



How States Can Build on the ACA To Improve Affordability and Lower Health Care Costs

By Maura Calsyn July 15, 2021

The health care portions of the American Rescue Plan (ARP) include the first-ever federal expansion of the Affordable Care Act (ACA).¹ The law increases financial assistance for people already purchasing health care coverage through the ACA's marketplaces and extends assistance to millions of Americans with incomes above the original ACA eligibility limits. While this federal action is significant, state action remains necessary. States should view the new changes made by the ARP as an opportunity for additional reforms.

Multiple states have already implemented or are advancing proposals to improve health care affordability and increase enrollment in the individual market.² These efforts—which include public options and other related reforms to lower prices in the private market—are a critical piece of broader efforts to address the coverage and affordability barriers across the health care system.

Specifically, states can consider additional financial assistance to lower deductibles and other out-of-pocket costs for people with lower incomes. Moreover, they should work to lower the underlying prices in the commercial health care market, given that the ARP's changes are an important step to improving affordability but do not address the underlying reason why premiums and other health care expenses are often too expensive. Not only are these reforms vital to further improving affordability, but they are also critical to ensuring that health care expansions are sustainable.³

This issue brief outlines ways in which states can use the ARP as a starting point for additional reforms, as well as how the changes made to the ACA give states additional flexibility and additional federal funding to help offset state costs in implementing these reforms. As a result, states are in an excellent position to adopt policies that increase coverage and improve affordability, both of which are critical steps that would improve health outcomes and reduce health disparities.

The Affordable Care Act and the American Rescue Plan

Under the ACA, people with family incomes from 100 percent to 400 percent of the federal poverty level (FPL) who purchase marketplace coverage qualify for tax credits to help them afford their premiums.⁴ These premium tax credits limit the amount that individuals or families pay for a silver plan on the marketplace to a percentage of their income. The ACA also includes cost-sharing reductions that lower copayments and deductibles for people whose incomes are from 100 percent to 250 percent of the FPL. This structure creates a significant affordability cliff at 400 percent of the FPL, as those with incomes higher than that limit struggle to afford unsubsidized premiums.⁵

To address this issue, the ARP builds on the ACA by extending tax credits to those making more than 400 percent of the FPL. Families with incomes higher than 400 percent of the poverty level now qualify for tax credits that limit their net premium for a silver plan to no more than 8.5 percent of their income.⁶ The ARP also increases the tax credit amount for those with incomes from 100 percent to 400 percent of the FPL.⁷ Additionally, it allows people who received unemployment at any point during 2021 to enroll in a silver plan without any premiums and with additional cost-sharing subsidies.⁸ Notably, the ARP's changes will remain in place through the 2022 plan year.

The Congressional Budget Office (CBO) has estimated that together, these changes will increase enrollment in the marketplaces by about 1.7 million people in 2022 and reduce net premiums for most people enrolled in marketplace coverage.⁹ Moreover, the CBO expects that about two-thirds of the new enrollees will be people with incomes higher than 400 percent of the FPL.¹⁰ In April 2021, the first month in which the ARP's increased tax credits were offered, 1.9 million consumers returned to the marketplace to claim the new expanded tax credits, saving an average of 40 percent on their monthly premiums.¹¹ In the same month, many of the nearly 470,000 new marketplace enrollees also benefited from the tax credits; on average, premiums for new consumers decreased by more than 25 percent and deductibles for new consumers dropped by nearly 90 percent.¹²

State actions to improve affordability and expand coverage

Since 2014, when the ACA's marketplaces went into effect, a number of states have taken steps to further lower premiums and out-of-pocket costs for those purchasing marketplace coverage, as well as offer financial assistance to those whose incomes are higher than 400 percent of the FPL.¹³ Similar to the ARP's affordability provisions, both reinsurance and additional supplemental financial assistance lower consumers' costs by increasing federal and state health care funding while also improving the risk pool.

Other types of reforms, including public options and related proposals, also target the underlying prices of medical services.

State reinsurance programs

Today, 14 states have reinsurance programs through which insurers are reimbursed for coverage of very high-cost marketplace enrollees.¹⁴ Because insurers do not have to worry about factoring those expenses into their premiums, reinsurance programs lower premiums. This, in turn, can improve the individual market's risk pool, as healthy people—especially those whose incomes do not qualify them for premium tax credits—will be more likely to enroll if the premiums are more affordable.¹⁵ And because premiums are lower, the federal government's spending on premium tax credits is also reduced.¹⁶

During the first three years of the marketplaces, the ACA included temporary risk-sharing programs, including a federal reinsurance program. Since then, states that have moved forward with their own reinsurance programs have kept premiums lower than states that have not.¹⁷ Some states, such as Alaska and Maryland, have reduced average unsubsidized premiums by nearly 40 percent in the early years of reinsurance implementation. While the rates of premium savings have varied widely across states, according to The Commonwealth Fund, “In most states, reinsurance has produced an annual reduction in premiums of more than 10 percentage points.”¹⁸

