Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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Recovery Legislation Should Build on ACA Successes to Expand Health Coverage, Improve Affordability

By Sarah Lueck and Tara Straw

The Affordable Care Act (ACA) expanded health coverage to more than 24 million people, sharply dropping the uninsured rate for people of all ages, of all racial and ethnic backgrounds, and at all education levels.[1] The recently enacted American Rescue Plan — particularly its two-year premium tax credit enhancements for marketplace enrollees and strong financial incentives for states to expand Medicaid — is expected to reach millions of the roughly 30 million people who remain uninsured, a group disproportionately composed of people of color. To address these disparities and make further strides toward universal coverage, an essential priority for recovery legislation, Congress should make broader, permanent improvements to marketplace coverage.

Many people who are uninsured are eligible for financial help to buy a marketplace plan but cite cost as an obstacle. The Rescue Plan took substantial steps to address this gap, primarily by enhancing premium tax credits to make coverage more affordable in 2021 and 2022. Low- and moderate-income people are eligible for significant discounts in the premiums they must pay to enroll in a plan, with some paying nothing. And people with higher incomes but high premium burdens are newly eligible for the premium tax credit under the Rescue Plan. The Congressional Budget Office (CBO) estimates these provisions will increase marketplace enrollment by 1.7 million people in 2022.[2]

Building on these successes to further strengthen marketplace coverage should be a top priority in recovery legislation. Permanently enhancing premium tax credits, reducing people's deductibles and other out-of-pocket costs, and extending marketplace coverage to more families whose employer-sponsored coverage is unaffordable, among other policies, would expand coverage to more people and make health care more accessible and affordable. These changes, when paired with steps to

[1] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's September 2020 Projections," September 29, 2020, https://www.cbo.gov/system/files/2020-10/51298-2020-09-healthinsurance.pdf; CBPP, "Chart Book: Accomplishments of Affordable Care Act," March 19, 2019, https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act.

[2] Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Ways and Means," February 15, 2021, https://www.cbo.gov/publication/57005.

strengthen and expand Medicaid,[3] would help ensure that the nation's recovery improves low-paid workers' health, well-being, and economic security and help address troubling racial inequities in access to health coverage and care.[4]

Permanent Premium Tax Credit Enhancements Would Make Coverage More Affordable for Millions

The American Rescue Plan's two-year premium tax credit increases are an important first step in making health insurance more affordable. They will eliminate or reduce premiums for millions of current marketplace enrollees and expand eligibility to millions more, ensuring that no marketplace enrollee spends more than 8.5 percent of their income on premiums. Some 3.6 million people will be newly eligible for financial help, which will likely not just reverse insured rate losses under the Trump Administration but restore the upward trend that ended in 2016.[5]

The Urban Institute estimated that if similar improvements were made permanent, which recovery legislation should do, about 4.5 million people would gain coverage.[6] Policymakers should also enhance the Rescue Plan's credits (and make the enhancements permanent) to provide further help to low-income people.

People's savings from the credits will already be significant. Marketplace enrollees with incomes below 150 percent of the poverty line (about $19,000 for a single person) will pay no premiums for a benchmark plan, after accounting for premium tax credits, and families with incomes between 150 and 400 percent of the poverty line (about $51,000 for a single person) will pay a lower share of income toward premiums than they did before. For example, a family of four making $50,000 will pay $67 rather than $252 per month in premiums for benchmark coverage (1.6 instead of 6.0

[3] For more on the added financial incentives for states to expand Medicaid, see Jesse Cross-Call, "House Bill Gives States Incentive to Quickly Expand Medicaid, Cover Millions of Uninsured," CBPP, February 25, 2021, https://www.cbpp.org/research/health/house-bill-gives-states-incentive-to-quickly-expand-medicaid-cover-millions-of.

[4] Sharon Parrott *et al.*, "Building an Equitable Recovery Requires Investing in Children, Supporting Workers, and Expanding Health Coverage," CBPP, March 24, 2021, https://www.cbpp.org/research/poverty-and-inequality/building-an-equitable-recovery-requires-investing-in-children.

