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How States Can Use New Revenue to Lower Consumer Costs for Individual Health Insurance

Introduction and Summary

On January 1, 2021, the federal government will abandon more than $15 billion in annual health insurance assessment (HIA) revenue. States that act promptly can capture the lion's share of these dollars, using them to reduce their residents' health care costs. By passing legislation in 2020, a state can do this without increasing the assessments that insurers pay. Such a state would take the money that its insurance companies now send to Washington, D.C., bring it back to the state, and use it to lower health insurance costs for residents. An accompanying issue brief, A Golden Opportunity for States to Make Health Insurance More Affordable: Rapid Action Required, explains what states can do to recapture this revenue rather than let it expire.

In this issue brief, we show how states could use these dollars to lower residents' health care costs in the individual market. We begin with a brief analysis of current affordability challenges facing people who use that market to buy insurance. We then analyze two general approaches states can use to help families overcome those challenges:

1. **Affordability assistance to consumers:** This approach supplements the premium tax credits and cost-sharing reductions that the Affordable Care Act (ACA) offers. States pursuing this approach would provide residents with additional financial assistance that helps them pay premiums or further lowers their out-of-pocket cost-sharing.
2. **Reinsurance to insurers:** This approach gives insurance companies publicly funded reinsurance, which pays the claims incurred by certain high-cost enrollees. Reinsurance substitutes for premiums in paying those claims, so it lowers premiums charged to consumers who buy insurance on their own, without any help from the ACA's premium tax credits.

More than five times as many people could be helped by the first than by the second approach. People helped by the first approach include a much higher proportion who are people of color (26% vs. 17%) and many fewer households with six-figure incomes (6% vs. 70%). The best possible of HIA revenue will vary from state to state. Nevertheless, devoting most or even all of the newly available money to directly provide low- and moderate-income consumers with additional financial assistance makes sense in most states.

Affordability Challenges in the Individual Market Are Widespread, Affecting People at Multiple Income Levels

Affordability challenges and their effects on coverage are broadly seen as among the most significant problems faced by people who buy coverage in the individual market. Some people do not enroll because premiums are too high. And even people who do buy insurance in the individual market may skip or delay necessary care because of high deductibles and other out-of-pocket costs.

Consumers who are ineligible for premium tax credits (PTCs)

Affordability challenges affect several groups of consumers who are ineligible for PTCs:

- Adults with incomes just above the PTC financial eligibility threshold of 400% of the federal poverty level (FPL), which is approximately $50,000 a year for an individual and slightly more than $100,000 a year for a family of four, may struggle to pay their premiums without financial assistance. For example, the average single 60-year-old with income at 401% of FPL is charged $11,744 a year — 23% of household income — for a silver plan.[1] At 400% of FPL, such an adult pays $4,886, less than 10% of income.
- PTCs are denied to people stuck in the ACA's notorious "family glitch:" to determine whether dependents are ineligible for PTCs because they are offered "affordable" group insurance, the ACA considers the cost of worker-only coverage, not the added expense of dependent coverage.[2]
- Undocumented immigrants are ineligible for PTCs. Moreover, the ACA forbids them from using their own money to buy insurance on health insurance exchanges.

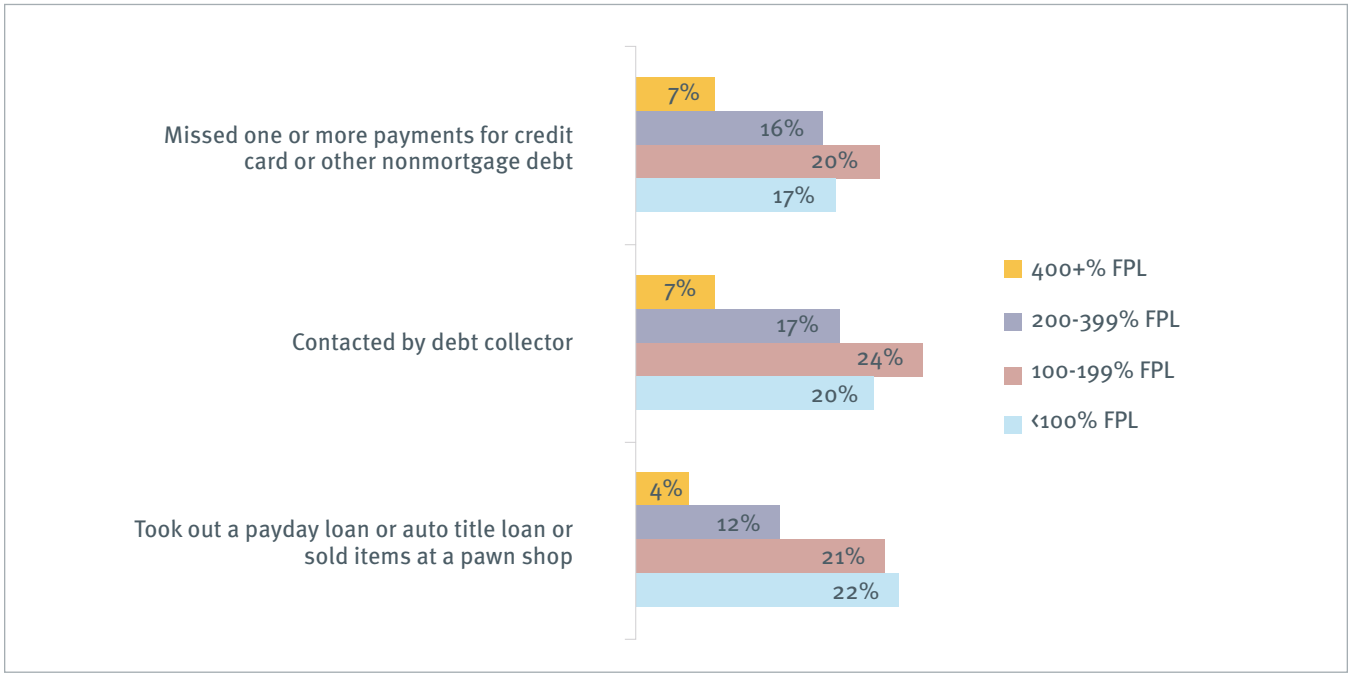
Consumers who are eligible for premium tax credits (PTCs)

People who qualify for PTCs can also experience affordability challenges. The ACA provided much less affordability assistance to low- and moderate-income consumers than many states had previously offered people with incomes above traditional Medicaid levels. Such pre-ACA state assistance included the Children's Health Insurance Program (CHIP), Medicaid waivers, and various state programs.

