EXPANDING ACCESS TO EXCHANGES: A PROPOSAL TO ADDRESS HEALTHCARE AFFORDABILITY IN THE UNITED STATES

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I. INTRODUCTION

Healthcare costs have increased significantly, especially over the last several years, such that healthcare affordability is a challenge for millions of Americans. While the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA),[1] enacted in 2010, went a long way to keep its promise to expand access to health coverage, it did little to rein in costs for patients (and their families). Most households in the United States rely on employer-provided health coverage where out-of-pocket expenses, including premiums, deductibles, and co-payments, have made medical care increasingly unaffordable for many.

We start by providing background information on the health insurance landscape in the United States and a sense of the unaffordability crisis due to rising costs to individuals and families. This paper documents some of the most adverse impacts of shifting ever-increasing costs to employees through employer-sponsored plans. We propose and discuss expanded access to government health insurance Exchanges—which are already in place—as an effective strategy for cost control and quality improvements. Our aim is to use a fact-and data-driven approach to help address this complex issue by proposing a strategy that is practical and has the potential to ease the healthcare cost burden for many.

II. CONTROLLING HEALTHCARE COSTS REMAINS ELUSIVE

Employer-sponsored coverage is the most prevalent way for individuals to obtain health insurance in the United States—covering more than half of the nonelderly population (under age 65)—approximately 165 million people (see Figure 1).[2]

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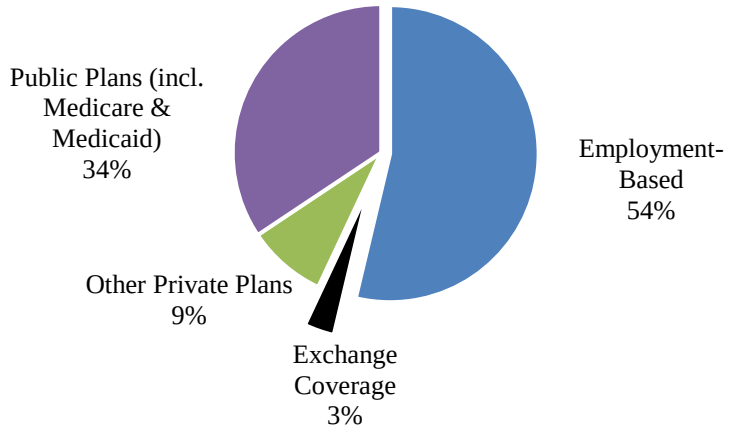
[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-48 (2010) (as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-52 (2010)).

[2] Sara S. Collins, *The Current Status of Employer Health Insurance Coverage in the United States*, COMMONWEALTH FUND (Oct. 20, 2021), https://doi.org/10.26099/6mv0-an15.

Fig. 1: Health Insurance Coverage in the US in 2020



Source: census.gov (2021)

Having health insurance tied to employment has many drawbacks. This includes preventing many from changing jobs, starting a business, or retiring early—a phenomenon referred to as "job lock." In addition, employers—particularly smaller employers—often shift a large share of cost-sharing for health care to their employees.

A. THE AFFORDABLE CARE ACT: PROMISE & SHORTCOMINGS

The Affordable Care Act is undoubtedly a significant piece of federal legislation that fundamentally changed health policy in the United States affecting individuals, employers, and health plans. Over the last decade, the ACA has faced numerous court challenges and several key provisions were rolled back.[3]

One of the principal goals of the ACA was to expand health insurance coverage for millions of Americans, and it did so, in part, through the establishment of Exchanges[4] and providing subsidies for those meeting income and other criteria. Exchange plans, which came into effect starting in 2014, are categorized by metal levels—bronze, silver, gold, and platinum.[5] The metal levels are

[3] *See, e.g.*, Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); California v. Texas, 2021 WL 2459255 (U.S. 2021); Braidwood Management Inc. v. Becerra, 2023 2703229 (N.D. Tex. 2023).

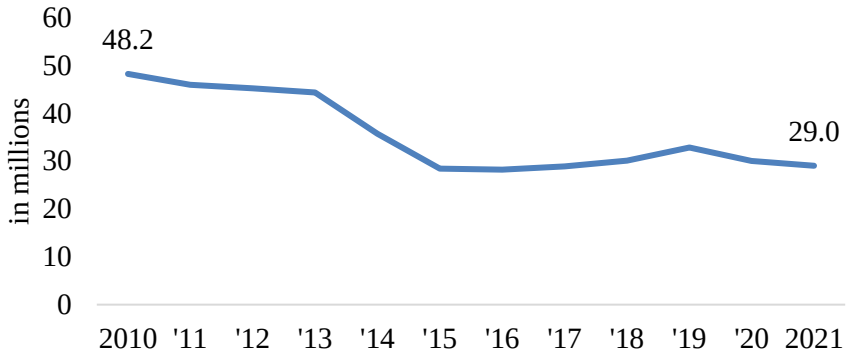
[4] Each state is required to establish its own Exchange (sometimes referred to as the Marketplace) or participate in a federally facilitated Exchange. Expansion of coverage also resulted from the option given to states to expand Medicaid beyond the minimum federal guidelines to provide coverage to more eligible individuals. Medicaid is a federal/state partnership with shared authority and financing providing health coverage for low-income individuals, children, and people with disabilities.

[5] Regardless of metal level, all plans must cover ten essential benefits, including coverage for (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services.

an indication of what portion of health care costs the plan will pay on average and what portion the individual will pay. In addition, certain individuals may be eligible for a premium tax credit toward the cost of purchasing health insurance coverage from an Exchange. Individuals who receive premium tax credit payments may also be eligible for cost-sharing reductions that reduce overall expenses. These Exchange subsidies are designed to reduce expenses related to out-of-pocket expenses, such as deductibles, co-payments, co-insurance, and annual cost-sharing limits.[6]

Although access to coverage has been expanded significantly under the ACA (see Figure 2, showing the decline in the uninsured rate), one of the criticisms of the law is that there has not been as much success in lowering overall costs.

Fig. 2: Nonelderly Uninsured Population in the United States



Source: National Health Interview Survey's (NHIS) Health Insurance Coverage Reports (2022)

There is some evidence that the ACA reduced the financial burden of medical bills on low-income adults on the national level.[7] Using data from a nationally representative sample of adults between 20 to 64 years of age, a 2020 study found that the number of adults experiencing catastrophic expenditures yearly declined from 13.6 million (7.4%) in 2010 to 11.2 million (5.9%) in 2017.[8] This study concludes that the ACA achieved one of its principal goals of improving financial protection for the lowest-income Americans. In contrast, improvements were not documented for higher-income populations as well as the privately insured.[9] Rather, the privately insured represent an increasing share of catastrophic expenditures cases. About one in three individuals with private insurance in the poorest quartile experience catastrophic spending per year, which explains why so many, including those with insurance, worry about healthcare

[6] An annual cost-sharing limit applies under a health plan, which is the total dollar amount an individual would be required to pay out of pocket for use of covered services in a plan year. Once the out-of-pocket spending meets this limit, the health plan generally pays 100% of covered costs for the remainder of the plan year.

[7] Hiroshi Gotanda et al., *Out-of-pocket spending and financial burden among low-income adults after Medicaid expansions in the United States: quasi-experimental difference-in-difference study*, BMJ (Feb. 5, 2020), https://www.bmj.com/content/368/bmj.m40.

[8] Charles Liu et al., *Catastrophic health expenditures across insurance types and incomes before and after the Patient Protection and Affordable Care Act*, JAMA NETWORK OPEN (Sept. 24, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770949.