[5] Department of Health and Human Services, "Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities," March 12, 2021, https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html. Also see Tara Straw, "Lower Premiums, More Time to Enroll Will Boost Marketplace Enrollment," CBPP, April 1, 2021, https://www.cbpp.org/blog/lower-premiums-more-time-to-enroll-will-boost-marketplace-enrollment; Matt Broaddus, "Health Insurance Coverage Losses Since 2016 Widespread," CBPP, October 22, 2020, https://www.cbpp.org/blog/health-insurance-coverage-losses-since-2016-widespread; and Matt Broaddus and Aviva Aron-Dine, "Uninsured Rate Rose Again in 2019, Further Eroding Earlier Progress," CBPP, September 15, 2020, https://www.cbpp.org/research/health/uninsured-rate-rose-again-in-2019-further-eroding-earlier-progress.

[6] Linda J. Blumberg *et al.*, "Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity," Urban Institute, February 2021, https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity.pdf.

percent of their income) — an annual savings of $2,220.[7] Four out of five enrollees can get a plan for $10 or less per month.

People with income above 400 percent of the poverty line are newly eligible for assistance and, like other marketplace enrollees, will pay no more than 8.5 percent of their income toward premiums. This is especially important to middle-income people, older people, and people who live in areas with high premiums, who bear the highest premium burdens.[8] For example, marketplace benchmark coverage for a 50-year-old in Charleston, West Virginia earning $55,000 a year (431 percent of the poverty line) costs about $1,021 per month, about 22 percent of income and more than 1.5 times the national average premium. Under the Rescue Plan this person will get a monthly premium discount of $632, bringing their premium down to $390 per month.[9] The premium tax credit enhancement will automatically phase out in lower-cost areas and at higher income levels because premiums are generally less than 8.5 percent of income.

About 8.9 million uninsured people were likely eligible for a premium tax credit under prior law, the Kaiser Family Foundation estimates. More than half of uninsured people eligible for credits are people of color, including 31 percent who are Latino and 15 percent who are Black.[10] About 16.8 percent of people with incomes between 138 and 250 percent of the poverty line are uninsured, compared to 3.7 percent for people with incomes above 500 percent of the poverty line.[11]

Data suggest that low- and moderate-income people still face the greatest challenges affording coverage and care.[12] Making permanent improvements to the premium tax credits would appreciably reduce uninsured rates and improve access to care.[13] And to better help the lowest-income people,

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[7] CBPP calculations. Examples assume consumers face the national average marketplace benchmark premium. The family of four is composed of two 40-year-old parents, a 5-year-old, and a 10-year-old. The benchmark plan is the second-lowest-cost silver-tier plan offered where the consumer lives.

[8] Aviva Aron-Dine, "Making Health Insurance More Affordable for Middle-Income Individual Market Consumers," CBPP, March 21, 2019, https://www.cbpp.org/research/health/making-health-i.nsurance-more-affordable-for-middle-income-individual-market.

[9] Kaiser Family Foundation, "2021 Calculator – Before COVID-19 Relief," March 10, 2021, https://www.kff.org/interactive/subsidy-calculator-2021-before-covid-relief/, and "Health Insurance Marketplace Calculator," March 10, 2021, https://www.kff.org/interactive/subsidy-calculator/.

[10] Daniel McDermott *et al.*, "Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach," Kaiser Family Foundation, January 27, 2021. https://www.kff.org/report-section/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach-appendix-tables/ This analysis does not include individuals who are over the age of 65, who are eligible for Medicaid, who have incomes below poverty, or whose immigration status makes them ineligible for marketplace coverage.

[11] CBPP analysis of Census 2019 American Community Survey data. See also Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," CBPP, March 21, 2019, https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing.

[12] *Ibid.*

[13] Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?" Commonwealth Fund, September 2017,

Congress could augment the Rescue Plan's improvements by raising the income threshold at which people qualify for zero-premium benchmark plans from 150 percent to 200 percent of the poverty line (roughly $25,500 for a single person).

