

Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges

Findings from the Marketplace
Affordability Project

April 10, 2024



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Introduction

The Affordable Care Act (ACA) dramatically changed the private insurance landscape for millions of people in the U.S. For people who lacked access to employer-sponsored insurance or were priced out or barred from the individual market, the ACA opened up new coverage options. It did this by coupling federal subsidies that make coverage more affordable for people with low and moderate incomes with protections that require plans to provide comprehensive, non-discriminatory benefits. As a result, ACA marketplace plans have seen record enrollment in recent years. (See Figure 1.)¹ Recent ACA reforms such as enhanced premium tax credits are also driving coverage gains for communities historically left behind by insurance, including Black people, Latino people, and people with lower incomes.²

These successes show that strategic policy interventions can significantly improve access to health coverage, particularly for communities that struggle the most with access. But further improvements are needed to build on these successes. While the expansion of federal financial assistance that reduces marketplace plan premiums have made buying coverage far more affordable, high deductibles and coinsurance still put necessary services out of reach for many enrollees.

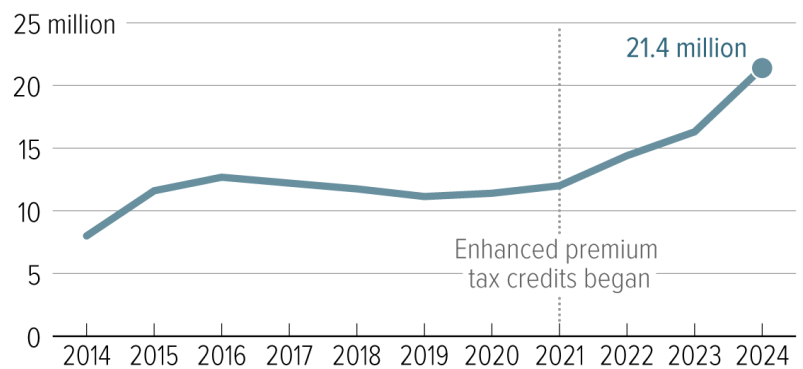
The ACA's private insurance reforms were modeled after the employer market, so the cost-sharing affordability challenges that marketplace enrollees experience are very similar to challenges faced by people with employer-sponsored insurance, especially those with low incomes. For people with little financial margin to cover large or unexpected costs, cost-sharing charges are a significant barrier to obtaining care when covered by private insurance.

This report focuses on policy solutions that would improve cost sharing in the ACA marketplace, as there are clear policy levers that Congress and the executive agencies can use to implement these improvements. However, similar improvements could also be applied to other forms of private insurance coverage.

Figure 1

Enhanced Premium Tax Credits Boosted ACA Marketplace Enrollment

Affordable Care Act (ACA) marketplace open enrollment plan selections



Source: 2024 data from CMS Health Insurance Marketplaces 2024 Open Enrollment Report

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The Challenge

While the ACA has created a path to coverage for millions where none existed, enrollees in the ACA's marketplace plans — like others with private insurance coverage — continue to struggle with high out-of-pocket costs, such as deductibles, coinsurance, and copayments. These affordability challenges have a pronounced impact on access to care and economic security. In a 2023 Commonwealth Fund survey, 37 percent of respondents enrolled in the marketplace or individual market reported that they or a family member delayed or skipped needed health care in the past 12 months because of cost.³ Seventy percent of respondents reported that they spent at least 10 percent — and 23 percent said they spent at least a quarter — of their monthly household budget on health care.

Unaffordable cost sharing affects people regardless of health status but can acutely affect the people who use and need health care the most. Individuals with complex or chronic conditions and disabilities struggle with specialty medication costs and frequent use of health care services, which can result in astronomical health care costs under high-deductible plans.⁴ Even relatively healthy individuals can encounter high deductibles and unmanageable cost sharing for more routine health services, such as primary, chronic, and urgent care.⁵ Most enrollees fall somewhere in the middle; they may struggle with surprise costs that come from unexpected medical needs or may be among the many adults thrown into medical debt due to a health emergency.⁶

Affordability challenges are also connected to institutional racism and structural inequities. The intersection of multiple health-related social needs tied to income, gender, LGBTQ status, race, ethnicity, and immigration status can compound disparities and affordability challenges, particularly for people of color and members of other marginalized groups. And lack of access to health care can have a ripple effect on people's lives, leading to hardship in areas such as food security, housing, and child care.

Out-of-pocket costs: Expenses for medical care that aren't paid for by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services, plus all costs for services that aren't covered. Out-of-pocket costs do not include premiums.

- **Coinsurance:** The percentage of costs of a covered health care service for which an individual is responsible (20 percent of the total bill, for example).
- **Copayment:** A fixed amount an individual pays for a covered health care service (for example, \$20 per doctor's visit).
- **Deductible:** The amount an individual pays for a covered health care service before their insurance plan starts to pay. With a \$2,000 deductible, for example, an individual would pay the first \$2,000 of covered services.

Summary of This Project

With support from the Robert Wood Johnson Foundation,⁷ the Center on Budget and Policy Priorities (CBPP) launched the Marketplace Affordability Project (MAP) in late 2022 to examine the causes of high out-of-pocket health care costs for low-income marketplace enrollees and identify federal policy solutions. Recognizing that many policy dynamics affect plan affordability, this project zeroes in on insurance plan designs that affect people’s cost sharing — including deductibles, coinsurance, and copayments. This report presents the MAP team’s findings from its work over the past 18 months.

Figure 2

Process to Identify and Finalize MAP Findings



Meaningful and lasting policy change will not happen without ensuring that the voices of those most affected by inequitable and unaffordable health care costs are at the center of the discussion. Fully understanding the nuanced and intersecting cost-sharing affordability challenges for low-income marketplace enrollees takes intentional engagement and conversation. The team convened approximately 40 individuals for a series of virtual meetings, focus groups, and one-on-one conversations. Participants included marketplace enrollees; people who provide marketplace application and enrollment assistance; patient groups; national groups representing specific racial, ethnic, disability, and age constituencies; and health policy experts.