Low-income households with incomes below 400% of FPL, the maximum threshold for PTC eligibility, often face significant financial pressures that can make it hard to buy insurance, despite PTCs. For example (Figure 1):

- About 15% of adults with incomes between 100% and 400% of FPL missed payments for credit cards or other non-mortgage debt in 2017.* The same was true of just 7% of adults with incomes above 400% of FPL.
- Debt collectors contacted 19% of adults with incomes between 100% and 400% of FPL in 2017. They contacted just 7% of adults with incomes above 400% of FPL.
- Approximately 17% of adults with incomes between 100% and 400% of FPL took out payday loans, obtained short-term auto title loans, or sold items to a pawnshop in 2017, compared to just 4% of people with incomes too high to qualify for PTCs. Such "alternative financing" gives consumers cash without assessing their credit-worthiness, but it charges extremely high interest rates that can lock borrowers into ongoing cycles of debt or cause the loss of a car or other assets.[3]

Figure 1. Types of Financial Insecurity that Adults Under Age 65 Experienced During the past 12 Months, by Income Group as a Percentage of the Federal Poverty Level (FPL), 2017



Source: K. Steven Brown and Breno Braga, *Financial Distress Among American Families: Evidence from the Well-Being and Basic Needs Survey* (Urban Institute, February 2019), https://www.urban.org/sites/default/files/publication/99771/financial_distress_among_american_families_0.pdf.

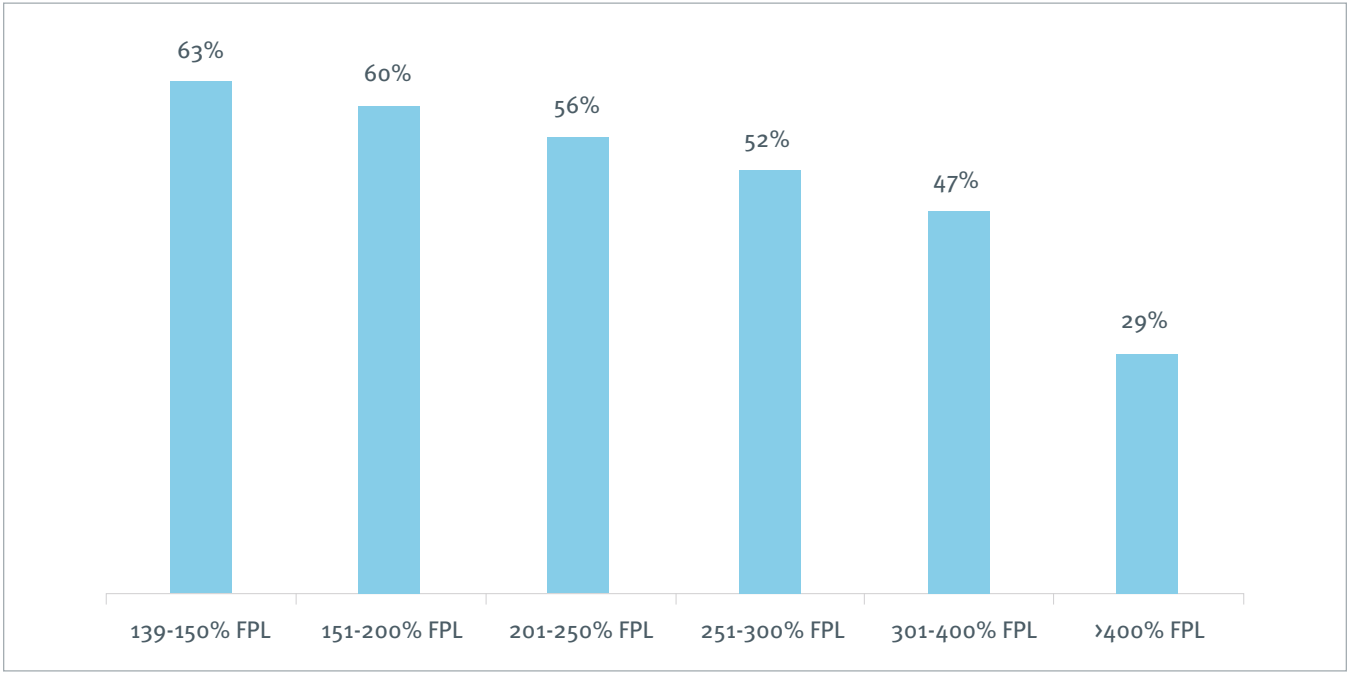
* For this and the following two bullets, the figure shows results for adults with incomes between 100% and 199% of FPL and between 200% and 399% of FPL. The text combines these two estimates into a single weighted-average result for all adults with incomes between 100% and 399% of FPL, the income eligibility range for PTCs. The weighting is based on the number of adults ages 18-64 in each income band, as shown by American Community Survey data for 2017. PUMS USA, University of Minnesota, www.ipums.org.

Along similar lines, food insecurity, defined as "difficulty providing enough food for all family members due to a lack of resources" at least once during the previous year, is experienced by:

- More than 28% of families with incomes between 150% and 199% of FPL
- More than 18% of families with incomes between 200% and 299% of FPL
- Approximately 15% of families with incomes between 300% and 399% of FPL and
- Less than 5% of families with income at 400% of FPL or higher.[4]

Because people with fewer resources face greater financial challenges, it is understandable that, even among adults who are potentially eligible for PTCs, the lowest-income people are the most likely to be uninsured. For adults with incomes between 139% and 150% of FPL, 63% of adults who potentially qualify for PTCs are uninsured (Figure 2). That proportion gradually declines as income rises, eventually reaching 47% for those with incomes between 301% and 400% of FPL, and 29% for people who are financially ineligible for PTCs because of income above 400% of FPL. Corresponding estimates for all states are available from the author, upon request.