Reducing Out-of-Pocket Costs Would Help People Access Care

Premiums are only one part of making health coverage affordable. Health plans also come with out-of-pocket costs in the form of deductibles,[14] copayments, and coinsurance that people must pay when they get care.[15] If these cost-sharing amounts are high, they can deter people from enrolling in a plan, even if premium help is significant. For people who do enroll, especially those with low incomes, high charges can lead them to delay or avoid getting care they need or can increase financial problems as medical bills go unpaid.[16] And research on cancer survivors suggests that high deductibles may magnify racial disparities in access to health care. While high deductibles are generally linked to cost-related problems for all patients, in one study Black patients in high-deductible plans experienced more barriers to care (such as delaying filling a prescription to save money or being unable to see a specialist because of cost) than their white counterparts.[17]

Under the ACA, people with incomes between the poverty line and 250 percent of the poverty line (about $13,000 to $32,000 for an individual and $26,000 to $66,000 for a family of four) are eligible for reduced deductibles and other cost sharing if they enroll in a silver marketplace plan.[18] These individuals enroll in a silver plan with reduced out-of-pocket costs compared to the standard silver plan. The law also caps the total cost-sharing charges that people can be required to pay under their plans each year, an amount that also decreases to provide greater financial protection to people with lower incomes.

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https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_sep_collins_2017_aca_tracking_survey_ib_v2.pdf.

[14] Deductibles are an annual amount that the enrollee must pay before the insurance plan begins to cover many or all covered items and services (e.g., a $2,000 deductible means that enrollee must pay that amount before the plan would begin paying for a portion of a hospital stay). Many plans cover lower-cost items, such as a certain number of physician visits or generic prescriptions, before the enrollee has paid the deductible, and the ACA requires certain preventive services to be covered at no cost to enrollees.

[15] Copayments are flat dollar amounts that plans charge enrollees for an item or service (e.g., $30 for a doctor visit). Coinsurance charges are a percentage of the cost (e.g., 30 percent of the cost of a prescription drug).

[16] Sara R. Collins *et al.*, "U.S. Health Coverage in 2020: A Looming Crisis in Affordability," Commonwealth Fund, August, 19, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial.

[17] Megan B. Cole *et al.,* "Association Between High-Deductible Health Plans and Disparities in Access to Care Among Cancer Survivors," JAMA Network, June 24, 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767589

[18] As noted, the ACA establishes metal tiers — bronze, silver, gold, and platinum — to organize plans for consumers and set standards for what deductibles and other charges insurers can include. See CBPP, "Cost-Sharing Charges in Marketplace Plans, Answers to Frequently Asked Questions," updated August 2020, http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-answers-to-frequently-asked-questions/.

Cost-sharing assistance is delivered by means of the actuarial value (or AV, which measures the share of costs a plan covers) for silver plans available to people at various income levels.[19] When people eligible for assistance enroll in a silver plan, they automatically receive a version with a higher AV than the standard silver value of 70 percent; depending on a person's income, current law provides silver plans that have AVs of 73 percent, 87 percent, or 94 percent. This significantly reduces deductibles and other cost-sharing charges for millions of people.

But the cost-sharing assistance phases down significantly starting at 200 percent of the poverty line, down to nothing for those at incomes higher than 250 percent. The resulting costs are especially significant for people with incomes between 200 to 300 percent of the poverty line. For example, a person with income of $26,000 a year (around 200 percent of the poverty line) would be eligible for a silver plan with an enhanced AV of 73 percent. But the average deductible for these plans in 2021 is about $3,400, or 13 percent of the person's income.[20] Even with a premium tax credit boost that allows them to get a plan for a zero-dollar premium, it would be challenging, and perhaps impossible, for them to pay the out-of-pocket costs associated with a hospital stay or ongoing treatment for a chronic condition.