The meetings and focus groups had three goals: 1) broaden the voices and perspectives

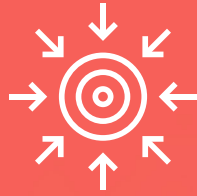
included in discussions of federal marketplace cost-sharing affordability policy; 2) identify affordability pain points and associated policy changes to address cost-sharing affordability challenges for low-income enrollees; and 3) build consensus around the affordability pain points and policy solutions to recommend at the federal level. (See Figure 2.)

Subject matter experts were engaged to present policy ideas at meetings and help facilitate the discussion. CBPP analysis of studies, policy proposals, and other research helped inform the policy recommendations.

The Findings

This report describes the affordability pain points identified by the MAP team and lays out federal policy recommendations to address or mitigate them. Some of the recommendations can be implemented on a shorter timeline, while others will require building political will for more significant congressional action. Many of the recommendations have surfaced in other settings at the federal or state level; this report ties them specifically to the pain points illuminated by the many contributors to this project. Taken together, the recommendations provide a vision for marketplace coverage that enrollees can afford to use, with a menu of policy steps that can be taken over time to achieve this vision.

While the report and recommendations focus on marketplace cost sharing, marketplace plans are part of a broader health system that includes employer-based coverage, which accounts for the vast majority of individuals in private plans and is rife with affordability issues and other problems.⁸ Both the pain points and policy recommendations discussed below are also relevant for other forms of private coverage.



Marketplace Affordability Pain Points

The participants in the MAP meetings and focus groups described a number of cost-sharing affordability pain points affecting marketplace enrollees with low incomes: how the cost-sharing rules operate, whom they affect, and how they affect enrollees' access to care and quality of life. The following are only some of affordability challenges marketplace enrollees face, but they represent the most prevalent and urgent topics among MAP participants.

1. Premium and cost-sharing affordability must be addressed together.

A recurring theme in MAP participants' discussions was the relationship between premiums and cost sharing and the importance of making both affordable. Enrollees and assisters noted the critical role that the enhanced premium tax credits (PTCs) enacted through the American Rescue Plan (and extended in the Inflation Reduction Act) have played in bringing down premiums for enrollees with low incomes, particularly enrollees with incomes below 150 percent of the federal poverty line (about \$22,000 for an individual, in 2023) who became eligible for plans with \$0 premiums.⁹ Some enrollee focus group participants said they would not have been able to remain enrolled in marketplace coverage if those enhanced subsidies had not been implemented in 2021 and continued through 2025.¹⁰

However, MAP participants also noted that premiums are only part of health plan costs. Even when premiums went down to \$0, many enrollees with low incomes were still exposed to unaffordable cost sharing, largely because of the limited availability of zero-deductible plans in most states and the growing use of coinsurance instead of copayments.¹¹

Insurers' increased use of coinsurance, particularly for high-cost drugs, is a particularly harmful cost shift for marketplace enrollees.¹² Copayments are set dollar amounts that enrollees are charged when someone uses a service, so the amount is fixed regardless of the cost of the service. Coinsurance, by contrast, requires people to pay a percentage of the total cost of the service, which is often impossible to know in advance. For high-cost services, including prescription drugs and hospitalizations, coinsurance can sharply increase the amount of an

Premium Tax Credits (PTC): Federal assistance under the ACA to help families afford marketplace coverage. During the COVID-19 pandemic, Congress expanded the generosity and availability of PTCs to lower premiums for marketplace coverage. As a result of these enhanced PTCs, lower-income enrollees are eligible for a silver plan for \$0 or a very low premium.

individual's cost sharing obligation. Coinsurance is also difficult or, in many cases, impossible to calculate in advance of receiving a service, so enrollees may delay or forgo care because they cannot plan for a potentially exorbitant expense.



“ The deductible part really plays a big role because people aren't just thinking about their monthly payment when they choose coverage. They learn about the deductible, that's when they start realizing, 'Oh, I can't afford this. I need to sacrifice something.' Those things play a major role in their decision-making.

Sierra Elrahal, Charlotte Center for Legal Advocacy

Affordability challenges are especially pronounced for certain racial and ethnic groups who have faced barriers to robust health coverage and good health because of racism and discrimination in areas such as employment, education, and housing. In a recent KFF survey, 23 percent and 18 percent of Black and Hispanic enrollees in private insurance, respectively, reported having problems paying a medical bill, compared to 15 percent of white enrollees.¹³

Affordability challenges also are more severe for people who have low incomes but get little help with deductibles and other cost sharing. Under the ACA, people with incomes up to 250 percent of the federal poverty level (FPL) (or about \$36,000 per year for an individual) qualify for cost-sharing reductions (CSRs). For many individuals with incomes of 200-250 percent FPL (about \$29,000-\$36,000 for an individual), the relatively small amount of CSRs they receive is

Cost-sharing reduction (CSR): A discount available to low-income enrollees with incomes up to 250 percent of the federal poverty level (FPL) that lowers the amounts they pay for deductibles, copayments, and coinsurance.

CSRs are automatically applied to silver plans for those eligible. When people who qualify for CSRs shop for coverage, they automatically see silver plans with lower deductibles and cost sharing, whereas people whose incomes are too high to qualify for CSRs will see the same plans but with standard deductibles and cost sharing. We refer to the plans that have the CSRs applied as “cost-sharing reduction plans.”

CSRs are based on income: people with incomes of 100-150 percent FPL receive the most cost-sharing assistance, and those between 200 and 250 percent FPL receive the least.

not sufficient to make cost sharing affordable.¹⁴ If the enhanced premium tax credits that have been available since 2021 are allowed to expire at the end of 2025, these affordability barriers will worsen because enrollees will have to pay more in premiums to purchase coverage with lower deductibles and cost sharing.