[9] *Id.*

affordability. This observation is consistent with data that shows that most respondents consider the affordability of healthcare either a very big (56%) or a moderately big (30%) problem.[10]

i. ROLLBACK OF KEY ACA PROVISIONS: INDIVIDUAL SHARED RESPONSIBILITY & CADILLAC TAX

Two key provisions that had been contemplated as ones that would help rein in costs in the long term were ultimately rolled back some years after the ACA's enactment.

Individual Shared Responsibility: The first provision imposed a penalty (often referred to as the "individual shared responsibility" or "individual mandate") for any months where an individual failed to maintain minimum health insurance coverage. This provision went into effect in 2014, but as of 2019, this requirement was effectively repealed, when any shared responsibility payment was reduced to zero.[11] The individual mandate was considered an important tool for encouraging individuals—especially young, healthy adults—to purchase health insurance. Without this penalty, healthier individuals often choose not to purchase coverage, thereby driving up premiums for those who remain in the insurance market.[12] Since the repeal of the penalty, a few states and the District of Columbia have adopted state individual mandate requirements.[13] For example, modeled after the federal provision, New Jersey enacted legislation in 2018 to implement its own individual mandate starting in 2019.[14] However, without the federal mandate, these handful of state-level mandates are not enough to make the insurance risk pools broad enough to have a meaningful impact in lowering overall health premiums.

Tax on High-Cost Coverage: The second provision that was likely to have made an impact on healthcare costs, the excise tax on high-cost coverage,[15] was repealed before it even went into effect.[16] This provision was intended to be a significant revenue raiser by imposing a 40% excise tax on the portion of employer health coverage that exceeded a specified threshold amount. The excise tax was included in the ACA to raise revenue to offset the cost of other ACA provisions (such as providing subsidized coverage under the Exchange) and to curb some of the tax advantages that economists argue lead to an overconsumption of coverage and health services.[17] The U.S. Congressional Budget Office estimated that the excise tax, had it taken effect, would

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[10] *See, e.g., Report: Biden Nears 100-Day Mark With Strong Approval, Positive Rating for Vaccine Rollout, Americans' views of the problems facing the nation*, PEW RES. CEN., (April 2021), https://www.pewresearch.org/politics/2021/04/15/americans-views-of-the-problems-facing-the-nation.

[11] Tax Cuts and Jobs Act, Pub. L. 115-97, § 11081(b), 43 U.S.C. § 5000A (Dec. 22,2017).

[12] Jennifer Tolbert et al., *State Actions to Improve Affordability of Health Insurance in the Individual Market,* KFF ISSUE BRIEF (July 17. 2019), https://www.kff.org/health-reform/issue-brief/state-actions-to-improve-the-affordability-of-health-insurance-in-the-individual-market.

[13] States that have so far enacted legislation to implement individual mandates with penalties for non-compliance include California, Rhode Island, Massachusetts, New Jersey, and Vermont.

[14] Individuals filing a New Jersey income tax return pay a penalty generally based on income and family size that is capped at the statewide average annual premium for bronze-level health plans on the statewide Exchange. *See* State of New Jersey Shared Responsibility Requirement, https://nj.gov/treasury/njhealthinsurancemandate/responsibilitypayment.shtml.

[15] 43 U.S.C. § 4980I(a) (repealed 2019).

[16] Further Consolidated Appropriations Act, 2020, Pub. L. 116-94, § 503 (2019).

[17] *Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief*, CONG. RES. SERV. (Mar. 24, 2016), https://crsreports.congress.gov/product/pdf/R/R44147/6.

have increased federal revenues by $87 billion between 2016 and 2025[18]—monies that could have been used to address some of the affordability concerns.

ii. ACA'S COST-SHARING LIMITS & FIRST-DOLLAR COVERAGE

The ACA also included certain consumer protection requirements designed to alleviate the out-of-pocket spending burden on individuals and families.

Cost-Sharing Limits: The ACA requires that "cost-sharing" be limited, thereby putting a cap on out-of-pocket maximum spending.[19] Before the enactment of this provision, health plans were not required to establish an annual out-of-pocket maximum. Plans that did establish such a limit had considerable discretion in designing the amount of the maximum and the expenses that counted toward it. These limits, which were first imposed starting in 2014, have been adjusted annually—for 2023, the overall cost-sharing limits are $9,100 for individual coverage and $18,200 for family coverage, marking a 4.6% increase above the 2022 limits. Since 2015, cost-sharing limits have risen sharply—from $6,450 to $9,100 for individual coverage and from $12,900 to $18,200—marking an increase of more than 41% in less than ten years. In addition, premiums (the amount the insurance company charges in exchange for providing health coverage) do not count toward the cost-sharing limit.

First-Dollar Coverage: A popular consumer-centric ACA provision is the requirement that most health plans and insurers provide certain preventive services (such as blood pressure screening, immunizations, and obesity screening) without imposing any cost-sharing.[20] As a result, deductibles, copays, coinsurance, or other cost-sharing may not be imposed on these services. This provision is often referred to as providing "first-dollar coverage." More than an estimated 150 million are benefiting from the ACA's preventive services provision across a range of services and conditions.[21] Gains in access to services were due in large part to uninsured individuals obtaining health coverage, including people who became covered under the Exchanges through the ACA starting in 2014.[22]

With the public health emergency starting in early 2020, the federal government required health insurers to cover COVID-19-related diagnostic products and related services furnished during urgent care or in an emergency room setting without cost-sharing.[23] The importance of the

[18] This figure was based on the tax's implementation beginning in 2018. *See* Cong. Budget Off., Insurance Coverage Provisions of the Affordable Care Act - CBO's March 2015 Baseline (Mar. 9, 2015).
[19] Affordable Care Act, Pub. L. No. 111-148, § 1302(c) (2010). Essentially, the maximum out-of-pocket spending limit is a financial safety net—after this amount is reached, the insurance company typically pays 100% for covered services for the rest of the year.
[20] Affordable Care Act, Pub. L. No. 111-148, § 2713 (2010). Recommendations and guidelines for covering required preventive services are updated regularly. *See Health Benefits & Coverage: Preventive Health Services*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/preventive-care-benefits.
[21] U.S. Dep't of Health & Hum. Serv., Off. of the Assistant Secretary for Plan. & Evaluation, Issue Brief, *Access to Preventive Services without Cost-sharing: Evidence from the Affordable Care Act* (HP-2022-01) (Jan.11, 2022), https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf.
[22] Sherry A. Glied et al., *Effect of the Affordable Care Act on Health Care Access*, COMMONWEALTH FUND (May 8, 2017), https://doi.org/10.26099/0e35-gh36.
[23] Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6001 (2020).

inclusion of these costs and services under the preventive services requirement cannot be overstated. Ongoing legal challenges over the constitutionality of the ACA's preventive services could eventually send this issue to the Supreme Court.[24] Even if eventually upheld by the high court, the uncertainty adds to the hardship and uncertainty for millions who have come to rely on the ACA's first-dollar coverage for certain covered services.

B. THE DILEMMA OF "UNDERINSURANCE"

In addition to the rising cost of health insurance, many face difficulty affording care–even with health insurance. "Underinsured" refers to people who have health insurance but who are still faced with large medical expenditures because their plan's coverage is inadequate. Underinsurance is the result of insurance plans that include prohibitively high deductibles or plans that fail to cover a significant portion of the costs that the covered individual incurred. The latter can be due to copays, limited coverage of services or procedures, and policies that feature inadequate in-network options while also having limited out-of-network reimbursements. While underinsured individuals are, by definition, not uninsured, they suffer many of the same adverse consequences when health care is unaffordable.