The recovery package should expand cost-sharing help to more people and reduce out-of-pocket costs for those who are already eligible, along the lines that Senator Jeanne Shaheen of New Hampshire proposed in 2019.[21] Legislation should raise the actuarial values of silver plans for everyone from the poverty line to four times the poverty line. Under this approach, people with incomes at 200 percent of poverty would be able to get the equivalent of a platinum plan with an average deductible in the range of $0 to $200. And someone at 300 percent of the poverty line would see plan deductibles drop several thousand dollars a year, from about $5,000 on average to about $1,000.[22] When combined with the proposed improvements in premium tax credits described above, everyone with incomes up to 400 percent of poverty could buy a marketplace plan that is at least the equivalent of a gold plan (with an 80 percent AV) for no more than 8.5 percent of their income.

Another way to reduce the burden of out-of-pocket costs, proposed in other legislation and in the plan President Biden released during his campaign, would be to benchmark premium credits to a gold plan instead of the current silver plan. But boosting the silver plan AVs can achieve a similar

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[19] AVs are a way to compare the generosity of different insurance plans. For example, silver plans, with a 70 percent AV, would be expected to pay 70 percent of the covered medical costs for a typical population, while gold plans, with an 80 percent AV, would cover 80 percent of covered costs of the typical population. Under the ACA, the premium tax credits are calculated based on the cost of the second-lowest-cost silver plan available where a person lives.

[20] Kaiser Family Foundation, "Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2021," January 15, 2021, https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/.

[21] Marketplace Certainty Act, S. 964, as introduced April 1, 2019, https://www.congress.gov/bill/116th-congress/senate-bill/964/text?format=txt.

[22] Deductibles and other cost-sharing charges can vary widely even among plans with the same AV. Under current law, the average deductible for a silver plan (70 percent AV) is near $5,000 in 2021. A new AV of 85 percent for people at 300 percent of poverty would result in average deductibles of about $1,000; the average 2021 deductible for plans with a slightly higher AV of 87 percent was $800. See Kaiser Family Foundation, "Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2021," *op. cit.*

result for enrollees — making plans with at least a gold AV available to everyone with income up to four times the poverty level — while also providing more help to those in need.[23]

Employer Coverage Improvements Would Help Low-Income Workers and Their Families

While employer coverage often works reasonably well for middle- and upper-middle-income employees, lower-income workers are frequently offered less robust coverage and required to pay a larger share of premiums out of pocket.24 Among people in families with job-based coverage, those with incomes below 200 percent of poverty spend an average of 14.0 percent of their income on premiums and out-of-pocket costs, compared to 7.9 percent for people with incomes between 200 and 400 percent of poverty, and 4.5 percent for people at or above 400 percent of poverty.25

Meanwhile, approximately 6 million workers and family members with incomes below 400 percent of poverty are uninsured but "firewalled" from accessing subsidized marketplace coverage because they have an offer of employer coverage.26 The ACA firewall prevents people from receiving premium tax credits if anyone in their family has an employer offer of coverage for which the employee-only premium is less than 9.83 percent of family income and for which the actuarial value is at least 60 percent (equivalent to a marketplace bronze plan), even when a premium tax credit would provide lower premiums — sometimes as low as zero — for a plan with a higher actuarial value.

Short of fully repealing the firewall, policymakers could make several modifications to expand coverage and significantly improve affordability for lower-income workers.

Fix the "Family Glitch"

Policymakers could fix the "family glitch" by determining the affordability of employer-sponsored coverage using the family premium rather than the premium for employee-only coverage. This would allow an employee's family members to access a premium tax credit when family coverage is unaffordable, even if the employee's self-only premium is affordable.[27]

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[23] If, as recommended, premium tax credits are made permanently available to people at higher income levels (over 400 percent of poverty) who have high premium burdens, then benchmarking the credits to gold instead of silver plans would have the unintended consequence of further boosting assistance to this group.

[24] Tara Straw, "Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers," CBPP, December 3, 2019, https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for.

