Healthcare Value Hub
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The State of Affordable Health Care: Opportunities for States to Make Marketplace Coverage More Affordable for Residents

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Health insurance affordability remains a pressing concern for consumers across the country, including those enrolled in coverage purchased on the health insurance Marketplace. Although the Affordable Care Act (ACA) requires plans offered on the Marketplace to cover certain essential health benefits and meet specific actuarial values, many individuals with Marketplace coverage experience greater cost burdens than those with employer-sponsored insurance coverage.

Unaffordable health insurance coverage leads to high rates of individuals who are un- and underinsured. When compared to residents with comprehensive health insurance coverage, the underinsured are more likely to struggle to pay medical bills and to forgo medical care and needed treatments because of cost. Enrollees with health problems are also at higher risk of being underinsured than healthier people, highlighting the complex relationship between insufficient coverage and financial, physical, and mental health.

Premiums and out-of-pocket costs (deductibles, copays, and coinsurance) are the two main cost-sharing components of health insurance. Much of the federal government's affordability criteria and support is based on premium amounts, which are the monthly payments a beneficiary will pay to the insurer to maintain coverage. Marketplace enrollees may be eligible for federal premium tax credits (PTCs) or cost-sharing reductions (CSRs).

PTCs are subsidies that lower monthly premiums in an amount based on the cost of the benchmark Silver plan and an individuals' income, capped at 8.5% for those earning above 400% of the Federal Poverty Level (FPL).[1] Similarly, CSRs reduce out-of-pocket costs, like deductibles and copays, for Silver plan enrollees if their income is between 100% and 250% FPL.

In 2024, 93% of Marketplace enrollees received PTCs, and 50% received CSRs. However, despite the subsidies, many adults still report being under- or uninsured. States have the authority to establish affordability initiatives and may augment federal premium subsidies with state funding to further lower consumers' premium costs.

State Opportunities to Address Premium Costs

High premium costs are a major barrier to coverage, and as premium costs increase consumers become more likely to disenroll from Marketplace plans.[2] Some states have established initiatives designed to lower premium costs for residents. For example, Massachusetts provides additional state-based premium subsidies to boost federal subsidies for individuals with incomes up to 500% of the federal poverty level (FPL). New Mexico also offers state-funded premium subsidies to individuals who earn up to 400% FPL and additional cost-sharing reductions for individuals earning up to 300% FPL.

Similarly, Connecticut uses state funds to provide health insurance coverage, dental coverage, and non-emergency medical transportation for individuals 19-64 who earn between 138 – 185% FPL and are enrolled in a Marketplace Silver plan. The state pays the consumer's portion of the premium and cost-sharing amounts directly to the insurer.

States may also consider establishing basic health programs (BHP) to further reduce premium cost burdens for residents earning between 133–250% FPL. New York, Minnesota, and Oregon currently operate a BHP in their state.[3]

Minnesota's basic health program covers individuals earning 133–200% FPL and legal residents who do not qualify for Medicaid up to 200% FPL. Premium costs are determined using a sliding scale based on income. Likewise, New York's basic health program (the Essential Plan) waives premium costs for individuals earning up to 250% FPL.

State Opportunities to Address High Out-of-Pocket Costs

Out-of-pocket costs typically include deductibles, which is the amount a beneficiary is expected to pay for covered health care services before an insurance plan will cover the costs; co-pays, which are fixed amounts the beneficiary is responsible to pay for a covered health care service after you've paid your deductible; and coinsurance, which is the percentage of the cost of a covered health care service a beneficiary is responsible for after their deductible is met.

High out-of-pocket costs, particularly high deductibles, often deter individuals from seeking care, especially those with chronic conditions.[4] Individuals who are enrolled in high-deductible health plans face higher out-of-pocket spending and lower health care utilization rates compared to those with other coverage types.[5] Although there were fewer high-deductible health plans available on the Marketplace in 2023 than in 2019, the average deductible for Marketplace plans in 2024 was still $3,057, with Bronze plans averaging $7,258 and Silver plans without cost-sharing reductions (CSR) averaging $5,241.