2. People can easily find themselves underinsured after a change in health status.

Health status is not static; people get hurt or sick and experience unanticipated health care needs and costs. Plan designs marketed to people based on whether they project “higher” or “lower” health needs in the coming year will leave some enrollees underinsured if they guess wrong. No amount of enrollment assistance, specialized plan comparison tools, or health insurance literacy education can prevent enrollees from becoming underinsured if their health status changes.

Younger enrollees — so called “young invincibles” — may be most at risk. Young adults often have less familiarity and contact with the health care system and are drawn toward lower-premium plans. But when they try to use their coverage, they find that high deductibles, coinsurance, and narrow provider networks¹⁵ can make needed care unaffordable. Nearly half of young adults have at least one chronic condition.¹⁶ One-third of all young adults report living with symptoms of depression and¹⁷ anxiety, for example, and the prevalence is even more severe among adults aged 18-25, where half report mental health issues.¹⁸

Intersecting identities may exacerbate these challenges. For instance, LGBTQ individuals have a higher prevalence of mental health conditions, largely because of stigma and discrimination.¹⁹ And yet marketplace plans — like other types of private insurance coverage — do not have plan designs that provide adequate coverage for mental health conditions, particularly among younger enrollees.²⁰ Therapist visits are often considered specialist visits and therefore have higher cost sharing than primary or preventive care. The combination of narrow marketplace provider networks and a shortage of

“ The fact is that when people select plans, especially young people, they’re not spending as much time comparing plans or planning to be sick even if they have a chronic condition that they should be managing. Our current health care plans fail to really reflect the needs and the economic reality of young people today.”

Martha Sanchez, Young Invincibles


qualified mental health providers forces many enrollees to go out of network for care, where they can rack up significant cost-sharing bills. In other instances, specific mental health services simply are not covered.

3. Individuals with chronic and complex conditions often face no-win choices.

Marketplace enrollees who participated in the MAP reported challenges gaining affordable access to prevention and management services for chronic conditions. Because these conditions — including many types of cancers, diabetes, HIV, and mental health conditions — have a disproportionate impact on marginalized and disenfranchised communities, cost-sharing affordability challenges have health equity implications in addition to negative individual and public health impacts.²¹ When choosing a plan, enrollees with chronic or complex conditions must weigh the relative value of in-network specialists, in-network primary

Figure 3

Tradeoffs in Marketplace Plan Selection

| | | | | |
|--|--|--|---------------------------|---------|
|  <p>200% FPL 40 years old Zip: 60647</p> <ul style="list-style-type: none"> • Needs access to prescription medication • Needs access to specialist for chronic conditions | Plan A (Gold Plan) | | Monthly premium with APTC | \$202 |
| | <ul style="list-style-type: none"> • Covers trusted specialist recommended for care • Includes prescription medicine on formulary with \$50 copayment | | Deductible | \$750 |
| | Plan B (Silver CSR 73) | | Monthly premium with APTC | \$90.95 |
| | <ul style="list-style-type: none"> • Covers trusted specialist recommended for care • Prescription medicine is not on formulary, costs \$400 per 30-day supply out of pocket | | Deductible | \$1,800 |
| | Plan C (Bronze Plan) | | Monthly premium with APTC | \$1 |
| | <ul style="list-style-type: none"> • Does not cover trusted specialist recommended for care; the specialist that is in network is on preferred provider tier with 45% coinsurance • Prescription medicine is on formulary, with 35% coinsurance after deductible | | Deductible | \$7,500 |

care providers, prescription drug coverage, plan deductibles, and cost sharing. In the example below (see Figure 3), which assumes the individual needs to spend no more than 10 percent of their income on health care and that the individual would struggle with an upfront high medical expense, no plan meets all of the individual's needs.

“ An LLS advocate with blood cancer knows when she enrolls in coverage that she will need additional care and likely have hospitalization events. And I think that makes her a much more savvy consumer because she knows exactly which doctors she needs in-network. But that also means that some plans are off the table unless that one particular cancer provider is in-network. She is not going to have much of a choice, maybe even regarding some of the cost-sharing pieces, because she knows the specialist she has to see.”

Bethany Lilly, The Leukemia & Lymphoma Society

4. Deductibles are a major barrier to affordability and a driver of exorbitant health care costs.

By far, the pain point that MAP participants cited most often and with the most vigor was high deductibles. This problem is particularly acute for enrollees who do not qualify for CSR plans and therefore faced average marketplace deductibles of roughly \$7,400 for bronze plans and \$4,800 for silver plans in 2023.²² Access to a CSR plan lessens the pain of the deductible but does not eliminate it for individuals who do not qualify for the maximum CSR amount. (See Figure 4.)

High deductibles are particularly problematic given many households' lack of emergency savings. According to a Consumer Financial Protection Bureau (CFPB) survey, nearly 1 in 3 individuals have a balance of less than \$500 in checking and savings accounts.²³ A separate CFPB survey found that 60 percent of individuals with incomes below 150 percent FPL (roughly \$20,000 per year) and roughly 40 percent of those with incomes between 150 and 400 percent FPL (approximately \$20,000 to \$50,000) have no emergency savings.²⁴ Black and Hispanic households are less likely to have emergency savings than white people, due to policies that limited the employment and wealth-



“ This summer I ended up in the ER. I have a bronze plan with a \$7,500 deductible and 40% coinsurance after that. Knowing that that deductible was there, I delayed. I simply did not have \$7,000 to dole out.”

