buy unsubsidized coverage. Many of those purchasers are asked to pay completely unaffordable amounts today. In deciding whether to move forward with this approach to help residents who are ineligible for PTCs, states may want to consider (1) potential increases in premium payments that would result for low- and moderate-income PTC beneficiaries who now choose the lowest-cost silver plan or a bronze plan and (2) whether to hold reinsurance in reserve to help establish federal deficit neutrality for future Section 1332 waivers that take major steps to improve coverage and care for people at all income levels.

One innovative idea, originally suggested by Michael Miller of Community Catalyst, would focus reinsurance exclusively on gold-level coverage, which has individual deductibles that average \$1,142—far less than average deductibles of \$3,937 and \$5,873 in silver and bronze plans, respectively.²⁹ If focusing

all reinsurance dollars on gold plans lowered such plans' premiums by 40 percent, or twice the reduction achieved by Minnesota's marketwide reinsurance for plans at all levels, gold plans would become less costly than silver plans in every state and less costly than bronze in 41 states.³⁰ PTC beneficiaries would not be harmed, since silver benchmark premiums would be essentially unchanged, and those with incomes above 200 percent of FPL would gain access to far more valuable plans. A wholesale shift to coverage with lower deductibles could result, improving access to health care while buttressing public support for post-ACA insurance markets.

This “go for the gold” strategy has one major trade-off. A state using a traditional approach to reinsurance can obtain a Section 1332 waiver with federal pass-through payments equaling the federal savings projected to result when benchmark silver plans become less expensive and PTC amounts decline. If a state instead used reinsurance to lower the cost of gold plans exclusively, the impact on silver premiums would be minimal. As a result, the state would need to pay reinsurance costs on its own, without federal dollars to offset some of the state's up-front costs.

Conclusion

Health coverage can improve financial security, access to care, and health status. Illustrating the benefits of health insurance, breast cancer is detected in women at earlier stages, when successful treatment is substantially more likely; more men with hypertension and diabetes can afford to fill the prescriptions that keep them healthy; and fewer families go through debt collection and bankruptcy. Put simply, people with good insurance tend to be healthier, more financially secure, and more likely to thrive and even survive.

Enlarging the circle of coverage also yields important gains for people who already have insurance. Private premiums generally decline as uncompensated care expenses fall for hospitals, which then pass on fewer costs to the rest of us. And, most important for purposes of this paper, individual insurance premiums drop when more young and healthy adults sign up for coverage. This path toward lower premiums avoids any need to create a two-tier insurance market, while preserving all current protections for people with preexisting conditions and other health care needs.

Every other advanced nation provides health coverage to all of its people. With the ACA, the U.S. took an enormous step forward, reaching an estimated 41 percent of those who previously went without insurance.³¹ More work is nonetheless required to build on that foundation. Approximately 38 million people remain uninsured, 75 percent of whom qualify for Medicaid, CHIP, or marketplace coverage but are not enrolled.³²

Now is the time to finish the job. With a national policy environment that continues to face serious challenges, state officials have an opportunity and the responsibility to assume major leadership roles, testing promising coverage innovations that blaze a trail for future federal lawmakers to follow.