Recent data suggests that this problem has been exacerbated over the last decade, even after the ACA's enactment. Actual healthcare expenditures and the risk of potential expenditures (deductibles) are compared with household income to determine an individual's underinsurance status.[25] According to estimates, more than one in five (21%) working-age adults in the United States were classified as underinsured in 2020, up from 16% in 2010.[26] Essentially, with these huge cost barriers, too many Americans have health insurance "in name only."[27]

C. LACK OF AFFORDABILITY LEADS TO SERIOUS CONSEQUENCES

The lack of affordability for a significant portion of the U.S. population has continued to be concerning. Based on U.S. Bureau of Labor Statistics data, healthcare expenses have significantly increased over the last two decades at a pace higher than overall inflation.[28] This trend has led to an increasing affordability crisis that is not new but constantly worsening as costs have risen two to three times faster than wages over the same period. Despite a multitude of healthcare policy initiatives, the trend of rising healthcare unaffordability has not been contained or even significantly slowed.

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[24] *See* Braidwood Mgmt. Inc. v. Becerra, 2023 2703229 (N.D. Tex. 2023).

[25] For this purpose, adults are counted as "underinsured" if they were continuously insured throughout the year but experienced one (or more) of the following: out-of-pocket costs (not including premiums) equaled 10% or more of income; out-of-pocket costs (not including premiums) equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

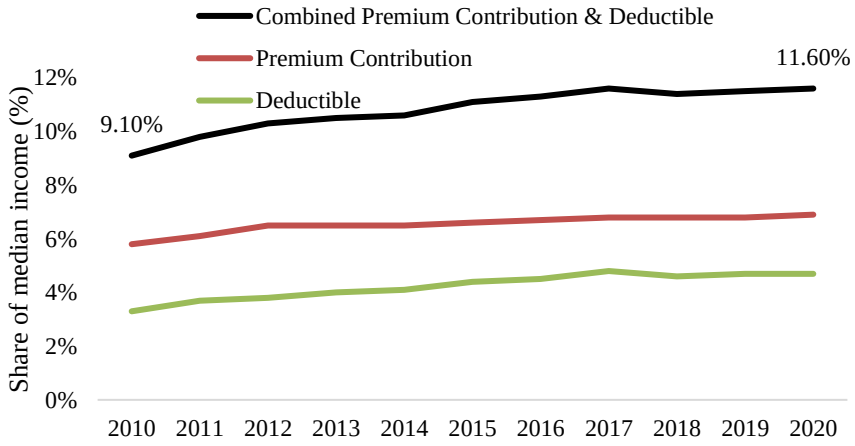
[26] Sara A. Collins et al., *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*, COMMONWEALTH FUND ISSUE BRIEF (Aug. 19, 2020), https://doi.org/10.26099/6aj3-n655.

[27] David Blumenthal & Sara Collins, *Millions of Americans have Health Insurance that isn't 'Good Enough'*, STAT (Nov. 4, 2022), https://www.statnews.com/2022/11/04/millions-americans-health-insurance-isnt-good-enough.

[28] Shameek Rakshit et al., *How Does Medical Inflation Compare to Inflation in the Rest of the Economy?* PETERSON-KFF HEALTH SYS. TRACKER (Nov. 30, 2022), https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy. (Using Bureau of Labor Statistics data, including the consumer price index and producer price index to analyze prices for medical care compared to other goods and services.)

An examination of data from the 2020 Medical Expenditure Panel Survey (MEPS–IC) reports consistent findings (see Figure 3). Focusing on the years from 2010 to 2020, the data shows that the sum of premium contributions and deductibles as a share of median household income has increased significantly from 9.1% to 11.6%.[29] The analysis further suggests that this trend has a particularly adverse impact on families with lower incomes. Employees in firms with lower average wages contribute a larger share of their overall premium and a larger dollar amount for family coverage, on average, than employees who work in firms with higher average wages.

Fig. 3: Healthcare Costs as a Share of Household Income in the United States

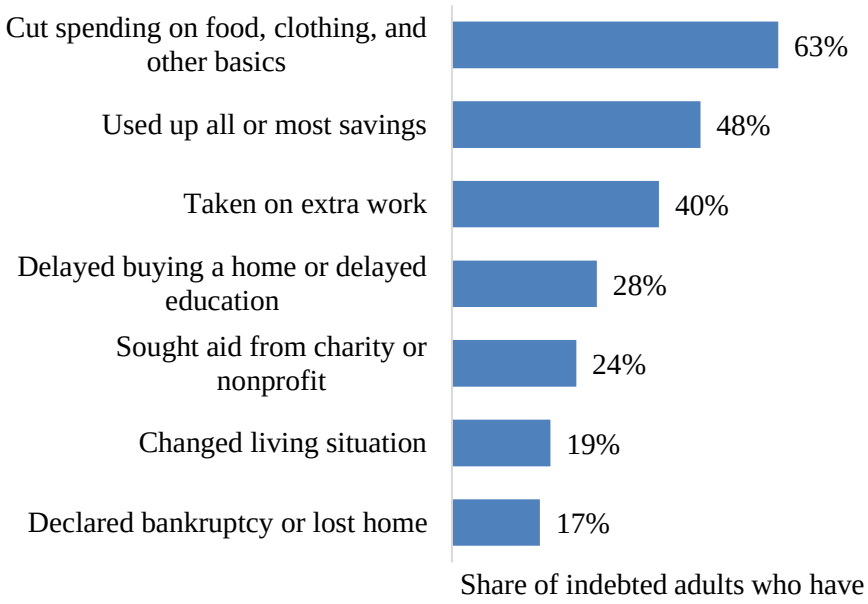


Source: The Commonwealth Fund (2022)

A 2022 investigatory survey on healthcare debt revealed that more than half of the adults in the United States report going into debt because of medical or dental bills over the course of five years.[30] The same data further shows that one in four adults with medical debt owed at least $5,000. While about 20% of debtors say that they do not expect to ever pay off their debt, this does not mean that the debt is having no adverse consequences (see Figure 4). Not surprisingly, medical debt causes significant burdens for those affected, from spending less on food, clothing, and other necessities to taking up additional work to combat financial insecurity.[31]

[29] Sara R. Collins et al., *State Trends in Employer Premiums and Deductibles, 2010–2020*, COMMONWEALTH FUND (Jan. 12, 2022), https://doi.org/10.26099/m5dt-5f70.
[30] Noam N. Levey, *100 Million People in America are Saddled with Health Care Debt*, KAISER HEALTH NEWS (June 16, 2022), https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt.
[31] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, KAISER FAM. FOUND. (June 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.