Miranda Wilgus, Marketplace Enrollee, Illinois

building of non-white households.²⁵

Rather than incentivize enrollees to make cost-effective choices in health care utilization (like reducing use of low-value services), deductibles deter them from seeking needed care.²⁶ High deductibles can also deter people from enrolling in a plan in the first place; as one MAP participant put it, “If someone doesn’t have \$5,000 to spend to reach their deductible, why would they spend \$30 a month on premiums?” The survey findings above showing that many people in the U.S. would face economic hardship due to even nominal unexpected expenses puts the mismatch between high deductibles and households’ economic reality into stark relief.²⁷ A recent Commonwealth Fund survey found that 33 percent of those in marketplace or individual market plans were paying off debt from medical or dental care.²⁸

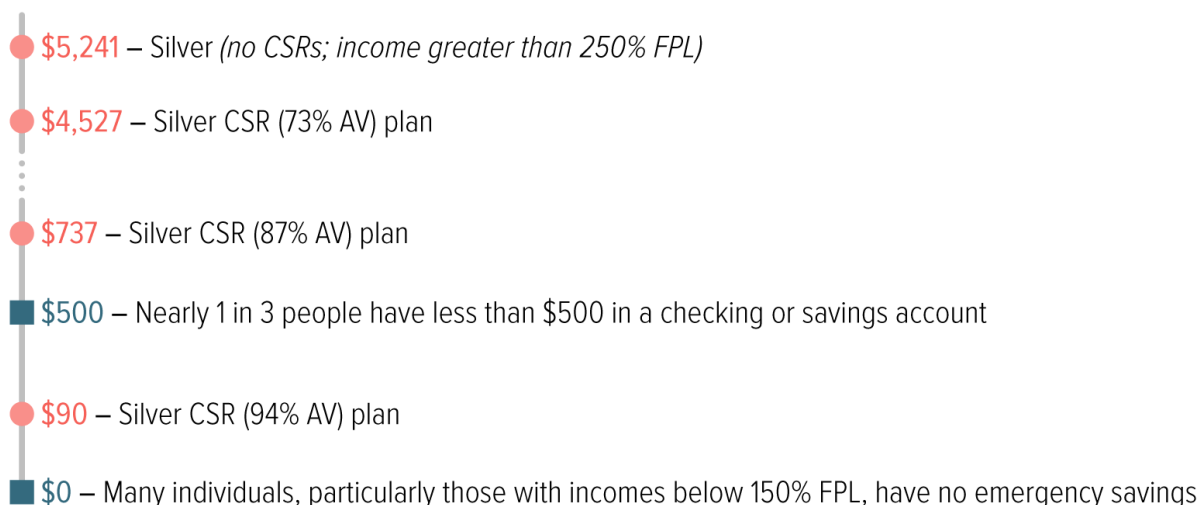
“ I needed surgery last year, but I kept putting it off and putting it off because I had no idea how much this surgery would cost, taking into account my deductible and other costs.”

M.M., 42, Illinois, marketplace enrollee

Figure 4

Deductibles Are Out of Reach for Many

Average annual marketplace deductibles for silver plans compared to economic situation of consumers



Note: FPL = federal poverty level, which is based on income and household size (\$15,050 for a household of one in 2024). CSR = cost-sharing reduction. People with incomes up to 250% FPL qualify for special silver-level marketplace plans with lower copayments, coinsurance, and deductibles than standard silver plans. There are three tiers of CSR plans: Silver CSR 94% for people up to 150% FPL, Silver CSR 87% for those 150-200% FPL, and Silver CSR 73% for those 200-250% FPL.

Source: Kaiser Family Foundation, “Deductibles in ACA Marketplace Plans, 2014-2024,” December 2023; Consumer Financial Protection Bureau, “Making Ends Meet in 2023,” December 2023; Consumer Financial Protection Bureau, “Emergency Savings and Financial Security: Insights from the Making Ends Meet Survey and Consumer Credit Panel,” March 2022.

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Combining a deductible (which requires individuals to pay the full negotiated cost of the service) with exorbitantly high underlying service prices (which are often opaque until after the service has been received) is a recipe for financial disaster.²⁹ This combination is likely why the majority of individuals with medical debt report that it is due to acute care, such as a hospital stay or treatment for an accident.³⁰ Simply put, the deductible amounts for marketplace plans — even CSR plans — are unaffordable for many given the economic realities of the enrollees in these plans.

5. Marketplace plans, like many private insurance options, are not designed in ways that recognize the needs of low-income enrollees.

Though both serve low-income enrollees, marketplace coverage provides much less than Medicaid in terms of affordability protections and enhanced supportive services to help enrollees meaningfully use their coverage. Research on the connection between economic well-being and insurance affordability challenges underscores this disconnect. One analysis found that, prior to recent legislation that improved marketplace financial assistance, 18 percent of marketplace and individual market enrollees reported spending 10 percent or more of their incomes out of pocket on health premiums and medical care, more than enrollees in all other coverage sources.³¹

Medicaid allows only nominal cost sharing and provides enrollees with a range of support services to help them coordinate and access care and other social services. Marketplace plans (and private insurance plans more generally) typically lack these types of support services, such as transportation to medical appointments and case management.³² This difference can be particularly difficult for low-income marketplace enrollees, many of whom were previously enrolled in Medicaid and may not be used to the features of private coverage. MAP participants described the myriad obstacles to accessing care for low-income marketplace enrollees, including high transportation costs (or lack of transportation altogether), difficulty getting time off

“ I have asthma and allergies. Seeing the specialist I want to see for asthma is not covered under my plan, nor is allergy testing. I assumed they would be covered under my plan as they are part of the routine treatment I need. It is frustrating to cover these expensive services after assuming insurance would protect me from that.”

Enola W., marketplace enrollee

from work, and difficulty securing child care.