Endnotes

- ¹ Dorn, S. (2018, October 25). Do they think we'll forget? *The Hill*.
- ² Gasteier, A. M., Brice, E., & Woltman, M. (2018, September 4). Why Massachusetts stands out in marketplace premium affordability [Web log post]. Retrieved November 6, 2018, from <https://www.healthaffairs.org/doi/10.1377/hblog20180903.191590/full/>;
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- ³ Coughlin, T. A., Holahan, J., Caswell, K., & McGrath, M. (2014). An Estimated \$84.9 billion in uncompensated care was provided in 2013; ACA payment cuts could challenge providers. *Health Affairs*, 33(5), 807–814. doi:10.1377/hlthaff.2013.1068; Kirby, J. B. & Cohen, J. W. (2017). Do people with health insurance coverage who live in areas with high uninsurance rates pay more for emergency department visits? *Health Services Research*, 53(2), 768–786. doi:10.1111/1475-6773.12659; Park, J. D., Kim, E., & Werner, R. M. (2015). Inpatient hospital charge variability of U.S. hospitals. *Journal of General Internal Medicine*, 30(11), 1627–1632. doi:10.1007/s11606-015-3352-0; U.S. House, House Committee on Education and the Workforce Subcommittee on Health, Employer, Labor, and Pensions Subcommittee. (2011). *Regulations, costs, and uncertainty in employer provided health care* (R. Pollack, Author) [H.R. Doc. from 112th Cong., First sess.]. Written Statement, October 13, 2011.
- ⁴ Future papers may explore such options as using Express Lane Eligibility to enroll uninsured but eligible children and expanding adult Medicaid coverage for people with incomes above 138 percent of the federal poverty level. The latter approach may be particularly fruitful in states where the federal government pays a high percentage of Medicaid costs.
- ⁵ Promising measures that we do not explore here include adoption of the ACA's core Medicaid expansion, which, among its many benefits, improves risk pools and cuts individual market premiums by covering many high-cost consumers outside that market; lengthening the open enrollment period; and standardizing plan design while providing automated decision aids and a carefully considered enrollment architecture. Measures in that final category make plan choices and enrollment decisions easier for consumers, thereby increasing participation levels. Standardization of plan design can also be used to improve the access to care furnished by bronze plans, incorporating significant pre-deductible coverage of generic drugs and office visits.
- ⁶ Gomez, R. (2018). Health care victories in the 2018 state legislative sessions (Rep.). Washington, D.C.: Families USA. https://familiesusa.org/sites/default/files/product_documents/HAN_State-Legislative-Wrap_Report.pdf; Volk, J., Curran, E., & Giovanelli, J. (2018). Health care sharing ministries: What are the risks to consumers and insurance markets? (Rep.). Georgetown University Center on Health Insurance Reforms. New York, N.Y.: The Commonwealth Fund. <https://www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries>; Lucia, K., Giovanelli, J., Corlette, S., Volk, J., Palanker, D., Kona, M., & Curran, E. (2018). State regulation of coverage options outside of the Affordable Care Act: Limiting the risk to the individual market (Rep.). Georgetown University Center on Health Insurance Reforms. New York, N.Y.: The Commonwealth Fund. https://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-affordable-care-act?redirect_source=/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca.
- ⁷ Policies that increase enrollment could also run afoul of Section 1332's methodology for calculating federal pass-through payments, which are based on the aggregate sum of federal financial assistance that would have been paid under a standard implementation of the ACA.
- ⁸ In addition, offering a public option to employers as part of the Section 1332 waiver would likely be "scored" as generating federal income tax revenue, which could offset a portion of increased enrollment costs. When employers spend less on health benefits, many actuaries and economists project that some of the savings are passed on to employees in the form of higher taxable earnings, which increase federal tax revenue.
- ⁹ Collins, S. R., Gunza, M. Z., & Doty, M. M. (2017). Following the ACA repeal-and-replace effort, where does the U.S. stand on insurance coverage? (Rep.). New York, N.Y.: The Commonwealth Fund.
- ¹⁰ Dorn, S. (2018). [Web log post]. Retrieved November 6, 2018, from <https://www.healthaffairs.org/doi/10.1377/hblog20180727.541089/full/>.
- ¹¹ The latter figure corrects an arithmetic error contained in the original blog post, which mistakenly included children in the estimate of total national take-up rates. The Massachusetts estimate was correct, limited to adults only. Dorn, 2018, op. cit.
- ¹² Massachusetts took other steps to lower premiums that deserve serious consideration by other states. For example, state law requires all carriers with 5,000 or more covered lives to offer marketplace plans. As a result, no plan corners the market in any part of the state. Each is subject to the discipline of competitors standing ready to snatch away market share by offering a better combination of low price and appealing coverage.

Also, the state marketplace makes it easier than in many other states for consumers to choose among plans. Plan designs are standardized “to facilitate apples-to-apples comparisons among carriers, which makes it easier for consumers to evaluate similar options at different price points.” Gasteier, et al., op. cit. Those designs also make coverage more valuable by lowering pre-deductible cost-sharing requirements. Moreover, the exchange provides strong tools for decision support and comparison shopping that help consumers sort through what is often a confusing choice process in other states.

¹³ Dorn, S. (2018). Assessing the promise and risks of income-based third-party payment programs (Rep.). New York, N.Y.: The Commonwealth Fund.

¹⁴ Kaiser Family Foundation. (2018, November 1). Health Insurance Marketplace Calculator. Retrieved November 15, 2018, from <https://www.kff.org/interactive/subsidy-calculator/>.

¹⁵ Office of Governor Mark Dayton. (2018, March 1). Governor Dayton urges passage of MinnesotaCare buy-in to give Minnesotans another, more affordable choice for health insurance [Press release]. Retrieved November 6, 2018, from <https://mn.gov/governor/newsroom/?id=1055-328090>.