Fig. 4: Consequences of Health Care Debt



Source: KFF Health Care Debt Survey (2022)

A 2020 survey found that 23 million people (nearly one in ten adults) owe significant medical debt.[32] According to the same survey, about 16 million people (6% of adults) in the United States owe more than $1,000, and 3 million people (1% of adults) owe medical debt of $10,000 or more. However, the prevalence and size of healthcare debt are notoriously difficult to estimate with precision because data is difficult to obtain and often incomplete. A more recent 2022 finds that more than four in ten adults report some debt caused by medical or dental bills, and an additional 16% of adults report having such debts in the past that have since been paid off.[33]

Medical debt (and the fear of it) also lead to seriously non-financial—that is, medical consequences by blocking or deterring individuals from accessing needed health care. About one in seven of those carrying debt said that they have been denied access to a hospital, doctor, or other health care provider because of unpaid bills. In addition, about two out of three adults reported putting off care that they or a family member needed due to cost.[34]

More than one in three adults who had a commercial insurance plan with a deductible of $1,000 or more reported not accessing needed health care due to cost. In addition, more than four in ten adults with a deductible of that size reported problems paying medical bills and accumulating

[32] Matthew Rae et al., *The Burden of Medical Debt in the United States.* PETERSON-KFF HEALTH SYSTEM TRACKER (Mar. 10, 2022), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states. (Analyzing data from the Survey of Income and Program Participation to understand how many people have medical debt and how much they owe. For purposes of this survey, a threshold of $250 was defined as "significant" medical debt to distinguish people who owe relatively small amounts.)
[33] Lopes, *supra* note 31.
[34] Levey, *supra* note 30.

medical debt.[35] These facts are not surprising in light of the limited financial resources of many in America. According to recent data, only 44% of respondents would pay for a $400 emergency expense with money currently in their bank accounts or with cash. About 15% would use a credit card and pay it off over time and 12% could not afford to pay for the expense at all.[36] These results are consistent with more recent data from 2022 where about half of adults say that they would be unable to pay a $500 unexpected medical bill without borrowing money. This statistic includes about 30% of people who currently do not have medical debt, which puts those individuals, and indeed their families and other dependents, at risk of falling into debt.[37]

With healthcare costs rising, there has been a rise in nontraditional options that market relief from the high out-of-pocket cost burden. However, these plans often do not provide comprehensive medical care, covering only a small portion of medical bills because of contractual plan limitations. Lacking transparency and consumer protections, these "skinny plans" often do not cover many standard benefits such as maternity care and hospitalization in addition to having no annual limit on how much patients can be required to pay out-of-pocket.[38]

D. BROAD CONSENSUS THAT COSTS ARE TOO HIGH AND NEED FOR REFORM

Healthcare reform remains a top priority for Americans. A 2021 survey finds that only 6% of participants consider this issue unimportant.[39] Data from this large, representative sample of adults in the United States (N = 5,360) shows that a majority of respondents (58%) think that the reduction of healthcare costs should be a top priority for the President and Congress. This highlights the need for effective policy proposals that address healthcare costs and affordability.

III. EMPLOYER COVERAGE CHALLENGES

In line with the overall rise in healthcare expenditures, health insurance premiums and worker contributions under employer-sponsored coverage have steadily increased for the past several decades while wages have stagnated.[40] Even after decades of providing health care to their workers, many employers appear to lack the necessary expertise to fully understand the health coverage they purchase and what they (and in turn, their employees) are paying as a result. As a

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[35] *2020 Biennial Health Insurance Survey*, COMMONWEALTH FUND, https://www.commonwealthfund.org/publications/surveys/2020/aug/2020-biennial-health-insurance-survey.

[36] Board of Governors of the Fed. Res. Bank, Report on the Economic Well-Being of U.S. Households in 2021 (May 2022), https://www.federalreserve.gov/publications/2022-economic-well-being-of-us-households-in-2021-executive-summary.htm.

[37] Lopes, *supra* note 31.

[38] Julie Appleby, *New Health Plans Offer Twists on Existing Options, With a Dose of "Buyer Beware,"* KAISER FAM. FOUND. (Nov. 4, 2021), https://khn.org/news/article/new-health-plans-offer-twists-on-existing-options-with-a-dose-of-buyer-beware.

[39] *Report: Biden Nears 100-Day Mark With Strong Approval, Positive Rating for Vaccine Rollout, Americans' views of the problems facing the nation*, PEW RES. CTR. (April 2021), https://www.pewresearch.org/politics/2021/04/15/americans-views-of-the-problems-facing-the-nation.

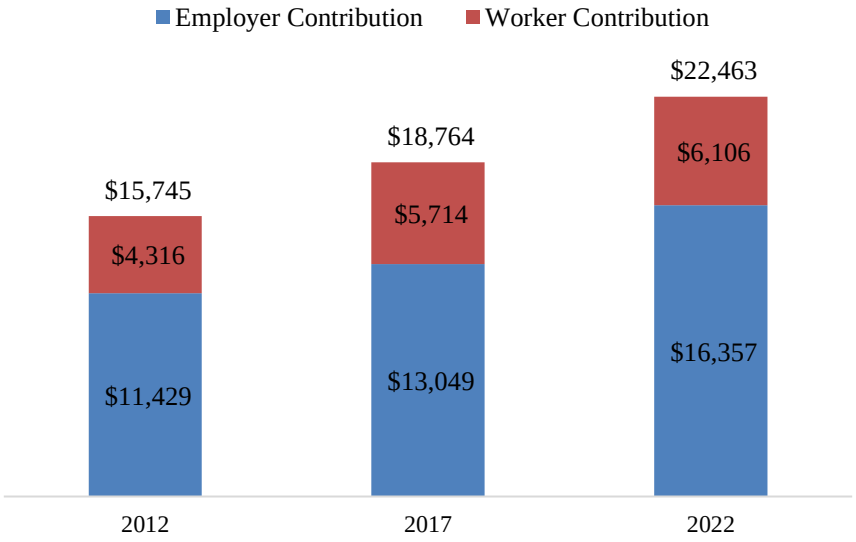
[40] Sam Hughes et al., *Health Insurance Costs are Squeezing Workers and Employers*, CTR. AM. PROGRESS REP. (Nov. 29. 2022), https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers. (The authors note that "without policies to keep in check health care prices for private insurance, high [employer-sponsored insurance] premiums and cost sharing; affordability problems; and income-based inequities among workers will continue to worsen.").

result, employers, both large and small, have been "forced to look around and assemble [a] hodgepodge of vendors [and] the vast majority don't have sophisticated benefit teams."[41]

A. CONTINUAL INCREASE IN EMPLOYEE PREMIUMS

In 2022, the average annual premiums for employer coverage increased to $22,463 for family coverage and $7,911 for single coverage.[42] This represents a 20% increase in average family premiums since 2017 and a 43% increase since 2012 (see Figure 5). Given the large share of individuals who obtain health care coverage through their employers, the fast pace of insurance premium increases—a cost that workers bear regardless of whether they are consuming health care or not—is a major factor contributing to the affordability crisis.

Fig. 5: Average Annual Worker and Employer Premium Contributions for Family Coverage Between 2012 and 2022



Source: KFF 2022 Employer Health Benefits Survey (2022)

The data shows that average premiums do not differ significantly by employer size though covered workers in small firms tend to contribute a larger percentage of the total premium (that is, the employer's share is lower) than workers who are employed in large firms. The difference in worker contributions is economically and statistically significant for both single coverage and family coverage. A similar trend is observed for firms that employ a larger share of lower-wage workers. Worker contributions towards the insurance premiums are particularly high for workers who have a family plan while working for a small employer. In 2022, workers in 31% percent of small firms paid more than half of the premiums while workers in another 28% of small firms paid

[41] Bob Hermon, *Employers are Flying Blind When Buying Health Coverage*, AXIOS (Feb. 25, 2022), https://www.axios.com/2022/02/25/employers-health-benefits-consultants-hr-rebates.

[42] *2022 Biennial Health Insurance Survey*, COMMONWEALTH FUND (Sept. 2022), https://www.commonwealthfund.org/sites/default/files/2022-09/Collins_state_of_coverage_biennial_survey_2022_db.pdf.

between 25% and 50% of the premium.[43] U.S. employers expect health benefit cost per employee to continue to rise,[44] which will undoubtedly push more employers to pass on some of that burden to employees by way of increased premiums and cost-sharing.