Finally, the challenges caused by the complexity of the health insurance system, including the investment of time and energy in navigating a labyrinth of plan decision points, are frustrating and directly affect access to care. This is true for other types of health insurance, as well. Out-of-date information about health care provider networks can cause unexpected costs when an individual ends up seeking care from an out-of-network provider. The need to devote hours of time to seek prior authorization for certain services eats into workdays. And the consequences of misjudging what is covered by a plan are significant, leading to unexpectedly high bills. These complexities have an especially profound impact on individuals with limited English proficiency; 45 percent of Spanish-dominant speakers in a recent KFF survey reported difficulty understanding an insurance document explaining their coverage and 35 percent reported that insurance documents are sometimes or never available in their preferred language.³³



Policy Solutions



A number of federal policies could make marketplace coverage more affordable for low-income enrollees. The policies below represent a menu of options. Some could be implemented administratively on a shorter timeline, while others would require congressional approval and thus may take longer. While some might require approval by the Department of Health and Human Services (HHS), state-based marketplaces could adopt many of these proposals — and some already have. Many of the policies included below have been proposed in other settings at the federal or state level; they are presented here because they would best address the pain points raised during this project.

While these policies focus on cost sharing for low-income marketplace enrollees, cost-sharing affordability is only part of a complex set of interlocking systems. Many of these policies would be more effective if coupled with systemic reforms that tackle the array of health care cost drivers for individuals, in areas such as prescription drug and hospital pricing, network adequacy, provider consolidation oversight, and medical debt interventions.

1. Ensure Affordable Premiums

MAP participants consistently underscored the importance of addressing premium and cost-sharing affordability in tandem. If a plan with a low deductible and reasonable cost sharing is only available at a premium amount that is unaffordable, then it is ultimately inaccessible to the enrollee. PTCs to help low-income enrollees afford their premiums have been critical to ensuring access to more generous plans with lower deductibles and cost sharing.

Congressional Action

- **Make enhanced PTCs permanent**

Federal financial assistance with premiums, including the enhanced federal PTCs that have been in place since 2021, has dramatically reduced premiums for marketplace enrollees with low incomes, leading to record marketplace enrollment.³⁴ However, these enhanced subsidies are slated to expire at the end of 2025. Maintaining at least the current level of premium affordability via legislation to extend or make permanent the enhanced PTCs after 2025 is critical. The cost-sharing improvements described in this report will not be effective if marketplace premium help suddenly becomes far less generous and people cannot afford to enroll in coverage. In addition, the enhanced PTC has improved the affordability of more generous silver and gold plans.



“ One of the biggest improvements in the last three or four years was the enhanced premium tax credits. For many people, the subsidies were not quite enough to cover the full cost of their premiums. And when increased access to those tax credits, we saw a big change. A lot of people could finally enroll in plans that would be affordable.”

Deepak Madala, Virginia Poverty Law Center

2. Reduce Cost-Sharing

The second area that federal policymakers should consider is improving both the generosity of marketplace plans (i.e., the availability of plans with lower deductibles and other cost sharing) and the amount of federal financial assistance that individuals receive to help with out-of-pocket costs such as deductibles.

Congressional Action

- **Eliminate or greatly reduce deductibles and other cost-sharing charges in marketplace plans**

Many of the pain points described above could be mitigated by requiring marketplace plans to be more generous and charge less when people use care. An important mechanism Congress has to boost the generosity of marketplace plans is through increasing the “actuarial value” (AV) of those plans. A plan’s AV dictates the proportion of costs a plan must cover versus the percentage of costs the enrollee must cover for a standard population, and insurers establish cost-sharing charges in each marketplace plan in accordance with AV standards. The ACA categorizes plans into four metal levels — bronze, silver, gold, and platinum — with each level increasing in AV.

Congress could increase the generosity of marketplace plans or increase the subsidies enrollees receive to afford generous marketplace plans in four ways:

1. *Increase the generosity of plans offered under the ACA.*

Congress could increase the AV of each plan level, which means that insurers would cover a larger share of covered health care costs for enrollees. Using this approach, current bronze plans with 60 percent AV would become the equivalent of silver plans with 70 percent AV, silver plans would have 80 percent AV, and gold plans would have 90 percent AV. As a result, people with plans in every metal level would have lower out-of-pocket maximums, deductibles, and other cost sharing.

If policymakers were to try to reduce cost-sharing requirements without raising the AV of plans, then enrollees would end up pay more in cost-sharing charges somewhere else.

Raising AV levels of all bronze, silver, and gold plans could allow Congress to require bolder plan design changes, such as eliminating deductibles altogether, which could be replaced by more reasonable copayments that are more transparent and don't require large outlays at the beginning of a plan year. In this scenario, platinum plans would likely go away as the gold plans would shift to being the highest metal level. It would also have the benefit of addressing affordability challenges for individuals whose incomes may be too high to qualify for CSR plans but who still struggle with deductibles and cost sharing. Administrative action could also be used to achieve these goals if the AVs are increased.

However, increasing the AV levels of each plan by itself would increase premium costs. To minimize the number of people who are priced out of the lowest-metal-tier plans, this change should be made in tandem with extending the enhanced PTCs.

Actuarial value (AV): The percentage of total costs for covered benefits that a plan will cover for a standard population. For example, if a plan has an AV of 70 percent, the overall population of enrollees would be responsible for paying 30 percent of the costs of all covered benefits through deductibles and cost-sharing charges.

“Decreasing the deductible amount would be great, but eliminating it altogether would be better. Decreasing the deductible is probably not going to really change how I use my coverage because I never understand what services are covered before my deductible and then what services the deductible applies to.”

Carrie R., 48, Iowa, marketplace enrollee

2. Eliminate deductibles.

Congress could also legislate in a more targeted way, prohibiting the use of deductibles in either all or a subset of marketplace plans. Ideally, this would be coupled with changes to AV to help to ensure that plans do not increase cost sharing elsewhere to make up for the absence of a deductible. Given the mounting evidence that deductibles do not serve a policy purpose other than to deter people from seeking health care,³⁵ this policy change would address one of the most significant pain points in marketplace affordability. California has implemented this policy at the state level, using state funding to eliminate deductibles in all silver CSR plans.³⁶ (See Figure 5.) California estimates the change will affect 39 percent of the state’s marketplace enrollees.