[25] Gary Claxton, Bradley Sawyer, and Cynthia Cox, "How Affordability of Health Care Varies by Income Among People With Employer Coverage," Kaiser Family Foundation, April 14, 2019, https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/#item-start.

[26] Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, "Marketplace Subsidies: Changing the 'Family Glitch' Reduces Family Health Spending But Increases Government Costs," *Health Affairs*, July 2016, https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491.

[27] A better approach would be to make the employee as well as family members eligible for marketplace coverage if the cost of family coverage exceeds the affordability percentage. Otherwise, the family would have to pay both the employer premium for single coverage and the marketplace premium for other family members, and so the total cost could still exceed the affordability standard. However, this approach could add significantly to cost.

An estimated 5.1 million people, about half of them children, would become eligible for a tax credit under this proposal, according to a Kaiser Family Foundation analysis.[28] A plurality of people gaining eligibility would be those with incomes between 250 and 400 percent of the poverty line.

People with incomes under 138 percent of the poverty line would experience the biggest premium reductions, with the average family premium falling from 20 percent of income in employer-sponsored coverage to 5.5 percent in the marketplace, according to an Urban Institute analysis.[29] People with incomes between 138 and 200 percent of the poverty line would see their premiums cut in half, from 17.6 percent to 8.2 percent of their income. A separate analysis concurred that fixing the family glitch would reduce families' average total health care spending by thousands of dollars and drop their risk of spending at least 20 percent of income on health care by more than two-thirds.[30]

Apart from a legislative solution, the Biden Administration could address the family glitch under its statutory authority to correct the Obama Administration's interpretation that created this gap. While the statute is clear that the employee is barred if they have an offer of affordable employer coverage, the same isn't necessarily true of family members. The Obama Administration's Treasury Department interpreted 26 U.S.C. 5000A to determine the employee's "required contribution" for coverage in one way for the firewall (measuring the affordability of family coverage by the cost of individual coverage) but in a different way for determining whether an individual responsibility payment was owed (measuring the affordability of family coverage by the cost of family coverage). The latter interpretation is more reasonable and could be adopted without a statutory change.

Lower the Employer Coverage Affordability Threshold

As explained above, employer-sponsored coverage is considered unaffordable if the employee's share of the premium for the lowest-cost plan exceeds roughly 10 percent of household income (9.83 percent in 2021). Reducing this threshold to correspond with the 8.5 percent of income premium cap could prod more employers to make the coverage they offer more affordable, especially given the penalties certain employers would otherwise face, as we explain below. For employers that don't meet the new standard, their workers would be free to seek subsidized marketplace plans. Lowering the affordability threshold would primarily benefit low-income workers, who are more likely to have high premiums relative to income and would be eligible for the most substantial assistance if no longer firewalled.

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[28] Cynthia Cox *et al.*, "The ACA Family Glitch and Affordability of Employer Coverage," Kaiser Family Foundation, April 7, 2021, https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage.

[29] Buettgens, Dubay, and Kenney, *op. cit.* Adults with incomes below 138 percent of poverty are eligible for Medicaid in states that expanded Medicaid under the ACA; a person with an offer of employer-sponsored coverage is not barred from Medicaid eligibility. The percentage of income includes the cost of employer-sponsored coverage, after accounting for the tax exclusion, plus the percentage of income the rest of the family would contribute toward marketplace coverage. The percentage of income an enrollee would pay for marketplace premiums is based on calculations under prior law, before enactment of the American Rescue Plan. The difference between enrollee premiums for employer-sponsored coverage compared to those in the marketplace is larger with the Rescue Plan's premium tax credit enhancements.

[30] Sarah A. Nowak, Evan Saltzman, and Amado Cordova, "Alternatives to the ACA's Affordability Firewall," RAND Corporation, 2015, https://www.rand.org/pubs/research_reports/RR1296.html.

Lowering the affordability standard could also increase employer penalty collections and help finance the shift of workers to marketplace coverage with premium tax credits. Currently, a penalty for each full-time worker is triggered if a firm doesn't offer coverage and any employee gets a premium tax credit in the marketplace. If the firm offers coverage but the employee-only premium is unaffordable or the plan doesn't meet a standard known as minimum value, the penalty applies to each full-time worker who receives a credit.