Figure 2. Percentage of Uninsured Among Adults Under Age 65 Who Are Potentially Eligible for Premium Tax Credits, by Income, 2018



Source: National Center for Coverage Innovation at Families USA analysis of American Community Survey (ACS) data for 2018. At each income level, the figure shows uninsured adults as a percentage of all adults under age 65 who are (1) either uninsured or buy individual market coverage and (2) either U.S. citizens or non-citizens estimated to have immigration status that qualifies them for PTCs, based on the results of Urban Institute imputation. The ACS data did not indicate which otherwise-eligible uninsured were ineligible for PTCs due to offers of employer coverage. PTC eligibility is limited to consumers with incomes between Medicaid levels and 400% of FPL. *Note:* FPL = federal poverty level.

Providing Affordability Assistance Can Help People at Multiple Income Levels

Several states provide or are considering affordability assistance that builds on but goes beyond the help that consumers generally receive under the ACA. These diverse initiatives illustrate what states can do:

- **Extra help for low-wage working families.** Using funding available under an Obama administration Medicaid waiver, Massachusetts provides significant assistance for consumers with incomes at or below 300% of FPL, supplementing the ACA's PTCs and cost-sharing reductions (CSRs).[5] This supplemental assistance eliminates deductibles and lets consumers pay either nothing in premiums or substantially less than the amounts charged to PTC-eligible consumers in other states.
  - As a result, Massachusetts has by far the country's highest coverage levels among consumers who are eligible for private insurance offered through health insurance exchanges: 62%, compared to a national average of 32%.[6] This is one major reason the state reached near-universal coverage, with only 3% of residents lacking insurance in 2018.[7]
  - The state's supplemental affordability assistance helps bring healthier consumers into the individual market, improving the risk pool and giving the state leverage to lower premiums.[8] Massachusetts thus has the country's third-lowest silver premiums charged by qualified health plans (QHPs) in health insurance exchanges.[9] This achievement is particularly noteworthy in light of Massachusetts having the country's third-highest overall health care costs.[10]
- **Basic Health Program (BHP).** New York uses the ACA's basic health program option to eliminate deductibles and either eliminate or substantially reduce consumer premiums for residents with incomes between Medicaid levels and 200% of FPL. Thanks to the additional assistance available through BHP, hundreds of thousands of previously uninsured residents signed up for free or very low-cost insurance. Since implementing BHP in 2016, New York state saw the country's largest decline in the proportion of uninsured with incomes in the affected range. Among people with incomes between 139% and 200% of FPL, the percentage without insurance fell from 18.4% to 13.7% in 2018, the most recent year for which data are available.[11]

Massachusetts has by far the country's highest coverage levels among consumers who are eligible for private insurance offered through health insurance exchanges.

- **Affordability assistance for consumers with incomes above 200% of FPL and above 400% of FPL.** In 2019, California enacted legislation providing supplemental affordability assistance that:
  - lowers premiums for consumers with incomes between 400% and 600% of FPL
  - modestly lowers insurance expenses for those with incomes between 200% and 400% of FPL

  The new assistance took effect in January 2020 and is projected to cost approximately $1.5 billion over three years.[12] During the first year this new assistance was available, the number of Californians newly enrolling in exchange coverage rose by 41%, increasing from 295,980 in 2019 to 418,052 in 2020.[13]
- **Additional affordability assistance to younger adults.** Maryland's Health Insurance Protection Commission has proposed giving extra help to younger adults.[14] This addresses the problem that, nationally, PTCs are now so low that the average 24-year-old with income between 275% and 400% of FPL saves money by being uninsured and paying for care out-of-pocket rather than buying a qualified health plan with the aid of PTCs.[15] Giving younger adults additional assistance with their premiums would lead many to enroll, lowering the number of uninsured and dropping premiums by improving the overall risk pool.
- **Solving the "family glitch" and helping undocumented immigrants enroll.** States could use the additional funds from a state-based HIA to provide affordability assistance to these vulnerable populations whom the ACA left behind, as described earlier.[16] California has already extended assistance to children and adults ages 25 and younger regardless of their immigration status.[17]

Several features of these affordability interventions are worth highlighting.

First, policies that increase enrollment among consumers who qualify for PTCs bring additional federal dollars into the state, which support local employment. Appendix table A-1 on p. 18 estimates the increased coverage and federal funding that would result if states achieved enrollment among consumers with incomes at or below 300% of FPL at levels comparable to Massachusetts. Nationally, 5.8 million uninsured would gain coverage, and total PTC receipt would increase by 67% (from $54.7 billion to $91.2 billion).

States could use the additional funds from a state-based HIA to provide affordability assistance to vulnerable populations whom the ACA left behind.

Second, state officials need to consider how they will administer supplemental affordability assistance. That task would be easier in a state with its own exchange, which can ensure that consumers choosing between QHPs are shown premium costs and plan options that automatically take into account state assistance. States that do not operate exchanges could consider using the approach employed by programs that pay the share of premiums for beneficiaries who receive PTCs. Programs worth emulating include:

- Ryan White programs
- Programs that serve American Indian/Alaska Native tribal members
- Programs that base eligibility on income and that are administered by municipal government or community-based nonprofit organizations[18]

Consumers apply to such programs for assistance, typically after qualifying for PTCs.

Third, if coverage becomes more affordable to low- and moderate-income consumers or to younger adults, the individual market risk pool improves. That lowers premiums that are paid by people who are ineligible for PTCs. Ironically, an intervention focused on a relatively narrow group winds up benefiting a much broader range of vulnerable consumers.

Reinsurance Primarily Benefits Higher-Income People Who Are Ineligible for PTCs and Potentially Puts Low- and Moderate-Income People at Risk

The previous section describes how states can improve affordability by offering consumers additional financial assistance that supplements help the ACA already provides. Another approach, which 12 states are already using, gives insurance companies publicly funded reinsurance. The latter approach uses waivers under ACA Section 1332 to obtain most of the necessary funding from the federal government.

Policymakers who are evaluating reinsurance as an affordability strategy need to carefully consider their state's specific circumstances. In many cases, increased affordability assistance will be a much better option for consumers overall.