Supplemental financial assistance

In addition to reinsurance programs, a number of states have supplemented the ACA's financial assistance, both by extending premium tax credits above 400 percent of the FPL and by supplementing those already receiving federal tax credits.¹⁹ For example, California, New Jersey, and Vermont marketplace enrollees qualify for additional state-funded assistance with their premiums.²⁰ In addition to premium tax credits, Massachusetts and Vermont supplement the ACA's cost-sharing reductions, which reduce the size of deductibles as well as lower cost sharing.²¹ Bolstering cost-sharing reductions is particularly important to address affordability for individuals whose incomes fall around 250 percent of the FPL, the income cutoff for this assistance.²²

Unsurprisingly, lower net premiums and more affordable coverage attract additional, healthier enrollees, again improving the individual market's risk pool.²³ For example, Massachusetts has the lowest uninsured rate in the nation and some of the lowest marketplace premiums.²⁴

State public options and related reforms

Public options and other similar reforms add a publicly backed health insurance plan as an option for marketplace enrollees. Washington state's Cascade Care is the first such approach to be implemented.²⁵ Beginning in the 2021 plan year, marketplace enrollees in the state can select public option standardized plans with lower deduct-

ibles and additional pre-deductible services. In order to keep these plans affordable, the state sets an aggregate provider payment amount of 160 percent of Medicare rates.²⁶ Because the payment limits are in aggregate, some providers may receive higher or lower payments. There is also a payment floor for primary care physicians and some hospitals in underserved areas to ensure that these providers receive adequate payments.²⁷ Private insurers can also offer these standardized benefit plans. However, Washington did not meet the premium savings goal of 5 percent to 10 percent during the first enrollment period.²⁸ Despite this adjustment period, the public option standardized plans cost less than privately offered standardized plans in nearly every county in which they are offered.²⁹

Nevada and Colorado have followed Washington in passing affordability laws that also target underlying prices. Similar to Washington's program, the Nevada law sets a premium reduction target and a payment floor based on Medicare rates.³⁰ The law also sets a target of 2026 for the Nevada marketplace to operate a public plan and would require that providers participate in the public plan as a condition of their participation in the state's Medicaid program and state employee health plan.

The Colorado Health Insurance Option requires private insurers to offer standardized benefit plans in the individual and small group markets in every county in which the insurer already participates.³¹ The law also sets premium reduction targets. If insurers fail to meet these targets, the Colorado Division of Insurance will hold a public hearing and, depending on its finding, may set provider payment rates in order to reach the target or to meet network adequacy requirements. The state would set payment rates above a floor based on a percentage of Medicare rates.

As Washington, Colorado, and Nevada demonstrate, most public option and related proposals have a focus on reducing the price of medical services and passing those savings on to consumers through lower premiums or out-of-pocket costs. Moreover, this approach can have a ripple effect by increasing competition and efficiencies across the private market. If the public option offers marketplace consumers a lower-cost, high-quality coverage option, other plans will need to negotiate lower payment amounts and offer robust benefits and strong networks in order to attract enrollment.

It is unsurprising that health care industry groups have largely opposed reforms that target the high prices of health care items and services. For this reason, any claim by the industry that the ARP has made additional state action unnecessary should be viewed with caution. In fact, the opposite is true: Now that the federal government has taken some of the pressure of needing to improve premium affordability off states, they can focus on other coverage and affordability priorities, such as lowering cost sharing, improving plan benefits, and tackling the underlying cost of care.

Next steps for states

States have a variety of options available to improve affordability and expand coverage. In addition, depending on the specific reforms a state adopts and how much they collectively lower health care costs, states can receive pass-through funding from the federal government to help pay for these coverage and affordability improvements.

The Affordable Care Act's Section 1332 waivers

Under Section 1332 of the Affordable Care Act, states can request federal approval for state innovation waivers. States may waive certain provisions of the ACA as long as the changes are within four so-called guardrails, which require that health care coverage is “at least as comprehensive and at least as affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit.”³²

If a state waiver will lower federal spending—for example, by lowering premiums—states can receive the federal savings as pass-through funding, which in turn can offset some of the state's costs in enacting the reforms.³³ The state's pass-through payment is the difference between the total amount of the premium tax credits, cost-sharing reductions, and small-business tax credits that the federal government would have spent without the Section 1332 waiver and the total amount of those same tax credits and cost-sharing reductions with the Section 1332 waiver in place.³⁴ Pass-through payments are calculated annually based on state-submitted data on rates and enrollment.

To date, Section 1332 waivers have been approved in 15 states,³⁵ 14 of which have used their waiver to implement state-level reinsurance programs.³⁶ Given the Trump administration's opposition to the ACA, it is unsurprising that in recent years, states have largely limited their waivers to reinsurance programs instead of more innovative approaches to strengthening the law.³⁷ But other state changes to the ACA that decrease premiums should also result in pass-through funding. For instance, Colorado's initial public option legislation, drafted prior to the ARP, recognized this opportunity. It would have required the state to apply for a 1332 waiver and use most of the pass-through funding to offset the expense of new premium tax credits for those families with incomes higher than 400 percent of the poverty level.³⁸

States can now look to the federal government as a partner committed to strengthening the ACA instead of sabotaging the law. Moreover, the ARP's enhanced premium tax credits and its expansion to those earning more than 400 percent of the FPL, as well as the resulting increased enrollment in marketplace coverage, will increase the amount of pass-through payments that states can expect for the next two years.