Deductibles constitute a large component of out-of-pocket costs and may serve as an expensive barrier to needed care. Many health care needs are unpredictable, and health plans selected during the previous year may not adequately meet future needs. Even individuals with chronic health conditions who may be able to afford higher level plans may still face excessive out-of-pocket costs due to their high health care needs. For instance, many people are unable to afford hundreds or thousands of dollars towards their deductible at one time, particularly at the beginning of the year when deductibles reset.

States can provide additional financial support to reduce consumers' out-of-pocket costs and limit the financial burden of obtaining needed care. Beginning plan year 2024, California leverages state funds to eliminate deductibles in all Silver CSR plans for individuals with incomes below 250% of the federal poverty level—providing affordable coverage for over 800,00 residents.

Similarly, Massachusetts has augmented federal cost-sharing reductions by using state funds to provide additional CSRs to residents that earn up to 300% FPL. Individuals who were covered by the plans with the additional state CSRs had lower out-of-pocket costs and were less likely to report delaying or going without health care due to cost compared to those without.

State Opportunities to Address Health Disparities

High out-of-pocket costs are not merely an affordability issue. Cost-sharing burdens exacerbate racial health disparities, as people of color often face higher rates of chronic conditions and financial hardship. States can mitigate some of these impacts by incorporating health equity targets into their affordability initiatives. For example, Massachusetts and the District of Columbia have both established coverage options that have little or no copay for services that address health disparities in their communities.

The District of Columbia Health Link plans reduce out-of-pocket costs for conditions that disproportionately impact people of color, like diabetes, and standard plans include coverage for doctor visits, labs, eye exams, podiatry, supplies, insulin, and prescriptions with no cost-sharing. Likewise, out-of-pocket costs for pediatric mental health visits and medications in the District are capped at $5 per visit and prescription, with no limit on the number of visits allowed.

Massachusetts has eliminated cost-sharing in its Marketplace plans for primary care sick visits, mental health outpatient services, and certain medications for conditions that disproportionately impact communities of color, such as diabetes, asthma, coronary heart disease, and hypertension.

State Opportunities to Define "Affordable"

Some states have also committed to creating a standard definition of affordability to facilitate solutions for improving affordable care and holding stakeholders accountable. Connecticut, for example, developed an affordability standard that considers the income a family needs to cover basic needs, including health care, housing, food, childcare, and transportation. By this definition, health care is deemed affordable only if a family can access it without compromising other basic needs or incurring excessive debt.

Connecticut also created a modeling tool to evaluate how different health policies and costs affect households. Likewise, Massachusetts' Marketplace (the Health Connector) releases an annual state affordability schedule that outlines the maximum amount an individual or family can realistically afford to pay monthly for coverage. The affordability schedule is used to ensure that the state's individual coverage mandate does not impose excessive costs on an individual.[6]

The state uses the affordability schedule to set the subsidized premium amount for ConnectorCare plans to ensure that the premium amount an individual or family pays does not exceed the affordability schedule.

Vermont has also established an affordability standard within its rate review process by defining a rate as affordable if the premium cost does not exceed the required premium contribution amount set by the federal government and if the combined deductible (e.g., for both medical and prescription drug costs) does not exceed 5% of household income.

Conclusion

Addressing the challenges of health insurance affordability requires innovative, state-led initiatives that not only reduce premiums and out-of-pocket costs but also prioritize health equity. By augmenting federal subsidies, eliminating deductibles, and designing programs that reduce cost-sharing for vulnerable populations, states like Massachusetts, New Mexico, and Connecticut demonstrate that meaningful progress is possible. These efforts are particularly impactful for individuals with lower incomes or chronic conditions, who are disproportionately burdened by high healthcare costs. Equitable access to affordable care ensures that fewer individuals are forced to choose between their health and other essential needs.

As states continue to experiment with new strategies, including the establishment of Basic Health Programs and the adoption of affordability standards, the ultimate goal remains clear: creating a health insurance system that is affordable for all. By focusing on affordability, states can mitigate the adverse effects of underinsurance and uninsurance, reduce health disparities, and improve overall health outcomes. A balanced, multi-faceted approach not only provides immediate relief to consumers but also strengthens the broader healthcare system by promoting preventive care, reducing financial barriers, and enhancing health equity across diverse populations.

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