Congress could also de-link the affordability standard for employees' premium tax credit eligibility from the affordability standard for the employer penalty. Under such a policy, failing to offer coverage or offering subpar coverage would trigger the penalty, irrespective of workers' enrollment in marketplace coverage with premium tax credits. This would allow more workers (particularly those with low incomes) to enroll in subsidized marketplace plans without necessarily penalizing more employers.

Raise the Minimum Value Standard

Another way to improve health care affordability for people with offers of job-based coverage would be to increase the share of anticipated health costs that the plan pays for. A large-employer or self-insured group plan currently meets the minimum value standard if it covers at least 60 percent of the plan's total allowed benefit cost. By contrast, the marketplace benchmark plan covers 70 percent of expected costs, and as noted, people with incomes below 250 percent of the poverty line are eligible for cost-sharing assistance that further lowers consumers' costs by increasing plans' actuarial values.

One option would be to raise the minimum value standard from 60 percent to 70 percent to align with the marketplace benchmark. Raising the minimum value standard wouldn't affect most employers since the average employer plan has an actuarial value of 85 percent.[31] While it could lead some employers to pass on premium increases to employees, the affordability standard would also constrain these increases. Other employers offering low-value plans may drop coverage altogether but, to the extent that employees are eligible for premium tax credits, this might give more workers and their families access to more affordable and comprehensive coverage in the marketplace.

Other Provisions Would Further Access to Affordable, High-Quality Coverage

Policymakers could implement several other policies to insure more people with comprehensive coverage and, in some cases, reduce costs.

Broaden Enrollment Periods for Marketplace Plans

Marketplace enrollment consistently falls during a typical year. If the system were working well, it would be roughly stable, as the number of people enrolling in plans during the year (because they lose job-based benefits or Medicaid, for example) would roughly match the number who leave

[31] Actuarial Research Corporation, "Final Report: Analysis of Actuarial Values and Plan Funding Using Plans from the National Compensation Survey," compiled for Office of Policy Research, Employee Benefits Security Administration, Department of Labor, May 12, 2017, https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/analysis-of-actuarial-values-and-plan-funding-using-plans-from-the-national-compensation-survey.pdf.

(because they become eligible for Medicaid or get a job with health coverage). But the system is not working well.

Many people who are eligible for "special enrollment periods" (SEPs) to enroll during the year aren't using them, possibly because they aren't aware of them or because the system is too confusing.[32] (A person needs an SEP to enroll in a plan after the annual open enrollment period for marketplaces has closed; SEPs are triggered by certain situations, such as losing other coverage and having a baby, but often are not available to people who have been uninsured or had gaps in coverage.[33]) The yearly decline in marketplace enrollment appears to be driving a troubling seasonal increase in those who are uninsured. The number of adults without coverage rose by more than 1 million between the first and fourth quarter of each year from 2016 through 2019, then fell by more than 1 million in the first quarter of the subsequent year (after marketplace open enrollment), National Health Interview Survey data show.

Enrollment periods should be expanded and simplified nationwide. The Biden Administration has temporarily opened HealthCare.gov to enrollment, in response to the COVID-19 public health emergency, and many states that run their own marketplaces have taken similar steps.[34] But beyond August 15, the current deadline for the emergency enrollment period, permanent changes will be needed to ensure that marketplace enrollment policies strike a better balance between the goals of expanding coverage and limiting adverse selection (which occurs when healthy people opt not to enroll, leaving a less healthy and higher-cost population in the insurance pool).