3. Broaden eligibility for CSRs and/or increase the amount of help CSRs provide to enrollees.

Congress could also boost the subsidies individuals receive to make their marketplace cost sharing more affordable by expanding who is eligible for CSRs and increasing the amount of assistance provided by the CSRs. CSRs

Figure 5

California Eliminates Deductibles for Low-Income Marketplace Enrollees

Recognizing that deductibles deter care, California has used state funding to eliminate deductibles in all silver CSR plans. The state estimates that the new plan design protection will impact 39 percent of the state’s marketplace enrollees.

| Benefit | Above 200, up to 250% FPL | | Above 150, up to 200% FPL | | 100% up to 150% FPL | |
|-----------------------------|---------------------------|-----------------------------------|---------------------------|-----------------------------------|------------------------|-----------------------------------|
| | 2024 Federal Silver 73 | California Enhanced CSR Silver 73 | 2024 Federal Silver 87 | California Enhanced CSR Silver 87 | 2024 Federal Silver 94 | California Enhanced CSR Silver 94 |
| Medical Deductible | \$5,400 | \$0 | \$800 | \$0 | \$75 | \$0 |
| Drug Deductible | \$150 | \$0 | \$50 | \$0 | \$0 | \$0 |
| Coinsurance (Member) | 30% | 30% | 20% | 20% | 10% | 10% |
| Maximum Out-of-Pocket Limit | \$7,550 | \$6,100 | \$3,150 | \$3,000 | \$1,150 | \$1,150 |

Source: Covered California, “Covered California Policy and Action Items,” July 20, 2023, https://board.coveredca.com/meetings/2023/2023.07.20_Policy_and_Action.pdf

increase the AV of silver plans based on enrollees' incomes, so expanding CSRs provides more targeted help to enrollees with low incomes than increasing AVs for all enrollees. Bills have been introduced in Congress to raise the CSR income eligibility threshold for individuals from 250 percent FPL to 400 percent and the amount of help CSRs provide by raising the AV of each income-eligibility band within the CSR structure.³⁷ Massachusetts enacted a version of this option using supplemental state subsidies, and the cost sharing savings for individuals with incomes just over the current federal CSR threshold were significant.³⁸ For example, HealthCare.gov enrollees with incomes above 250 percent FPL (about \$36,000 for an individual) can expect to pay thousands of dollars for inpatient hospitalization under a bronze or silver plan. But in Massachusetts, a person with an income of 300 percent FPL (about \$44,000 for an individual) would pay just \$250 for inpatient hospital services.³⁹

4. *Make gold plans, rather than silver plans, the benchmark for PTCs.*

Under current law, the PTC amount is calculated by first identifying the second-lowest-cost silver plan (the “benchmark plan”) that is available to each member of the household; the PTC equals the total cost of the benchmark plan minus the individual’s or family’s expected contribution for coverage (which is based on income). Switching the benchmark plan from silver to gold would better enable individuals to afford higher-value plans that may have more generous cost-sharing protections and broader provider networks. Currently, the premiums for most such plans are out of reach, even after PTCs are applied.

Researchers believe the biggest impact of switching to the gold standard would be to increase the availability of lower-deductible plans.⁴⁰ This option could represent a more limited, incremental step as compared to raising the actuarial value of plans but would lower deductibles and cost sharing for many enrollees. Administrative policy changes could also be used to make similar improvements.

- **Set monthly caps on out-of-pocket costs**

Congress could change the out-of-pocket maximum structure of the ACA to require plans to set *monthly* caps on cost sharing, replacing deductibles and the current annual cap on out-of-pocket costs. This would more closely reflect the way individuals are paid at their jobs and manage their household budgets, while

also reducing cost-sharing peaks that occur when individuals need an expensive emergency or hospital intervention, especially when they are still in the deductible phase of coverage.⁴¹ Congress could set a dollar amount for the maximum monthly out-of-pocket limit, similar to the way that the annual out-of-pocket maximum is set currently.

- **Allow states to cover higher-income enrollees in a Basic Health Program (BHP)**

The ACA allows states to enact a BHP, which is a mechanism to cover individuals who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP), or other minimum essential coverage and have income between 138 percent and 200 percent FPL.⁴² In a state with a BHP, people who meet the eligibility requirement receive coverage through the BHP instead of through an ACA marketplace plan. States receive 95 percent of what the federal government would have spent for enrolled individuals in the marketplace to run their BHP. The goal of the option is to allow states to set up less-expensive coverage options for enrollees with benefits at least as robust as in the marketplace. To date, only Minnesota and New York have implemented BHPs, and both states have used the program to offer additional benefits and limit cost sharing. The BHP is typically designed to resemble Medicaid, with little or no cost sharing. Congress should expand BHP eligibility in two ways. First, it should permit states to use the BHP to cover eligible individuals regardless of immigration status. Second, it should allow states to expand coverage to populations above 200 percent FPL.⁴³

Administrative Action

- **Use standardized plan designs to reduce cost-sharing burdens**

HHS should refine its standardized plan requirements to increase plan options with more generous cost-sharing designs. For instance, HHS should move to a model that requires copayments (rather than coinsurance) for every service, not just select ones. Use of coinsurance is intentionally opaque and inherently discriminatory, foisting a larger share of costs onto individuals with complex conditions that require high-cost services. Because plans must still operate within AV restrictions, administrative changes to standardized plans, while important, cannot achieve the same magnitude of reductions in deductibles and cost sharing as legislative changes to AV. This is because the AV sets the proportion of total costs a plan must cover and total

costs that are be passed to enrollees for a standard population.

A plan that wanted to, for instance, make diabetes care free for every enrollee likely would have to raise cost sharing for other services to keep within in the AV limits. While HHS can require marketplace plans to abandon coinsurance and use copayment schedules only, plans would have to increase copayment levels or otherwise make cost-sharing adjustments to maintain the same AV. It may still be positive for enrollees to have the transparency that copayments provide, but on average, with no change in the AV, the change to copayments won't reduce average out-of-pocket costs, though it could reduce them for some enrollees with more significant health care needs and increase them for others.