B. EMPLOYEE COST-SHARING ON THE RISE

Most health insurance policies feature cost-sharing provisions, meaning that a covered individual must pay a share of the cost when accessing covered services. Cost-sharing can be in the form of general deductibles (an amount that is paid by the enrollee before expenses are paid for by the plan), copays (a fixed amount), or coinsurance requirements (a share of the covered amount). As discussed in more detail above in Section II, while the ACA established annual limits on cost-sharing (out-of-pocket expenses), those limits are quite high and increase year-over-year.

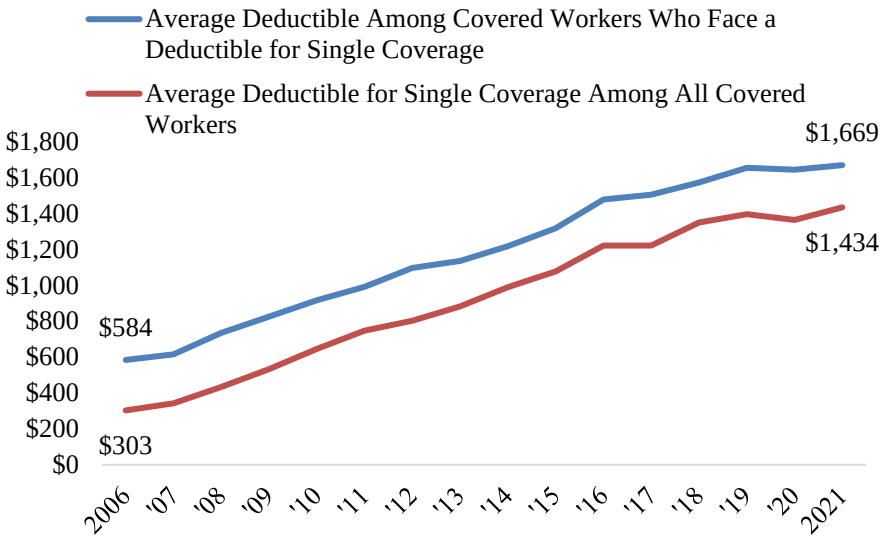
Workers with employer coverage that included a deductible faced an average annual deductible of $1,669 for single coverage in 2021.[45] This figure has increased by 13% from 2016 and about 68% over the previous decade. While almost three in ten workers have deductibles over $2,000, the likelihood of facing a large deductible is significantly higher for those who work in small firms (45% vs. 22%). It is important to keep in mind that these amounts do not include other types of cost sharing, such as copays, which often exist as part of the same plans. In addition to increasing average deductibles, the data also shows that a growing share of covered workers have a plan with a deductible, meaning that fewer plans have no deductible. This information is represented by the red line in Figure 6. The average general annual deductible for single coverage is $1,434 in 2021, which represents a 92% (17%) increase from 2011.

[43] *2022 Employer Health Benefits Annual Survey*, KAISER FAM. FOUND. (Oct. 2022), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

[44] Beth Umland et al., *Health Benefits Cost Growth Will Accelerate to 5.6% in 2023* (Aug. 11, 2022), https://www.mercer.us/our-thinking/healthcare/health-benefit-cost-growth-will-accelerate-in-2023.html. Because health plans typically have multi-year contracts with health care providers, it is likely that the impact of the price inflation will be phased in over the next few years as contracts come up for renewal and providers negotiate higher reimbursement levels.

[45] *2021 Employer Health Benefits Annual Survey*, KAISER FAM. FOUND. (Nov. 2021), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

Fig. 6: Average Annual Deductibles for Single Coverage



Source: KFF 2021 Employer Health Benefits Survey (2021)

While other factors can have an impact on a person's ability to access health care, insurance status is the most important determinant.[46] Unsurprisingly, however, studies show that high deductibles and significant cost-sharing can become a barrier to care as individuals, especially those with lower incomes, are discouraged from accessing services even when urgently needed. This is part of the underinsurance problems since a large percentage of adults who are insured all year nonetheless report cost-related problems getting health care.

C. LIMITED PLAN CHOICE

For the overall commercial healthcare market, "[p]rices that stem from a lack of competition, and thus a lack of choice, are unlikely to reflect value to consumers."[47] Three in four firms offer only one single plan type (with 21% offering two and 4% offering three or more). Large firms tend to offer more choices while also employing a larger number of individuals whereas 38% of covered workers in small firms are limited to "choosing" from one single plan type. [48]

This is consistent with anecdotal evidence that employers, especially smaller ones, often lack the necessary expertise to make informed health coverage purchasing decisions.[49] A large share of

[46] Mary Sue Coleman et al., *Hidden Costs, Value Lost: Uninsurance in America*, INST. MED. NAT'L ACAD., https://nap.nationalacademies.org/catalog/10719/hidden-costs-value-lost-uninsurance-in-america.
[47] Benedic N. Ippolito, *Increasing Cost Pressures in the Commercial Health Care Market*, AM. ENTERPRISE INST. REP. (Sept. 27, 2021), https://www.aei.org/research-products/report/increasing-cost-pressures-in-the-commercial-health-care-market.
[48] *2021 Employer Health Benefits Annual Survey*, KAISER FAM. FOUND. (Nov. 2021), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.
[49] Herman, *supra* note 41.

employees in the United States work for smaller employers—according to census data, firms with less than 500 workers employed more than 61 million individuals in 2019.[50]

IV. AFTER A ROCKY START, EXCHANGES HAVE BECOME ROBUST

Launched in 2014, the Exchanges were created under the ACA as a single point of access for individuals to enroll in government-facilitated health coverage and to apply for income-based subsidies (depending on eligibility). The first annual open enrollment period began in October 2013 and was fraught with technical difficulties as a new health insurance marketplace was launched from scratch. While the ACA encouraged each state to establish its own Exchange, a federally facilitated Exchange was needed for states that elected not to establish their own.[51] This led to several problems with the initial deployment. Despite the rocky start, approximately eight million individuals signed up for Exchange coverage between October 2013 and March 2014. Since the initial launch, the federal government took key steps to address the technical concerns by increasing support capacity for the systems, requiring additional software quality reviews, and improving the functionality of key information technology systems.[52]

As the technological problems were addressed and the familiarity with the Exchanges for consumers and insurers grew, enrollment began to increase in 2015 and 2016. The number of enrollees stabilized between 2016 and 2021, ranging between 11.5 and 12.5 million (see Figure 7). A record number of people signed up through the Exchanges to obtain health coverage for 2022, a year-over-year growth rate of more than 20% resulting in almost 14.5 million enrollees.[53]

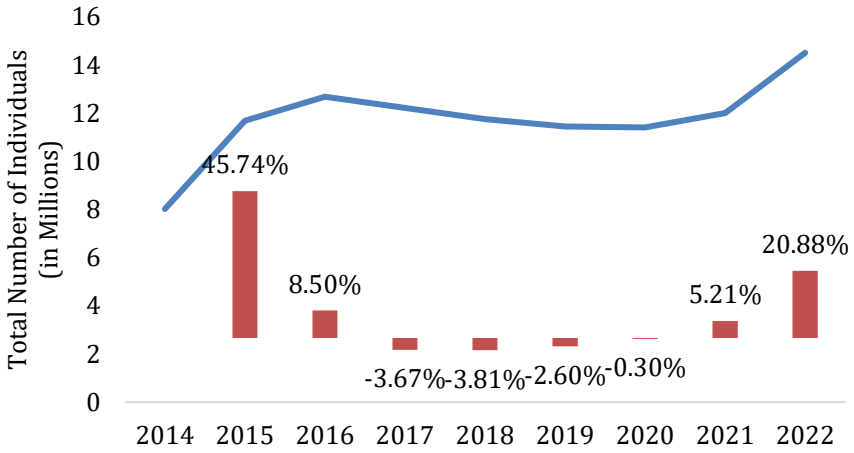
[50] U.S. CENSUS BUREAU, 2019 STATISTICS OF U.S. BUSINESSES (SUSB) ANNUAL DATASETS BY ESTABLISHMENT INDUSTRY, https://www.census.gov/data/tables/2019/econ/susb/2019-susb-annual.html.