The original purpose of reinsurance. The ACA created a temporary reinsurance program that lasted for just three years. Federal policymakers added this provision because they knew that insurers could not confidently predict how markets might change in 2014, when insurers could no longer discriminate against people with preexisting conditions. Policymakers were concerned that insurers might protect against that uncertainty by raising premiums or leaving the market entirely. The ACA thus provided publicly funded reinsurance to "help reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' claims associated with high cost enrollees."[19] The reinsurance program gradually phased down from 2014 through 2016, ending in 2017.

How reinsurance works. Most reinsurance uses the same basic structure as the ACA's original three-year program: If a member's claims fall within a specified range over the course of a year — such as $50,000 to $200,000 — the reinsurance pays a certain percentage of those claims. The ACA used public dollars for this purpose, even though insurers often buy their own reinsurance in other insurance markets.

What reinsurance accomplishes today. After more than five years of full ACA implementation, insurance companies no longer face the uncertainty that led the ACA to provide temporary reinsurance. Moreover, the ACA's permanent risk adjustment program now covers 60% of health care costs for the most expensive enrollees, whose claims exceed $1 million.[20] Nevertheless, reinsurance continues to serve important purposes. For example, substituting public reinsurance dollars for premiums to pay a portion of covered claims lowers premiums across the board in the individual market. It can also attract insurers to underserved markets or keep insurers from abandoning markets.[21]

Reinsurance primarily benefits higher-income people who are ineligible for PTCs. These people pay full premiums. Nationally, 3.7 million people are in this group, comprising 31% of enrollees in the individual market (Table 1 on p. 11.)

Low- and moderate-income people who qualify for PTCs do not generally benefit from reinsurance and may even be harmed. This group includes 8.4 million people, or 69% of the people enrolled in the individual market (Table 1 on p. 11). Citizens and lawfully present non-citizens qualify for PTCs if they earn between 100% and 400% of FPL and are not offered Medicare, Medicaid, or employer-based coverage that meets the ACA's standards for affordability and comprehensiveness.

PTC amounts are set so that beneficiaries can buy the second-lowest-cost silver plan offered in the health insurance exchange while paying a specified amount, which varies based on income. Reinsurance that lowers premiums does not help a PTC beneficiary who is enrolled in the second-lowest cost silver plan, often termed the "benchmark plan." That is because their costs for that plan are based entirely on income.[22] Lower premiums for benchmark plans cut federal PTC amounts, not premium spending for PTC beneficiaries in those plans. However, lower PTC amounts can increase net premiums for beneficiaries enrolled in plans other than the benchmark, as illustrated in the text box on p. 10.

Most reinsurance uses the same basic structure as the ACA's original three-year program: If a member's claims fall within a specified range over the course of a year — such as $50,000 to $200,000 — the reinsurance pays a certain percentage of those claims.

The precise results of reinsurance depend on the characteristics of the state's market and the details of reinsurance.

- In Colorado, reinsurance elicited public protest when it increased net premiums charged to many PTC beneficiaries, due to the dynamics noted in the text box on p. 10.[23]
- In Maryland, the state's use of reinsurance brought an end to serious market instability. Reinsurance compensated for the many expensive enrollees who had shifted to individual insurance from the state's high-risk pool, which was one of the country's largest such pools before the ACA. The bulk of Maryland reinsurance dollars went to one high-cost insurer that did not sponsor lower-cost QHPs in competitive markets. Reinsurance thus did not substantially cut the purchasing power of PTCs in Maryland's somewhat unusual circumstances.

Reinsurance allows for significant federal matching funds under current law. Traditionally structured reinsurance lowers premiums for the second-lowest cost silver plan, along with premiums charged for other individual market coverage. Cutting premiums for benchmark silver plans reduces average per-capita PTC amounts. Using waivers granted under ACA Section 1332, the federal government gives the state the resulting PTC savings in the form of "federal pass-through payments." The state can use those federal dollars to help fund reinsurance. In effect, the federal government provides a high matching rate for state reinsurance programs, which is one reason why they are relatively widespread. Note that with the additional revenue provided by a state HIA, the availability of federal matching funding may become less important to states as they decide how best to lower their residents' insurance costs.

Traditionally structured reinsurance lowers premiums for the second-lowest cost silver plan, along with premiums charged for other individual market coverage.

Examples of How Reinsurance Can Help Some People, Leave Others Unaffected, and Hurt Others

Neighbors Ali, Bobbie, and Chris are 40-year-old single adults who buy insurance in the individual market. Ali and Bobbie enroll in their county's second-lowest-cost silver plan, the "benchmark," which costs $462 a month. Chris buys the lowest-cost bronze plan, which costs $331. Ali earns $80,000 a year, too much to qualify for PTCs. Bobbie and Chris each qualify for PTCs with incomes of $31,225.

Today:

- Ali pays $462 a month, the full premium.
- Bobbie pays $216 a month, which is her income-based premium contribution for benchmark coverage. The remaining $246 is covered by her PTC.
- Chris pays $85, because of his PTC. Bobbie and Chris have the same income and are offered the same benchmark coverage, so they have the same $246 PTC. But Chris chose a plan that was less generous than the benchmark, so he pays only $85 — namely, the difference between the $331 premium for a bronze plan and his $246 PTC.

Suppose reinsurance cuts premiums by 25%. Ali's and Bobbie's silver, benchmark plan now charges only $347, and Chris's bronze plan drops to $248. Who wins, who is unaffected, and who loses?

- *Ali, who earns too much to qualify for PTCs, saves money.* He pays full premiums. As a result, his monthly costs fall from $462 to $347, a 25% drop.
- *Bobbie, who is enrolled in benchmark coverage with a PTC, is unaffected, but the federal government spends less on her coverage.* She pays the same income-based $216 charge. With reinsurance, her PTC is 47% lower — just $131, the difference between her unchanged income-based charge and the new benchmark premium with reinsurance in effect.
- *Chris, who is enrolled in bronze coverage with a PTC, pays more in premiums.* Reinsurance lowers the benchmark premium, so Chris's PTC, like Bobbie's, falls from $246 to $131. The bronze premium falls as well, but not by enough to make up for Chris's reduced PTC. Chris pays $117 for premiums, the difference between the new $248 bronze full premium and his smaller PTC. Reinsurance thus raises Chris's insurance costs by almost 40%.