Federal regulatory steps that can assist states and consumers

In 2018, the Trump administration released guidance that replaced the Obama administration's 2015 guidance on Section 1332 waivers.³⁹ The new guidance encouraged states to submit waivers that would undermine the ACA's consumer protections.⁴⁰ Using this guidance, the Trump administration approved a waiver from Georgia that would have, among other provisions, removed the state from HealthCare.gov.⁴¹ Prior to the end of the Trump administration, the 2022 Notice of Benefit and Payment Parameters adopted the 2018 interpretation of Section 1332's guardrails.⁴² The Biden administration then issued a "regulatory freeze" that covered the final rule, as well as an executive order revoking the 2018 guidance.⁴³ The Biden administration subsequently issued a proposed rule to rescind the Trump administration's 1332 regulation.⁴⁴ The proposed rule is largely consistent with the Obama administration's 2015 guidance.

The proposed rule restores critical consumer protections; for instance, states must once again consider a waiver's impact on vulnerable and underserved residents. The proposed rule also seeks comments on how states could use 1332 waivers to focus on equity and expand access to comprehensive coverage. The proposed rule does not, however, propose to modify the interpretation of budget neutrality, which states have cited as a potential barrier to reforms that would increase enrollment.⁴⁵ The Biden administration could assist states by interpreting its definition of budget neutrality to clarify that reforms that reduce premiums—and as a result boost enrollment—are permissible, even if federal costs increase due to new enrollment. This interpretation would be consistent with Medicaid budget neutrality requirements for that program's Section 1115 demonstration waivers, under which states ask for approval to test Medicaid policies that differ from federal statutory requirements.⁴⁶

In addition, the Biden administration can act within its existing authority to fix the so-called family glitch. Fixing the glitch would allow family members of a person with employer-sponsored insurance to qualify for subsidized marketplace coverage if the job-based coverage is unaffordable for the entire family.⁴⁷ Changing this would eliminate another affordability challenge facing states and potentially increase the amount of a state's pass-through payment.

State-specific assessments

Because each state has its own specific affordability and coverage challenges, a necessary first step to developing state-level reforms is understanding the barriers to health care coverage and access across the state. For example, knowing the number of uninsured residents alone is insufficient. Instead, policymakers must have a clear picture of who in the state is uninsured, including by income, immigration status, age, and geography. In addition, states should evaluate which insured individuals face affordability challenges because of issues such as high deductibles.

With this information, each state can tailor its reforms to address its specific challenges. For example, if a large portion of the uninsured are eligible for existing subsidies or Medicaid, a state may wish to focus on enrollment outreach and education about the ARP's existing subsidies. Or if a state analyzes its data and realizes that its residents are underutilizing key health care services, it can design a standardized benefit package that dramatically reduces or eliminates cost sharing for those services.

In particular, states with high numbers of undocumented immigrants should consider how best to cover these individuals given that the ACA prohibits premium tax credits and other financial assistance to this group. California, for instance, previously submitted a Section 1332 waiver to allow undocumented immigrants to purchase coverage through Covered California—the state's marketplace—without federal assistance.⁴⁸ Yet the state withdrew the waiver request just before the start of the Trump administration.⁴⁹ A similar waiver, combined with reinsurance to lower overall premiums, would be a helpful start to improving coverage rates among undocumented immigrants.

States wishing to pursue a public option must undertake additional evaluations. A key issue in any public option design is the amount that providers will be paid when they care for enrollees. States should survey the provider payment and plan choice landscape as an initial step in developing a public option. Furthermore, they should consider reducing unwarranted price variation across providers, as well as examine ways to support providers who are essential to underserved populations. A public option design that accounts for those essential providers—while also setting overall payment rates based on Medicare rates—can lower premiums, improve affordability, and be a critical first step to addressing health disparities.⁵⁰

States that have conducted these analyses prior to the ARP should reconsider how the law's changes may alter their priorities. For instance, states that had previously planned or implemented an expansion of premium tax credits to individuals above 400 percent of the FPL could decide to instead reinvest the pass-through payments in additional affordability measures for lower-income residents—for example, by providing additional cost-sharing reductions or bolstering the generosity of benchmark plan benefits.

Conclusion

States were leaders in advancing critical affordability reforms even before the coronavirus pandemic. Now, it is time for action from an administration and congressional leaders similarly invested in improving the ACA. The ARP provides critical, temporary new federal funding that can help with these efforts. But Congress must act to make these changes permanent, as states will feel more confident investing in bold changes if they have certainty that the enhanced ARP subsidies will remain in place.

Legislation, such as the Improving Health Insurance Affordability Act,⁵¹ can increase federal assistance for cost-sharing expenses and allow states to turn their focus to more expansive reforms such as public options. Moreover, additional federal regulatory action to clarify the scope of Section 1332 can further support innovative state health care reforms.

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