- **Reform risk adjustment policy**

Marketplace plans are expected to serve enrollees with varying health care needs. Regulatory requirements such as network adequacy and non-discrimination provisions are designed to ensure that plans do not reduce the quality of certain offerings in an effort to dissuade some people from selecting their plan and effectively allow the plan to cherry-pick healthier enrollees. The ACA also established policies for risk adjustment to compensate plans that attract higher-risk enrollees and thereby encourage plans to serve enrollees with varying health care needs.

An enrollee's risk score is based on a number of demographic factors, including age, plan metal tier (e.g., bronze, silver, etc.), and health conditions. HHS then uses the average plan risk scores to transfer payments from insurers with enrollees who are unlikely to use a lot of health services to insurers with enrollees who are likely to use a lot of health services. Risk adjustment payments are meant to ensure that plans that cover enrollees with high-cost conditions are not financially disadvantaged. However, there are signs that the payments may not be high enough to deter insurers from taking steps to reduce their overall risk, including increased reliance on narrow networks of providers⁴⁴ and persistent reluctance to offer high-AV, platinum plans.⁴⁵ These actions effectively shift costs to enrollees if the risk adjustment payments are not large enough to accurately reflect the risk pool.

Risk adjustment: A policy that requires health insurance plans with lower-cost enrollees to make payments to plans with higher-cost enrollees, in order to reduce the incentive for insurers to design plans that attract healthier people.

The Centers for Medicare & Medicaid Services (CMS) should examine potential improvements to risk adjustment payment structure that would ensure that the payments adequately compensate insurers that offer more generous plan designs, including broader networks, that appeal to enrollees with chronic or complex health conditions. Other changes to risk adjustment could reduce insurers' incentives to seek to attract enrollees who use relatively little health care rather than offering good coverage for a reasonable price.

Risk adjustment reform alone would not ensure that insurers offer appropriately designed plans. However, if coupled with other regulatory measures, it may help create more low-deductible and broad-provider-network options or make those options more affordable.

3. Strengthen Coverage Requirements

Coverage requirements, coupled with cost-sharing protections for specific services, are also important in addressing affordability pain points.

Congressional Action

- **Expand ACA consumer protections to require coverage of additional high-value services without cost sharing**

The ACA requires most private health plans to cover a set of clinically reviewed and recommended preventive services without cost sharing. These are some of the most popular ACA consumer protections among insured individuals.⁴⁶ However, there are other high-value services where cost is a barrier to access, such as curative treatments and interventions that catch disease early or keep chronic conditions from worsening. Congress could use a health equity lens to identify and require coverage of those services with no or lower cost sharing, prioritizing conditions and services that would especially benefit vulnerable and marginalized groups, such as diabetes supplies or medication-assisted treatment of opioid use disorders. Congress could couple this type of plan design change with changes to AV to ensure that reducing or eliminating cost sharing in one area would not need to be offset in another area. This approach is sometimes referred to as “value-based insurance design” or “equity-enhancing benefits.”⁴⁷



“ I have diabetes and need both insulin and supplies to help me measure my blood sugar. But my insurance doesn’t cover glucometers, which need to be replaced every few months. As a result, I only check my blood sugar every 3-6 months instead of once or twice a day.”

Mazhar B., 53, Illinois, marketplace enrollee

Administrative Action

- **Review and update the ACA’s essential health benefits (EHB) to help close coverage gaps and add or improve equity-enhancing benefits**

Many affordability pain points are exacerbated by coverage gaps that leave people with unexpected cost sharing when the service they need either is not covered or is subject to such stringent utilization management that coverage is essentially excluded. As a result, it is difficult for people to know what their plan will cover when they select it. HHS should use its authority under the ACA⁴⁸ to periodically review and update the EHBs to ensure that EHB standards reflect the services that people need to stay healthy.

As part of this review, HHS should clarify which specific services, at a minimum, fall under the ten EHB categories to ensure that people are not left to guess which components of each EHB will be covered and which will not. This update should include robust national coverage standards in key areas that can advance health equity, such as pediatric services, maternal health, and mental and behavioral health.⁴⁹ The update should also include other services not currently defined as EHBs, such as dental and vision benefits for adults.

Essential Health Benefits (EHBs): A set of ten categories of services health insurance plans must cover under the ACA. These include doctors’ services, hospital care, prescription drugs, pregnancy and childbirth, mental health services, preventive care, and more. Each state decides which specific services it considers to be EHBs by selecting or designing an EHB benchmark plan; all individual and small group health plans in the state must offer coverage that is “substantially equal” to the benchmark plan. As a result of this approach, each state has a different standard for which specific services marketplace plans must cover.

- **Encourage states to adopt equity-enhancing plan designs**

Some states are moving forward with health equity priorities in their plan design requirements, and with encouragement and technical assistance more could decide to do so. For example, some states are requiring all ACA marketplace plans to cover services, such as behavioral health care, opioid reversal agents, and Hepatitis C medications, that are expected to address unmet health needs in the state.⁵⁰ Other states are using federal 1332 waiver authority to set up public options aimed at lowering cost sharing and/or expanding marketplace eligibility.⁵¹ If a state's policy changes under a 1332 waiver generate federal savings, the state can use those "pass-through" savings to fund equity-enhancing benefits and reduced cost sharing. Colorado, for instance, has used 1332 savings to help fund new requirements that all marketplace issuers offer plans with significantly reduced cost sharing for low-income enrollees.⁵²

In addition to the EHB changes discussed above, HHS could better support states by releasing guidance and best practices on how to use 1332 authority to invest in plan changes that would have a disproportionate impact on communities with the largest gaps in health care access and the greatest affordability challenges. The 1332 process can be complex, so states may benefit from additional resources and technical assistance on how to use 1332 waivers to advance health equity goals.