While the Administration has broad authority to modify marketplace enrollment rules, for example to lengthen the yearly enrollment period and add new events that trigger an SEP, Congress could include legislative provisions to set this process in motion. For example, legislation could guarantee people who are eligible for significant financial assistance the ability to enroll in a marketplace plan year-round. This would help more people access the improved financial assistance recommended above. In Massachusetts, a similar policy gives broad access to people who have incomes up to 300 percent of the poverty level; enrollment in the state's marketplace is stable over the course of the year.[35] Massachusetts also consistently has among the lowest marketplace premiums in the country, showing that more open enrollment policies can be compatible with maintaining a broad risk pool. Any changes to enrollment rules (or to financial assistance) should be

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[32] Matthew Buettgens, Stan Dorn, and Hannah Recht, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," Urban Institute, November 2015, https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf.

[33] CBPP, "Special Enrollment Period Reference Chart," updated October 2020, http://www.healthreformbeyondthebasics.org/wp-content/uploads/2020/10/REFERENCE-CHART_Special-Enrollment-Periods-10.20.pdf.

[34] "HHS Announces Marketplace Special Enrollment Period for Covid-19 Public Health Emergency," Department of Health and Human Services press release, January 28, 2021, https://www.hhs.gov/about/news/2021/01/28/hhs-announces-marketplace-special-enrollment-period-for-covid-19-public-health-emergency.html.

[35] Sarah Lueck, "Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage," CBPP, June 5, 2019, https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve.

accompanied by a robust public outreach and enrollment assistance effort, to ensure that eligible people are aware of what's available and how to sign up.

Help States Improve Affordability and Access through the Basic Health Program

The ACA established the Basic Health Program (BHP), an optional program available to states to provide more affordable coverage to people with low incomes who are otherwise eligible to purchase subsidized marketplace coverage. States adopting a BHP can use it to cover those with incomes between 138 and 200 percent of poverty, as well as lawfully present immigrants who have an immigration status that doesn't qualify them for Medicaid. The federal government pays the state 95 percent of the amount of premium tax credits and cost-sharing reductions that would have otherwise been provided to eligible individuals to purchase marketplace coverage, and the state is required to provide coverage at least as generous as that provided through the marketplace.

Minnesota and New York — the two states that took up the BHP option — are able to provide coverage with lower premiums and cost sharing, and with fewer access barriers, than otherwise available marketplace coverage.[36] The more generous coverage costs the states less because they use plan procurement processes that result in provider payment rates that fall in between commercial coverage and Medicaid. Both Minnesota and New York have exceptionally low uninsured rates, with their BHPs likely a contributing factor.

To create a new pathway for states to make major coverage expansions and improvements, a recovery package should:

- Allow states to open BHP coverage to people at higher income levels, rather than restricting it to people with incomes below 200 percent of poverty. States should continue to receive federal funding equal to 95 percent of premium tax credits and cost-sharing assistance amounts for people otherwise eligible for subsidized marketplace coverage.
- Broaden options for the delivery of care model, to make BHP more feasible for states that have limited or no use of managed care in Medicaid. For example, statutory language could be added to allow for other models that also promote coordinated care, such as integrated care models like those Minnesota uses (e.g., Hennepin Health), or the use of an administrative service organization, which Connecticut uses in its Medicaid program.
- Provide upfront funding for BHP implementation. The statute prohibits states from using BHP trust funds to finance administrative costs; they can only use them to lower cost-sharing charges or provide additional benefits.

Public Option

Private health insurance plans spend more per enrollee than Medicare or Medicaid does, largely due to higher provider payment rates, and the difference is growing.[37] One approach to bringing

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[36] Jennifer Tolbert, Larisa Antonisse, and Stan Dorn, "Improving the Affordability of Coverage through the Basic Health Program in Minnesota and New York," Kaiser Family Foundation, https://www.kff.org/health-reform/issue-brief/improving-the-affordability-of-coverage-through-the-basic-health-program-in-minnesota-and-new-york/.

[37] Karyn Schwartz *et al.*, "Limiting Private Insurance Reimbursement to Medicare Rates Would Reduce Health Spending by About $350 Billion in 2021," Kaiser Family Foundation, March 1, 2021, https://www.kff.org/report-

down provider rates would be to create a public plan that pays providers rates based on Medicare's, whether equal to Medicare's or to some specified multiple of Medicare rates.