[51] Based on U.S. governmental data, as of January 31, 2023, there were twenty-one state-based Exchanges, with three state-based exchanges using the federal platform. *See* Centers for Medicare & Medicaid Services: State-based Exchanges, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/state-marketplaces#:~:text=As%20of%20January%2031%2C%202023,platform%20(SBE%2DFPs).

[52] Gov't Accountability Off. Rep., *CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices* (Mar. 2015), https://www.gao.gov/assets/gao-15-238.pdf.

[53] Press Release, U.S. Dep't of Health & Hum. Serv., All-Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go (Dec. 22, 2021), https://www.hhs.gov/about/news/2021/12/22/all-time-high-13-million-people-signed-up-for-health-coverage.html.

Fig. 7: Marketplace Plan Enrollment and Year-to-Year Percentage Changes in the US



Source: KFF (2022)

A. EXCHANGES OFFER SAVINGS, CHOICES, STANDARDIZATION, AND ASSISTANCE

In light of the complex health insurance landscape and the challenges associated with employer coverage, the Exchanges can offer a larger selection of plans, more affordable coverage due to available subsidies, and the ability for consumers to make a more informed decision by offering plan standardization and assistance during the enrollment process.

i. COST SAVINGS (PREMIUMS & DEDUCTIBLES)

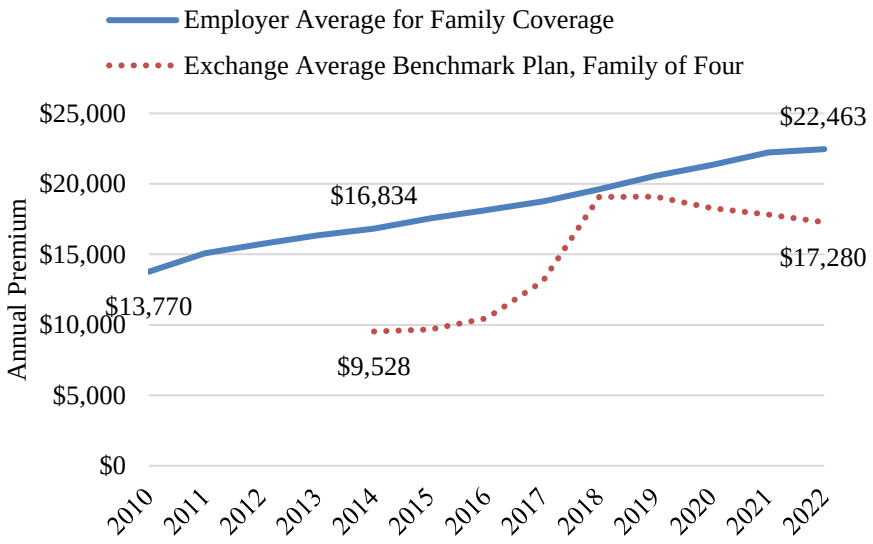
The median deductible for an individual enrollee on the Exchanges decreased between 2017 and 2021 from $1,000 to $750 after subsidies.[54] This decline was driven by cost-sharing reduction subsidies, which were part of the ACA that offset the trend of increasing deductibles for more than half of enrollees. As a result, Exchange enrollees generally have smaller deductibles than those who rely on employer coverage if they qualify for subsidies. The shift towards plan enrollment with lower deductibles offers greater financial protection to consumers, especially in cases of unforeseen medical emergencies and conditions that require long-term treatment, including chronic illnesses.

Another important dimension to affordability is the monthly premiums that a plan charges. Figure 8 compares the average annual premium for family coverage of the average employer plan to the average "benchmark plan" for a family of four on the Exchanges. In contrast to the steady increases in premiums for the average employer plan, the average annual premium for Exchange coverage has declined since 2019. In 2021, the average Exchange premium for family coverage was almost 20% lower than the average employer plan. It is important to note that this difference does not account for additional subsidies—which are available on the Exchanges – that further

[54] U.S. Dep't of Health & Hum. Serv. Rep., Off. of Assistant Secretary for Plan. Eval., *Health Insurance Deductibles Among Healthcare.gov Enrollees, 2017-2021* (Jan. 13, 2021), https://aspe.hhs.gov/reports/marketplace-deductibles-federal-platform-2017-2021.

decrease costs for eligible individuals and families. The average annual premium was only $1,968 in 2021 and further dropped to $1,596 in 2022 after the premium tax credit is considered.[55] This difference between employer coverage and the Exchanges is meaningful, both statistically and economically, and has the potential to address healthcare unaffordability for certain segments of the population.

Fig. 8: Annual Family Plan Premiums 2010 to 2022



Source: The Commonwealth Fund 2021 Biennial Health Insurance Survey (data from here, here, and here)

Notably, legislation enacted in October 2022 extended the eligibility for enhanced financial assistance by lowering premiums for qualifying individuals for coverage purchased on the Exchange through December 31, 2025.[56]

ii. MORE PLAN CHOICES

The 2022 Exchange open enrollment period saw near-all-time high participation from insurers. A total of 213 insurers offered coverage on the Exchanges–an increase of 32 insurers compared to 2021.[57] This meant that the average consumer had close to six insurers to choose from–up from four to five insurers in 2021. On average, 5.9 insurers were available to consumers in each state, which is close to the maximum of 6.0 in 2015 and an increase of 18% from the prior year. Overall, the pattern of insurers participating closely reflects the Exchange open enrollment pattern since the launch of the Exchanges in 2014.

[55] The premium tax credit is a refundable tax credit that helps cover the health insurance premiums for eligible individuals and families if plans are purchased via the Exchanges. More information is available from the IRS at https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics.
[56] Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 12001 (2022).
[57] Press Release, U.S. Dep't of Health & Hum. Serv., All-Time High: 13.6 Million People Signed Up for Health Coverage on the ACA Insurance Marketplaces With a Month of Open Enrollment Left to Go (Dec. 22, 2021), https://www.hhs.gov/about/news/2021/12/22/all-time-high-13-million-people-signed-up-for-health-coverage.html.

In addition to the number of participating insurers, each insurer offers a variety of plan choices on the Exchanges with varying features categorized into four "metal tiers" (bronze, silver, gold, and platinum) based on how much of the out-of-pocket costs are covered through the plan.

iii. PLAN STANDARDIZATION

While both employer-sponsored plans and Exchange plans have disclosure requirements to increase transparency, an individual may be able to get a more reliable estimate of anticipated spending based on the Exchange. This is because "standardized plans" are a policy option that has the potential to greatly simplify consumer comparison shopping on the Exchanges and bring more value to consumers by offering the same actuarial value, maximum out-of-pocket spending, deductibles, and cost-sharing for a given metal level of coverage. The ACA already requires qualified health plans to cover the various predetermined categories of essential health benefits and limit maximum out-of-pocket spending. The actual deductibles and cost-sharing for specific services vary widely within these broader requirements and limits offering meaningful choices among those standardized plan options.