Table 1. Individual Market Participants, by State and Use of PTCs to Buy Coverage, 2018

State	Total with Insurance	Consumers Who Use PTCs to Buy Insurance		Consumers Who Buy Insurance without PTCs	
		#	% of market	#	% of market
AL	179,435	138,233	77%	41,202	23%
AK	16,761	14,125	84%	2,636	16%
AZ	143,891	119,495	83%	24,396	17%
AR	301,776	49,431	16%	252,345	84%
CA	2,041,101	1,196,566	59%	844,535	41%
CO	203,829	100,869	49%	102,960	51%
CT	126,830	74,045	58%	52,785	42%
DC	16,870	966	6%	15,904	94%
DE	23,509	17,032	72%	6,477	28%
FL	1,615,046	1,371,754	85%	243,292	15%
GA	393,308	330,535	84%	62,773	16%
HI	30,162	13,729	46%	16,433	54%
ID	101,628	76,425	75%	25,203	25%
IL	364,240	240,510	66%	123,730	34%
IN	135,250	92,956	69%	42,294	31%
IA	41,293	37,164	90%	4,129	10%
KS	94,740	71,108	75%	23,632	25%
KY	77,918	58,204	75%	19,714	25%
LA	106,813	76,250	71%	30,563	29%
ME	72,801	57,883	80%	14,918	20%
MD	193,227	110,632	57%	82,595	43%
MA	Data not available				
MI	332,551	210,416	63%	122,135	37%
MN	148,943	62,832	42%	86,111	58%
MS	83,248	64,178	77%	19,070	23%
MO	207,983	174,062	84%	33,921	16%
MT	53,302	35,760	67%	17,542	33%
NC	486,334	406,670	84%	79,664	16%

State	Total with Insurance	Consumers Who Use PTCs to Buy Insurance		Consumers Who Buy Insurance without PTCs	
		#	% of market	#	% of market
ND	39,553	16,893	43%	22,660	57%
NE	82,469	73,513	89%	8,956	11%
NV	101,924	62,054	61%	39,870	39%
NH	84,800	30,065	35%	54,735	65%
NJ	312,923	178,312	57%	134,611	43%
NM	58,677	33,803	58%	24,874	42%
NY	320,383	133,154	42%	187,229	58%
OH	216,807	143,676	66%	73,131	34%
OK	139,419	120,156	86%	19,263	14%
OR	190,899	98,489	52%	92,410	48%
PA	456,147	299,649	66%	156,498	34%
RI	44,286	26,394	60%	17,892	40%
SC	201,785	162,859	81%	38,926	19%
SD	34,083	24,684	72%	9,399	28%
TN	204,129	175,560	86%	28,569	14%
TX	999,480	807,405	81%	192,075	19%
UT	195,212	156,607	80%	38,605	20%
VT	Data not available				
VA	343,919	277,453	81%	66,466	19%
WA	250,883	128,435	51%	122,448	49%
WV	25,684	19,390	75%	6,294	25%
WI	206,934	164,999	80%	41,935	20%
WY	25,261	20,869	83%	4,392	17%
USA	**12,128,447**	**8,356,247**	**69%**	**3,772,200**	**31%**

Source: Centers for Medicare & Medicaid Services, Trends in Subsidized and Unsubsidized Enrollment, August 12, 2019, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf.

Note: CMS does not provide data for Massachusetts and Vermont.

People of color are far more common among people potentially helped by affordability assistance, and six-figure incomes are far more common among people helped by reinsurance.

The Characteristics of Consumers Helped by Different Approaches

As noted earlier, 69% of consumers enrolled in the individual market use PTCs to buy insurance. States thus may be able to help more of their residents if they do not limit their use of HIA dollars to reinsurance, but instead focus HIA funds on providing additional financial assistance to people who already qualify for some federal help but still find insurance hard to afford.

Generally speaking, reinsurance is not likely to lower premiums enough to lead large numbers of previously uninsured people to enroll. However, increasing financial assistance for low- or moderate-income people and broadening eligibility for that assistance can greatly lower the number of uninsured, as noted earlier for California, Massachusetts, and New York. The number of people who could potentially benefit from increased affordability assistance, including insured people with PTCs and uninsured people who are eligible for PTCs, is thus significantly larger than the number who would benefit from reinsurance alone. And the characteristics of the two groups are very different, with people of color far more common among people potentially helped by affordability assistance and six-figure incomes far more common among those helped by reinsurance (Table 2):

- 3.7 million people buy insurance in the individual market without PTCs and so would see their premiums decline as a result of reinsurance. Only 17% of them are African Americans, Latinos, or American Indian/Alaska Natives. Fully 70% have family incomes above $100,000 a year, and 23% earn more than $200,000 a year.
- 20 million people either use PTCs to buy insurance or appear eligible for PTCs but are not enrolled. This much larger group would not benefit from reinsurance but would potentially gain from increased affordability assistance. Approximately 26% are African Americans, Latinos, or American Indian/Alaska Natives. Just 6% earn more than $100,000 a year, and only 0.3% make more than $200,000.

Table 2. Consumers Potentially Benefiting from Reinsurance vs. Those Potentially Benefiting from Increased Affordability Assistance, by State, 2018