Not only would the public plan itself pay much lower prices for hospital and specialty physician services than commercial plans currently do, it would also increase private insurers' bargaining power with providers. If the provider and the plan did not reach agreement on a price allowing the plan to set premiums competitive with the public option's, the private plan's customers would leave for the public option, and the provider would be stuck with the public option rates. Thus, the public option would exert downward pressure on commercial payment rates as well.[38]

The public plan would also directly compete with insurers, likely forcing them to reduce the profit margin built into premiums in areas of the country with limited insurance market competition. The Urban Institute estimates that a public plan paying Medicare rates that was offered only in the ACA marketplaces could save over $150 billion over ten years.[39] (It would also significantly reduce the cost of the premium tax credit improvement package above.)

Introducing a public plan could increase coverage, but the impact would be very small unless the affordability and access improvements discussed above were adopted as well. For example, just introducing a public plan in the marketplaces, without other changes, would increase the number of people with health coverage by only about 200,000, according to Urban's estimates. That's because it would lower prices only for the relatively small number of uninsured people not eligible for premium tax credits.

Close Subpar Plan Loopholes

Subpar plans proliferated in recent years amid the Trump Administration's rule changes and anti-ACA rhetoric, as well as aggressive marketing to the public. These plans are not required to meet ACA standards or abide by the ACA's pre-existing condition protections. They expose people to health and financial risks the ACA aimed to address. For example, patients experiencing lymphoma, a heart attack, or a hospitalization for mental health care would face tens of thousands of dollars in out-of-pocket costs if they had a so-called short-term plan rather than an ACA plan.[40] Subpar plans

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section/limiting-private-insurance-reimbursement-to-medicare-rates-would-reduce-health-spending-by-about-350-billion-in-2021-issue-brief/. See also Eric Lopez *et al.*, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature," Kaiser Family Foundation, April 15, 2020, https://www.kff.org/report-section/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature-issue-brief/ and Rabah Kamal, "How has U.S. spending on healthcare changed over time?" Kaiser Family Foundation, December 23, 2020, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime_10.

[38] Matthew Fiedler, "Capping prices or creating a public option: How would they change what we pay for health care?" Brookings Institution, November 19, 2020, https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/.

[39] Linda J. Blumberg, "Estimating the Impact of a Public Option or Capping Provider Payment Rates," Urban Institute, March 2020, https://www.urban.org/sites/default/files/2020/03/23/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf.

[40] Dane Hansen and Gabriela Dieguez, "The impact of short-term limited-duration policy expansion on patients and the ACA individual market," Milliman Research Report, February 2020, https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf.

also increase premiums for comprehensive coverage because they pull healthier people out of the ACA risk pool, leaving a costlier group of people behind. This increases affordability problems for people who are not eligible for ACA subsidies, especially those with pre-existing health conditions. And intense, sometimes deceptive marketing of subpar plans leads people to think they have decent coverage and then find out, when they get sick, that they don't.[41]

Congress should act to comprehensively address subpar plans. Rule changes could redefine short-term plans as those lasting up to three months instead of a year or longer (as under Trump-era changes) and strengthen standards for other forms of subpar coverage.[42] It's especially hard to see the purpose of low-quality products that undermine ACA protections for people with pre-existing conditions if financial assistance is expanded and improved so that people can enroll in affordable, comprehensive health coverage through the marketplaces.

[41] Government Accountability Office, "Private Health Coverage: Results of Covert Testing for Selected Offerings," August 24, 2020, https://www.gao.gov/assets/710/708967.pdf; and Michelle Andrews, "Think your health care costs are covered? Beware the 'junk' insurance plan," National Public Radio, December 12, 2020, https://www.npr.org/sections/health-shots/2020/12/03/941620737/think-your-health-care-costs-are-covered-beware-the-junk-insurance-plan.

[42] Christen Linke Young, "Taking a Broader Look at Junk Insurance," Brookings Institution, July 6, 2020, https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/.