Beginning in 2023, federal regulations require insurers to offer standardized plans if they wish to sell their qualified health plans through the federal Exchange.[58] For now, state-based Exchanges operating their own eligibility and enrollment platforms and state-based Exchanges using the federal platform have the option to require standardized plans by metal level to make it easier for consumers to compare plans. Research shows that consumers struggle to understand the meaning of basic healthcare terms, such as deductibles, coinsurance, and out-of-pocket limits. Thus, further standardization is expected to support more informed decision making and better outcomes.[59]

According to health policy experts, standardized plans have the potential to "facilitate competition among [insurers] by improving transparency for consumers and distilling competition down to crucial factors like premium price, provider network, and plan quality, rather than allowing [issuers] to compete based on complicated and opaque cost-sharing structures."[60] To this end, insurers offering coverage on the Exchanges are required to submit to network adequacy reviews and provide information on whether providers participating in their network offer services through telehealth.[61]

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[58] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 45 CFR pt. 144, 147, 153, 155, 156, & 158, 87 Fed. Reg. 27,208 (May 6, 2022).

[59] ACA required standards for definitions of certain insurance-related terms, which led to the requirement that insurers provide access to the uniform glossary developed by federal agencies. *See* Quincy L, *What's Behind the Door: Consumers' Difficulties Selecting Health Plans,* CONSUMERS UNION (Jan. 2012), https://advocacy.consumerreports.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf.

[60] Rose C. Chu et al., & Sommers, B.D, Issue Brief No. HP-2021-29, Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, U.S. DEP'T OF HEALTH & HUM. SERV., ASSISTANT SECRETARY FOR PLANNING & EVALUATION (Dec. 28, 2021), https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces.

[61] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 45 CFR pt. 144, 147, 153, 155, 156, & 158, 87 Fed. Reg. 27208, 27,322 (May 6, 2022).

iv. ASSISTANCE TO APPLICANTS

Since the Exchanges are supported by the government, investments are made over time to offer assistance. So-called "Navigators" are required to be trained and certified before they assist applicants on the Exchanges. Since they are not affiliated (or employed) directly by a provider, they can provide unbiased information to facilitate health plan selection among the various options offered on the Exchange. In addition, Navigators help applicants determine eligibility and apply for subsidies (premium tax credits or cost-sharing reduction subsidies).

For the 2023 Exchange open enrollment, the federal government invested millions in additional funding to support Navigators in states using the federally facilitated Exchanges. These funds were used for outreach, education, and direct enrollment efforts.[62] This figure represents the largest marketing investment for open enrollment since the launch of the Exchanges in 2014. As a direct consequence, Exchange plan enrollment has continued to hit all-time highs in recent years.

Another initiative to improve plan selection requires independent (often web-based) brokers to display a prominent and clear rationale for all explicit Exchange health plan recommendations. In addition, the methodology for the default display order of plans on their websites (for example, alphabetically based on a plan name, from lowest to highest premium, etc.) will be required to be clearly indicated to ensure that consumers are better able to make informed decisions by shopping for and selecting from those Exchange plans that best fit their needs.[63]

B. MORE AFFORDABLE COVERAGE FOR FAMILY MEMBERS OF EMPLOYEES

One of the most significant administrative actions since the passage of the ACA has been to fix the so-called "family glitch"—by amending the existing regulations regarding eligibility for premium tax credits on the Exchanges. The revised rules provide that affordability of employer coverage for family members of an employee would be determined based on the employee's share of the cost of covering the employee and those family members.[64] Previously, affordability had been based on the cost of covering ***only*** the employee. This change took effect in 2023, allowing more individuals to enroll in Exchange coverage and qualify for subsidies. According to government estimates, this policy change is projected to increase the number of individuals with premium tax credit-subsidized Exchange coverage by about 1 million.[65]

This revised rule provides that an employer plan is considered affordable for related individuals only if the portion of the annual premium the employee must pay for family coverage does not exceed 9.5% of household income. Thus, the modification to the rule enables access to subsidized

[62] Press Release, U.S. Dep't of Health & Hum. Serv., HHS Announces Additional Navigator Resources to Support the Extended Healthcare.gov Open Enrollment Period (Dec. 16, 2021), https://www.hhs.gov/about/news/2021/12/16/hhs-announces-additional-navigator-resources-to-support-extended-healthcaregov-open-enrollment-period.html.

[63] U.S. Dept. of Health & Hum. Serv., Fact Sheet, HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet (April 28, 2022), https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet.

[64] Affordability of Employer Coverage for Family Members of Employees, 26 C.F.R. pt. 1, 87 Fed. Reg. 61,979 (Oct. 13, 2022).

[65] The modified rule is based on the current administration's conclusion that it is a "better reading of [statutory] provisions."

Exchange coverage for those individuals who are covered by family coverage through a family member's employer that costs more than 9.5% of their household income. Households in this situation are given additional options that provide health coverage at a lower cost and/or with more comprehensive benefits. The revised interpretation of the rule is deemed more equitable as family members of employees would not be required to pay more out of pocket as a share of household income for employer coverage than they would if they were on the Exchange.

While certainly a welcome step toward giving families a more affordable option, the modified rule has its challenges. Notably, since the employee would still be deemed as being offered affordable self-only coverage, the employee would not be eligible for premium tax credits on the Exchange. The family would thus have to purchase two policies—one for the employee through the employer and one through the Exchange for the remaining family members. Having to enroll in multiple plans could be burdensome for families who would then have to navigate different provider networks and drug formularies and incur separate deductibles and limits on out-of-pocket spending. For these reasons, it is expected that many who become eligible for coverage under the modified rule may not opt for Exchange coverage, but rather purchase one employer plan for all family members.[66]

For some families "split coverage" (that is, the employee enrolling in employer-sponsored coverage and the family members enrolling in the Exchange) could lead to lower premiums and cost-sharing for the family as a whole or could even lead to uninsured individuals gaining health coverage. For other families, the cost of the two coverages could be higher, such as having two deductibles and out-of-pocket maximums to satisfy. Thus, it would be desirable for Exchanges to provide clear resources to help ensure that families who choose to enroll in split coverage are truly benefitting from doing so.[67] In addition, employees may need specific information (such as coverage eligibility and cost) from their employer to evaluate whether to enroll family members in subsidized Exchange coverage. Currently, there is no requirement that an employer must provide this information to employees, creating a further "stumbling block" and highlighting that implementation of the family glitch fix is an area where more trained assistance on the Exchanges would be beneficial to help individuals make the right decision for them.[68] Since many may not be aware of those changes and their new subsidy eligibility, for example, if they were previously not eligible to receive financial assistance to purchase Exchange coverage, targeted outreach is critical. Thus, the success of the fix to the "family glitch" will largely depend on the ability of the Exchanges to update their technology, broadcast the new opportunity, and help consumers understand their new coverage options.[69]

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[66] Timothy S. Jost, *A Fix for the Family Glitch*, TO THE POINT BLOG, COMMONWEALTH FUND (April 12, 2022), https://doi.org/10.26099/zr4t-en75.

[67] American Benefits Council, *Comment Letter: Affordability of Employer Coverage for Family Members of Employees (REG-114339-21)* (June 6, 2022), https://www.americanbenefitscouncil.org/pub/?id=45F8BCE5-1866-DAAC-99FB-C6C96B558A99.

[68] Kaye Pestaina & Karen Pollitz, *Navigating the Family Glitch Fix: Hurdles for Consumers with Employer-Sponsored Coverage* (Nov. 21, 2017), https://www.kff.org/health-reform/issue-brief/navigating-the-family-glitch-fix-hurdles-for-consumers-with-employer-sponsored-coverage/#.

[69] Rachel Schwab, et al., *Implementing the Family Glitch Fix on the Affordable Care Act's Marketplaces,* TO THE POINT BLOG, COMMONWEALTH FUND (Dec. 8, 2022), https://doi.org/10.26099/p0d8-v245.