State	Reinsurance (Individually Insured Ineligible for PTCs Because of Income >400% FPL)				Increased Affordability Assistance (Individually Insured + Uninsured with Incomes Between 139% FPL and 400% FPL)			
	# (thousands)	% African American, Latino, or American Indian/ Alaskan Native	% Earning >$100,000	% Earning >$200,000	# (thousands)	% African American, Latino, or American Indian/ Alaskan Native	% Earning >$100,000	% Earning >$200,000
AL	41.2	21%	65%	18%	398.3	35%	3%	0%
AK	2.6	14%	71%	28%	47.2	32%	5%	3%
AZ	24.4	19%	65%	21%	428.2	50%	5%	0%
AR	252.3	12%	66%	17%	160.6	22%	4%	1%
CA	844.5	22%	75%	28%	2,069.1	48%	9%	0%
CO	103.0	12%	71%	24%	293.5	30%	6%	0%
CT	52.8	11%	74%	32%	141.0	36%	4%	0%
DE	6.5	27%	64%	19%	42.2	38%	6%	0%
DC	15.9	35%	70%	41%	21.0	83%	1%	1%
FL	243.3	26%	68%	22%	2,266.2	46%	4%	0%
GA	62.8	28%	66%	20%	893.0	44%	4%	1%
HI	16.4	7%	80%	30%	47.9	15%	11%	1%
ID	25.2	9%	62%	20%	156.1	15%	5%	0%
IL	123.7	14%	71%	22%	618.9	39%	5%	0%
IN	42.3	7%	62%	20%	364.0	19%	5%	0%
IA	4.1	7%	61%	18%	148.8	16%	4%	0%
KS	23.6	8%	69%	22%	214.4	21%	5%	0%
KY	19.7	4%	66%	17%	204.3	11%	3%	0%
LA	30.6	16%	71%	22%	257.0	35%	3%	0%
ME	14.9	0%	66%	15%	90.8	3%	2%	0%
MD	82.6	30%	76%	29%	229.3	49%	9%	0%
MA	-	9%	73%	27%	-	15%	8%	0%
MI	122.1	9%	68%	20%	479.5	18%	4%	0%
MN	86.1	4%	64%	21%	126.6	15%	4%	0%
MS	19.1	25%	62%	20%	234.1	42%	2%	0%
MO	33.9	9%	63%	19%	482.8	19%	5%	0%
MT	17.5	5%	66%	16%	78.2	12%	5%	3%
NE	9.0	4%	55%	14%	117.2	14%	4%	1%
NV	39.9	13%	71%	25%	173.6	41%	4%	0%
NH	54.7	4%	71%	26%	59.0	7%	5%	0%
NJ	134.6	19%	77%	30%	414.2	42%	8%	0%
NM	24.9	36%	65%	22%	112.5	66%	4%	0%

State	Reinsurance (Individually Insured Ineligible for PTCs Because of Income >400% FPL)				Increased Affordability Assistance (Individually Insured + Uninsured with Incomes Between 139% FPL and 400% FPL)			
	# (thousands)	% African American, Latino, or American Indian/ Alaskan Native	% Earning >$100,000	% Earning >$200,000	# (thousands)	% African American, Latino, or American Indian/ Alaskan Native	% Earning >$100,000	% Earning >$200,000
NY	187.2	20%	72%	25%	488.5	44%	7%	0%
NC	79.7	17%	62%	20%	876.8	33%	3%	0%
ND	22.7	5%	67%	12%	46.0	26%	3%	0%
OH	73.1	8%	65%	20%	539.2	19%	4%	0%
OK	19.3	15%	67%	19%	345.8	28%	4%	0%
OR	92.4	8%	69%	22%	237.1	17%	5%	1%
PA	156.5	9%	69%	21%	623.8	20%	5%	0%
RI	17.9	4%	69%	27%	37.8	24%	9%	2%
SC	38.9	21%	68%	23%	422.5	34%	3%	0%
SD	9.4	3%	70%	24%	79.3	24%	2%	0%
TN	28.6	14%	65%	19%	547.4	22%	5%	0%
TX	192.1	31%	72%	23%	2,873.4	60%	7%	0%
UT	38.6	6%	77%	24%	237.5	18%	10%	0%
VT	-	5%	62%	15%	11.8	2%	2%	0%
VA	66.5	18%	71%	26%	549.3	34%	6%	0%
WA	122.4	6%	71%	27%	317.4	23%	5%	0%
WV	6.3	5%	66%	15%	80.8	6%	3%	0%
WI	41.9	5%	57%	16%	315.1	17%	4%	0%
WY	4.4	28%	70%	20%	49.2	13%	3%	1%
USA	3,772.2	17%	70%	23%	20,037.7	26%	6%	0.3%

Sources: Estimates of the number of individually insured, by state, buying coverage with and without PTCs, come from Centers for Medicare & Medicaid Services, *Trends in Subsidized and Unsubsidized Enrollment*, 2019, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf. Estimates of the number of uninsured who qualify for PTCs come from the Kaiser Family Foundation, "Marketplace Enrollment as a Share of the Potential Marketplace Population: 2019," and "Marketplace Enrollees Receiving Financial Assistance as a Share of the Subsidy-Eligible Population," *State Health Facts*, https://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Estimates of the racial, ethnic, and family income characteristics of individuals within each category are based on National Center for Coverage Initiatives at Families USA analysis of 2018 American Community Survey (ACS) data, using IPUMS USA, University of Minnesota, www.ipums.org. *Note:* In analyzing the characteristics of PTC-eligible consumers, we used ACS data for individuals with incomes between 139% and 400% of FPL. As a result, we do not include the characteristics of PTC-eligible uninsured adults who earn between 100% and 139% of FPL and who live in states that have not expanded Medicaid. The right-hand panel therefore understates the percentage who are African American, Latino, or American Indian/Alaska native and overstates the percentage with incomes above $100,000 and $200,000. We estimated satisfactory immigration status, within ACS data stratified by citizenship, based on the results of Urban Institute imputations. We did not estimate the incidence of employer coverage offers that preclude PTC eligibility and that are not reported in ACS data. Estimates for race, ethnicity, and family income for PTC-eligible consumers with individual market coverage and who are uninsured reflect ACS estimates for the characteristics of consumers in each group, weighted by the administrative totals reported by CMS for PTC beneficiaries and the estimated number of PTC-eligible uninsured reported by the Kaiser Family Foundation.

Facilitating Rapid Consensus Through Selective Clarity

In many states, enacting HIA bills in 2020 could be challenging. Passing such bills could be easier if states structure their legislation to include two features.

First, a bill could dedicate all or a defined portion of the HIA funds to making the individual market more affordable, taking whatever steps make sense under state law to prevent the revenue from being diverted to serve other goals. Using HIAs to create a dedicated funding stream can help build support among health insurers by alleviating fears that, after they agree to continue paying current assessment levels, others will reap the benefits.