¹⁶ New York used BHP to refinance a state-funded program for lawfully present immigrants ineligible for federal Medicaid funding of non-emergency services, and Minnesota used BHP to refinance a longstanding program, MinnesotaCare, that drew down matching federal Medicaid dollars before switching to BHP financing. Tolbert, J., Antonisse, L., & Dorn, S. (2016). Improving the affordability of coverage through the Basic Health Program in Minnesota and New York (Rep.). Menlo Park, Cal.: The Kaiser Family Foundation.

¹⁷ Sommers, B. D., Maylone, B., Nguyen, K. H., Blendon, R. J., & Epstein, A. M. (2015). The impact of state policies on ACA applications and enrollment among low-income adults in Arkansas, Kentucky, and Texas. *Health Affairs*, 34(6), 1010–1018. doi:10.1377/hlthaff.2015.0215.

¹⁸ Hoppe, O. (2018, September 21). Massive navigator funding cuts pose risks for consumers, marketplaces [Web log post]. Retrieved November 6, 2018, from <http://chirblog.org/massive-navigator-funding-cuts-risks/>.

¹⁹ Dorn, S., Buettgens, M., & Dev, J. (2015). Tax preparation services and ACA enrollment potential contributions and issues (Rep.). Washington, D.C.: Urban Institute.

²⁰ Many factors suggest that enrollment levels would rise if sign-ups overlapped with tax season. Dorn, et al., 2015, op. cit.

²¹ Author’s calculations, Rae, M., Levitt, L., & Semanskee, A. (2017). How many of the uninsured can purchase a marketplace plan for less than their shared responsibility penalty? (Rep.). Menlo Park, Cal.: The Kaiser Family Foundation.

²² Dorn, S. (2018, February 26). New study shows why Maryland families need the health insurance down payment plan [Web log post]. Retrieved November 6, 2018, from <https://familiesusa.org/blog/2018/02/new-study-shows-why-maryland-families-need-health-insurance-down-payment-plan>.

²³ Rae, et al., 2017, op. cit.

²⁴ Immigrant families, including those that have both U.S.-citizen children and immigrant parents, need safeguards to ensure their ability to control applications for health coverage, given the emerging risk that such applications could be used against them under “public charge” rules. With one possible approach, if data-matching to Social Security Administration records does not confirm citizenship status for all household members, the household would need to affirmatively authorize further data sharing and explicitly request coverage before an application is submitted or the state health agency takes any other steps.

²⁵ Congressional Budget Office. (2017, November). Repealing the individual health insurance mandate: An updated estimate. Washington, D.C.: Congressional Budget Office. <https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf>.

²⁶ Blumberg, L., Buettgens, M., & Holahan, J. (2018). How would state-based individual mandates affect health insurance coverage and premium costs? (Rep.). Washington, D.C.: Urban Institute.

²⁷ Altman, D. (2016, September 18). The missing debate over rising health-care deductibles [Web log post]. Retrieved November 6, 2018, from <https://www.kff.org/health-costs/perspective/the-missing-debate-over-rising-health-care-deductibles/>.

²⁸ United States, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. (2018). 2017 Medical Expenditure Panel Survey-Insurance Component. Table II.F.1, Percent of private-sector employees enrolled in a health insurance plan that had a deductible by firm size and state: United States, 2017; Table II.F.2, Average individual deductible (in dollars) per employee enrolled with single coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and state: United States, 2017.

²⁹ Pearson, C.F., Carpenter, E. Avalere. (2017, November 30). Plans with more restrictive networks comprise 73% of exchange market

[Press release]. Retrieved November 6, 2018, from <http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market>.

³⁰ Kaiser Family Foundation. (2018). [Change in average marketplace premiums by metal tier]. <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>.

³¹ Long, S. K., Bart, L., Karpman, M., Shartzter, A., & Zuckerman, S. (2017). Sustained gains in coverage, access, and affordability under The ACA: A 2017 update. *Health Affairs*, 36(9), 1656–1662. doi:10.1377/hlthaff.2017.0798.

³² 25 percent of the uninsured qualify for Medicaid or CHIP under state law as of 2018; 25 percent qualify for PTCs; and 25 percent could enroll in marketplace coverage but do not qualify for PTCs because of income over 400 percent of FPL or ESI offers that the ACA classifies as affordable. The remaining 25 percent are either (1) ineligible for insurance affordability programs because of immigration status or (2) ineligible for Medicaid, despite income below the poverty level, because of their state's decision not to expand Medicaid eligibility as permitted by the ACA. Blumberg, L., Holahan, J., Karpman, M., & Elmendorf, C. (2018). Characteristics of the remaining uninsured: An update (Rep.). Washington, D.C.: Urban Institute.



1225 New York Avenue NW, Suite 800 | Washington, DC 20005 | 202-628-3030 | info@familiesusa.org
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