- **Better enforce ACA protections regarding coverage of preventive services and cost sharing**

At least some affordability pain points could be addressed through more robust enforcement of existing ACA protections, including its requirement to cover preventive services.⁵³ Despite clear statutory language and reams of regulations and sub-regulatory guidance, many plans subject to the ACA's preventive services protections do not comply with federal law.⁵⁴ Vague, outdated, or inaccurate plan coverage policies leave enrollees facing erroneous cost sharing for preventive services despite ACA protections. HHS should use its enforcement authority to examine a subset of marketplace plans, perhaps starting with services with especially large health equity implications.



“ Last year in December, we found out my mom had breast cancer. This year we decided, okay, well let’s all us females from the same family or whatnot, let’s just go get checked out to make sure. And I find out that the mammograms aren’t covered. Something as simple as preventive care -- a mammogram screening -- is not covered.”

Sindy Caraballo, Marketplace Enrollee, Florida

4. Create Federal Backstops for Coverage

The ACA’s Medicaid expansion enabled many low-income people to gain coverage. In the 40 states that have so far expanded Medicaid, all eligible individuals with income up to 138 percent FPL (about \$18,700 annually for an individual) are eligible for Medicaid. But in the ten remaining states, people with income between 100-138 percent FPL (between \$13,500 and \$18,700 annually for an individual) are instead eligible for marketplace coverage. People in non-expansion states who have incomes below the poverty line but are not eligible for an existing Medicaid eligibility category are in the Medicaid coverage gap, meaning they have no affordable path to health coverage at all.

In addition to creating a backstop for people left out of Medicaid expansion, the federal government could also reduce underlying health care prices and encourage more generous plan designs by creating a federal public option. Congress could also substantially reduce uninsurance by removing immigration-related barriers to Medicaid and marketplace coverage.

Congressional Action

- **Create a federal coverage pathway for people in the Medicaid coverage gap**

There are more than 1.6 million people in the Medicaid coverage gap.⁵⁵ Congress should address this gap by creating a federal pathway for comprehensive coverage in every non-expansion state. This backstop could take a number of forms. Congress could expand ACA marketplace subsidies to individuals below the poverty line and offer them plan choices that are similar to Medicaid. Alternatively, Congress could instruct CMS to set up a federal Medicaid option in states that did not expand Medicaid under the ACA.⁵⁶

- **Create a federal public option**

A public option in the federal marketplace could leverage the bargaining power of the federal government to offer more competitive marketplace plans. Congress has an array of policy choices in setting up a public option, including negotiating fair prices for provider rates and prescription drugs and requiring providers that participate in Medicare or Medicaid to join the public option's provider network.⁵⁷ Early data from state adoption of some form of a public option — including in Colorado and Washington — show that these options can drive down cost sharing and premiums for public option enrollees⁵⁸ and may lower premiums for all marketplace plans.⁵⁹ The policy would also have to consider the impact on PTC amounts.

- **Eliminate immigration-related barriers to coverage**

Everyone should have access to affordable health coverage, including people who immigrated to the U.S. (immigrants), who make countless contributions to their communities and this country.⁶⁰ Congress should create additional flexibilities to allow immigrants (including those without a documented immigration status) to access affordable coverage through Medicaid and the marketplaces, or to expand states' ability to cover these individuals.

5. Simplify Plan Options and Enrollment Pathways

All of the pain points described by MAP participants are exacerbated by a backdrop of complex systems that are frustrating and time consuming to navigate. The stakes are high; people who fail to successfully navigate the labyrinth of enrollment choices and insurer requirements to utilize care can find themselves with unexpected, unaffordable health care costs or with serious unmet health care needs. Research shows that education and shopping tools cannot make up for deficient plan designs.⁶¹ However, in combination with other reforms, policies that simplify the process of enrolling in and using insurance can help people make cost-effective choices.

Congressional Action

- **Appropriate new federal funding for Consumer Assistance Programs (CAPs) through existing ACA mechanisms**

Federal funding for CAPs to assist people with questions and problems with their private insurance (including marketplace and non-marketplace plans), authorized in the ACA but not appropriated for many years, should be renewed.⁶²

Administrative Action

- **Continue to reduce the number of plans that each issuer can offer on HealthCare.gov**

In tandem with strengthening standardized plan requirements, HHS could continue reducing the total number of plans available to enrollees. While this may result in plan-switching in the short term as issuers consolidate plan options, reducing the dizzying array of plan options would ultimately help enrollees understand their coverage options and make informed decisions about enrollment.

- **Fund additional assistance once people are enrolled to help them navigate using their benefits**

In addition to enrollment assistance needed to ensure people enroll in the right plan, more resources should be allocated to post-enrollment support. Once enrolled in plans, people are confronted with barriers to utilizing care, including understanding how their plan designs operate (e.g., what services are available pre-deductible or for free and how much utilization of certain services would cost) and navigating increasingly complex and opaque requirements for prior authorization and utilization management. The entire enrollment assistance workforce — including Navigators as well as agents and brokers — should be trained to provide more of these post-enrollment support services.

These policy proposals presented throughout this report are focused on marketplace plan design issues that specifically address cost-sharing affordability. A range of other related policies also affect affordability, including how insurance plans cover and charge enrollees for prescription drugs, the availability and pricing of health care services, and the growing role of insurance practices such as utilization management in creating barriers to necessary care. While many of these policy areas are beyond the scope of this report, making health care affordable requires a holistic approach, including but certainly not limited to plan design issues related to cost sharing. In addition, while this paper is focused on marketplace coverage, many of the ideas discussed above, like eliminating deductibles and coinsurance and using predictable copayments for cost-sharing requirements instead, would also improve other types of health coverage.

Conclusion

The ACA laid an important foundation for coverage, providing unprecedented access to an individual market that had been out of reach for millions of people without the law's protections and financial assistance to make coverage affordable. Federal policymakers have an opportunity to build on that success to ensure that marketplace plans provide comprehensive and affordable coverage for people who have low incomes.

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