Second, especially in states with short 2020 legislative sessions, state HIA bills could be crafted to let trusted policymakers decide key details at a later point, within broad parameters set by the legislation. Using examples from legislation introduced early in 2020:

- In Maryland, Senate Bill 124 (Feldman) and House Bill 196 (Pena-Melnyk) direct the state's health insurance exchange to use HIA revenues – which were already targeted for a dedicated fund administered by the exchange – to finance either reinsurance or "state-based health insurance subsidies … to provide subsidies to individuals for the purchase of health benefit plans in the individual health insurance market."
- In New Mexico, House Bill 278 (Armstrong and Thomson) places HIA revenues into a "health care affordability fund" to "provide initiatives to reduce the cost of health care coverage for New Mexico residents, such as costs of premiums and cost-sharing." At least 60% of the money must be used to help people who currently qualify for premium tax credits. A specified portion of the revenue goes to the state general fund. By no later than December 1, 2020, the Human Services Department must send the legislature detailed recommendations for specific affordability initiatives.

Conclusion

States have a unique opportunity to make insurance substantially more affordable by claiming the significant revenue that the federal government will abandon in 2021. To access this revenue without raising assessments on insurers, states must pass legislation in 2020. There are many different ways to structure those assessments and allocate the resulting revenue to lower consumers' costs in the individual market. The best possible approach will vary by state. Giving insurers publicly funded reinsurance may be part of sensible affordability improvements in selective geographic areas and markets. Nevertheless, most states would be well-served by enacting a robust HIA and using as much of the revenue as possible to directly provide consumers with affordability assistance.

Appendix Table A-1. Increased Exchange Enrollment and Federal PTC Funding If Each State Achieved Participation Levels among PTC-Eligible Consumers with Incomes under 300% of FPL Comparable to Those Massachusetts Achieved by Providing Supplemental Affordability Assistance

State	Exchange Enrollment by Consumers with Incomes at or Below 300% of FPL			Federal PTC Funding for Consumers at All Income Levels (millions)		
	Current	With MA-Level Participation	Difference	Current	With MA-Level Participation	Difference
AL	143,000	280,000	136,000	$1,025	$2,025	$1,000
AK	13,000	41,000	28,000	$110	$335	$224
AZ	115,000	224,000	109,000	$700	$1,350	$650
AR	53,000	77,000	24,000	$246	$359	$112
CA	1,117,000	1,488,000	371,000	$6,945	$9,068	$2,123
CO	100,000	140,000	40,000	$749	$1,010	$261
CT	56,000	70,000	14,000	$430	$514	$84
DE	16,000	38,000	22,000	$159	$360	$201
DC	1,000	1,000	0	$4	$5	$1
FL	1,591	2,509	918	$9,939	$15,907	$5,968
GA	384,000	865,000	480,000	$2,320	$5,422	$3,102
HI	12,000	13,000	1,000	$100	$107	$7
ID	Data not available			Data not available		
IL	220,000	336,000	117,000	$1,501	$2,239	$738
IN	91,000	148,000	57,000	$375	$609	$233
IA	36,000	43,000	7,000	$448	$524	$76
KS	70,000	106,000	36,000	$516	$775	$259
KY	60,000	83,000	23,000	$371	$509	$138
LA	73,000	119,000	47,000	$439	$718	$279
ME	53,000	74,000	21,000	$399	$551	$152
MD	96,000	133,000	37,000	$674	$884	$210
MI	200,000	271,000	72,000	$990	$1,324	$334
MN	44,000	50,000	6,000	$229	$253	$24
MS	83,000	186,000	103,000	$552	$1,291	$739
MO	174,000	334,000	160,000	$1,154	$2,263	$1,109
MT	31,000	44,000	14,000	$250	$346	$97
NE	68,000	81,000	13,000	$788	$917	$129
NV	64,000	115,000	51,000	$317	$575	$258

State	Exchange Enrollment by Consumers with Incomes at or Below 300% of FPL			Federal PTC Funding for Consumers at All Income Levels (millions)		
	Current	With MA-Level Participation	Difference	Current	With MA-Level Participation	Difference
NH	27,000	41,000	14,000	$149	$220	$70
NJ	169,000	264,000	95,000	$755	$1,171	$416
NM	31,000	59,000	28,000	$153	$285	$132
NY	111,000	122,000	12,000	$533	$579	$46
NC	414,000	678,000	264,000	$3,421	$5,566	$2,144
ND	16,000	25,000	9,000	$84	$127	$44
OH	140,000	238,000	98,000	$678	$1,151	$474
OK	128,000	265,000	137,000	$1,035	$2,100	$1,065
OR	91,000	130,000	39,000	$546	$760	$214
PA	271,000	338,000	67,000	$1,813	$2,247	$433
RI	25,000	28,000	3,000	$109	$122	$13
SC	178,000	417,000	240,000	$1,289	$3,021	$1,731
SD	23,000	37,000	13,000	$170	$258	$88
TN	176,000	305,000	129,000	$1,214	$2,158	$944
TX	907,000	2,276,000	1,369,000	$5,017	$12,949	$7,932
UT	155,000	192,000	37,000	$850	$1,033	$183
VT	19,000	20,000	2,000	$115	$122	$8
VA	254,000	413,000	159,000	$1,672	$2,812	$1,141
WA	117,000	173,000	56,000	$648	$924	$276
WV	17,000	32,000	15,000	$162	$298	$136
WI	144,000	190,000	46,000	$1,228	$1,572	$345
WY	18,000	32,000	14,000	$234	$384	$150
USA	**8,391,000**	**14,143,000**	**5,752,000**	**$54,710**	**$91,203**	**$36,493**

Sources: Estimates of current enrollment of people with incomes between 100% and 150% of FPL, 151% to 200% of FPL, 200% to 250% of FPL, and 250% to 300% of FPL; per capita PTC amounts; and total PTC amounts come from Kaiser Family Foundation, "Marketplace Plan Selections by Household Income: Open Enrollment 2019," *State Health Facts*, downloaded on February 4, 2020, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-household-income-2/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Estimates of individual market enrollment and the number of uninsured, by state and income band, come from 2018 ACS data for individuals with incomes between 139% and 400% of FPL. The National Center for Coverage Initiatives at Families USA obtained the data through IPUMS USA, University of Minnesota, www.ipums.org. *Note:* Our analysis of individual market coverage and the uninsured estimates satisfactory immigration status, within ACS data stratified by citizenship, based on the results of Urban Institute imputations. We did not estimate the incidence of employer coverage offers that preclude PTC eligibility and that are not reported in ACS data. We applied the proportionate increase in enrollment shown by ACS if each state achieved Massachusetts' level participation within each income band, as shown by ACS data for 2018, to the number of current enrollees reported by the Kaiser Family Foundation. Data were not available for Idaho.