C. WHO IS MOST LIKELY TO BENEFIT FROM EXPANDED ACCESS TO EXCHANGES?

While the shortcomings of employer coverage are apparent when looking at the cross-section of all covered individuals, the extent to which health care is affordable and meets the needs of the insured differs widely. The proposed expansion of access to Exchanges is expected to benefit particularly those who are currently not well served by their employer-provided plan, which can be due to a wide variety—and multiple—factors.

More than one in three covered workers (38%) experience a lack of options and are forced to pick from a single plan type provided by their employer.[70] In contrast, Exchanges offer significantly more provider choices and plans are available in four metal tiers to allow the customer to choose the optimal coverage, given their specific circumstances and preferences. Almost three in ten (29%) workers with employer coverage face a deductible over $2,000—a situation that is about twice as likely to involve employees who work for small firms. Similarly, a total of 22 states in the United States show an average deductible of five percent or more of the median household income as of 2020. Approximately 140 million Americans live in one of those states with high deductibles based on 2021 census.gov data. While it is outside the scope of this paper to examine the causes of why the deductibles in these states are higher, accessing coverage through the Exchanges opens up additional plan options and subsidies to avoid situations in which individuals find themselves subject to adversely high deductibles for those who qualify.

For premiums, the data shows that the average employee share of the insurance premium is 8.5% or more of the median household income in eight states (as of 2020). This includes populous states such as Texas and Florida. Importantly, many employees are paying high premiums (relative to their income) while simultaneously facing a large deductible as part of their plan. This goes against the widespread intuition that higher premiums should be associated with better coverage and lower deductibles.[71] Workers often pay more of the insurance premium, both in relative and absolute terms, when they work for a small firm and are enrolled in a family plan.[72] By offering more choices and professional assistance, the Exchanges are expected to improve outcomes through lower costs and more comprehensive coverage in those circumstances.

Individuals who are at risk of job loss or who frequently change employers can experience adverse consequences when their health insurance coverage is tied to their employment. The so-called "Great Resignation" of 2021 and 2022 saw all-time high numbers of workers quit their jobs.[73] According to the U.S. Bureau of Labor Statistics, a record-breaking number of 48 million workers quit their jobs in 2021—a trend that continued into 2022. Since deductibles are reset when coverage changes due to a change in employment, individuals may end up paying more than the maximum deductible per year even if they maintain uninterrupted coverage.

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[70] 2021 Kaiser Family Foundation (KFF) Employer Health Benefits Annual Survey (Nov. 2021), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

[71] Collins, *supra* note 29.

[72] 2022 Kaiser Family Foundation (KFF) Employer Health Benefits Annual Survey (Oct. 2022), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

[73] Roy Maurer, *Will Workers Continue to Leave Their Jobs in Record Numbers?*, SOC'Y HUM. RESOURCE MGMT. NEWSL. (Dec. 7, 2021), https://www.shrm.org/ResourcesAndTools/hr-topics/talent-acquisition/Pages/BLS-Quits-JOLTS-Great-Resignation-Record-Numbers.aspx.

In 2022, more than one in five adults with employer-provided coverage were underinsured.[74] While this could be due to multiple factors (limited plan availability, unfit plan choice due to lack of knowledge and inadequate assistance, etc.), access to Exchanges can help reduce the underinsurance problem by offering more affordable, comprehensive coverage and assistance with plan selection. Finally, subsidies available via the Exchanges are explicitly designed to provide additional financial support to those who need it the most.

V. EXCHANGES OFFER VIABLE POTENTIAL TO CONTROL COSTS

The United States has long had a history of the provision of health insurance via employer-sponsored coverage. But as the cost of healthcare continues to increase, employers often shift more of the burden onto employees in the form of higher out-of-pocket expenditures.[75] In recent years, there has undoubtedly been a shift toward more of a gig-based economy along with job separations spiking—according to the U.S. Bureau of Labor Statistics, almost 70 million Americans either quit, were fired, retired, or otherwise left their jobs in 2021. This "job market churn" inevitably disrupts many people's health coverage as highlighted by the COVID-19 crisis, which underscored the "risks of having health insurance tied to employment."[76] As the public health emergency is lifted with many COVID-19-related costs and services no longer being covered without cost-sharing, access to affordable coverage takes on a renewed significance and the Exchanges can serve as a "critical safety net."[77]

While several of the ACA provisions fell short of curbing healthcare costs, the vehicle within the ACA that offers a potential promise is the already-established Exchanges in each of the states. Rising costs are at the forefront of the minds of voters—as an example, Oregon became the first state in the United States to approve a ballot measure in explicitly declaring affordable health care a fundamental human right.[78]

The "safety net" created by expanding access to the Exchanges as well as enhanced subsidies have made it easier for qualifying individuals to enroll in, and afford the cost of, health coverage. Navigators and other Exchange personnel provide logistical support that is crucial for individuals struggling to understand complex plan options and cost features. More changes are on the horizon for Exchanges, including improvements to the plan selection process to make standardized plan displays more readily identifiable for consumers and more marketing and facilitation by Exchange navigators and consumer assisters.[79] In addition, the recently revised rules to address the "family

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[74] 2022 Commonwealth Fund Biennial Health Insurance Survey (Sept. 2022), https://www.commonwealthfund.org/sites/default/files/2022-09/Collins_state_of_coverage_biennial_survey_2022_db.pdf.

[75] Jake Spiegel & Paul Fronstin, *Issue Brief No. 564: Recent Trends in Patient Out-of-Pocket Cost Sharing*, EMP. BENEFIT RES. INST. (July 28, 2022), https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_564_oopcostsharing-28july22.pdf?sfvrsn=9d57382f_4.

[76] Bob Herman, *Workers are Changing Health Plans More than Ever*, AXIOS (Feb. 25, 2022), https://www.axios.com/workers-change-health-plans-more-than-ever-a5f3fd65-5e91-47be-ad68-0813f5837929.html.

[77] Sabrina Corlette & Maanasa Kona, *Mitigating Coverage Loss When the Public Health Emergency Ends*, COMMONWEALTH FUND BLOG (Apr. 26, 2022), https://doi.org/10.26099/qzxs-1r33.

[78] Oregon Measure 111, Right to Healthcare Amendment (2022).

[79] Timothy S. Jost, *New Rule Proposed to Simplify ACA Consumer Choice and Aid Enrollment*, COMMONWEALTH FUND BLOG (Jan. 17, 2023), https://doi.org/10.26099/j06a-ma64.

glitch" go a long way in making family members eligible for lower-premium subsidized Exchange plans, thereby relieving some of the economic hardship.

Given the promise and continuing growth of Exchanges over the last decade, Congressional action to enhance and more permanently fund cost-sharing reduction subsidies that further reduce copayments, deductibles, and other out-of-pocket payments for the more vulnerable lower-income families would be advantageous.[80] This would reduce uncertainty leading to more individuals turning to the Exchanges as a reliable alternative to employer coverage, with more robust insurer competition acting as a check on premiums. In turn, more healthy people would likely choose to buy coverage previously deemed unaffordable[81]—with a healthier risk pool further lowering premiums and cost-sharing for all.

[80] *See* Michael Simpson et al., *How Polices to Expand Insurance Coverage Affect Household Health Care Spending*, COMMONWEALTH FUND (Jan. 19, 2023), https://doi.org/10.26099/fv5e-sh06.

[81] John Holahan et al., *Changes in Marketplace Premiums and Insurer Participation, 2022-2023*, URB. INST. (Apr. 2023), https://www.urban.org/sites/default/files/2023-03/Changes%20in%20Marketplace%20Premiums%20and%20Insurer%20Participation%2C%202022-2023.pdf.