Endnotes

[1] This analysis is for U.S. average coverage, from Kaiser Family Foundation, *Health Insurance Marketplace Calculator*, Kaiser Family Foundation, October 31, 2019, downloaded on February 11, 2020, https://www.kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=percent&income=401&employer-coverage=0&people=1&alternate-plan-family=&adult-count=1&adults%5B0%5D%5Bage%5D=60&adults%5B0%5D%5Btobacco%5D=0&child-count=0.

[2] For an analysis of the more than 6 million people whom the Urban Institute found are affected by the glitch, see Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, *Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending but Increases Government Costs* (Urban Institute, July 6, 2016) https://www.urban.org/research/publication/marketplace-subsidies-changing-family-glitch-reduces-family-health-spending-increases-government-costs.

[3] "The Ugly Truth About Payday, Pawn Shop and Car Title Loans," *Aol.com*, May 24, 2014, https://www.aol.com/article/finance/2014/05/25/ugly-truth-payday-pawnshop-car-title-loans/20891495/.

[4] Diane Whitmore Schanzenbach, Lauren Bauer, and Greg Nantz, "Twelve Facts about Food Insecurity and SNAP," *Economic Facts* (The Hamilton Project, April 2016). https://www.hamiltonproject.org/assets/files/twelve_facts_about_food_insecurity_and_snap.pdf.

[5] Vermont provides such assistance as well. As a result, that state achieves exchange participation levels far above the national average: 48% of eligible residents are enrolled. That is the country's second-highest level, far above the national average of 32%. Kaiser Family Foundation, "Marketplace Enrollment as a Share of the Potential Marketplace Population: 2019," *State Health Facts*, downloaded on February 4, 2020, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-as-a-share-of-the-potential-marketplace-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] Kaiser Family Foundation, "Marketplace Enrollment as a Share of the Potential Marketplace Population: 2019," *State Health Facts*.

[7] Kaiser Family Foundation, "Health Insurance Coverage of Nonelderly 0-64: 2018," *State Health Facts*, downloaded on February 4, 2020, https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[8] Audrey Morse Gasteier, Emily Brice, and Marissa Woltmann, "Why Massachusetts Stands Out in Marketplace Premium Affordability," *Health Affairs Blog*, September 4, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180903.191590/full/.

[9] Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2020," *State Health Facts*, downloaded on February 4, 2020, https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[10] Kaiser Family Foundation, "Health Care Expenditures per Capita by State of Residence," *State Health Facts*, downloaded on February 4, 2020, https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[11] The text's comparison of New York to other states excludes states that either (1) experienced changes that were not statistically significant at the p<.05 level or (2) expanded Medicaid coverage for adults during the years when New York's BHP took effect. National Center for Coverage Innovation at Families USA analysis of American Community Survey data through IPUMS USA, University of Minnesota, www.ipums.org.

[12] https://health-access.org/wp-content/uploads/2019/06/CA-Budget-Affordability-Assistance-Fact-Sheet_6.24.19.pdf.

[13] State tax enforcement of the ACA's individual mandate also went into effect in 2020, which may have played a role in the jump in new enrollment. Covered California, *New California Policies Make Huge Difference, Increasing New Signups during Covered California's Open Enrollment by 41 Percent* (Covered California, February 18, 2020), https://www.coveredca.com/newsroom/news-releases/2020/02/18/new-california-policies-make-huge-difference-increasing-new-signups-during-covered-californias-open-enrollment-by-41-percent/.

[14] *Report of the Maryland Health Insurance Coverage Protection Commission*, December 2019, http://dls.maryland.gov/pubs/prod/NoPblTabMtg/MryHltInsCovCmsn/2019-Report-of-the-MD-Health-Insurance-Coverage-Protection-Commission.pdf.

[15] Greg Fann, "The True Cost of Coverage," *The Actuary*, December 2015/January 2016, https://theactuarymagazine.org/the-true-cost-of-coverage/.

[16] Several features of these options are important to note. First, extending state-funded assistance to people who are ineligible for PTCs does not draw down additional federal PTC dollars or leverage state investments by coupling them with federal PTC dollars. Second, fixing the family glitch would typically lower family insurance costs by letting people move from employer-based coverage to PTC-funded qualified health plans. It would not have a major effect on the number of uninsured, however, since most people affected by the family glitch currently pay the money needed to obtain employer-based insurance. Buettgens, et al., *Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending but Increases Government Costs*.

[17] Bobbieby Allyn, "California Is 1st State to Offer Health Benefits to Adult Undocumented Immigrants," *NPR*. July 10, 2019, https://www.npr.org/2019/07/10/740147546/california-first-state-to-offer-health-benefits-to-adult-undocumented-immigrantsy.

[18] See Stan Dorn. *Assessing the Promise and Risks of Income-Based Third-Party Payment Programs*. Commonwealth Fund. May 21, 2018. https://www.commonwealthfund.org/publications/issue-briefs/2018/may/assessing-promise-and-risks-income-based-third-party-payment.

[19] Center for Insurance Information and Consumer Oversight (CCIIO), U.S. Department of Health and Human Services, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, Revised September 17, 2015, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

[20] Katie Keith, "The 2020 Final Payment Notice, Part 2: Risk Adjustment," *Health Affairs Blog*, April 20, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190420.666282/full/.

[21] Some advocate public options as strategies to accomplish the latter goals. These options do not require a new infusion of public dollars, such as is required for publicly funded reinsurance.

[22] The only exception involves tobacco-rating: Most states let carriers raise premiums for smokers. Such premium surcharges are usually set as a percentage of premiums. PTCs cannot be used to cover those costs. When premiums decline, tobacco surcharges for PTC beneficiaries fall.

[23] John Ingold, "Colorado's Program Has Been Lauded as a Way to Reduce Health Care Costs. Here's the Fine Print," *The Colorado Sun*, November 1, 2019. https://coloradosun.com/2019/11/01/colorado-reinsurance-health-premium-increases/.

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COV2020-10