Projecting the Impact of an Individual Market Stabilization Package for 2018

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Overview

Lower than expected enrollment, rising premiums, and declining issuer participation have led to an increased focus by state and federal policymakers alike on stabilizing the individual health insurance market. Legislative proposals aimed at addressing these concerns are currently being discussed and may include a range of policies, including funding for a reinsurance program, a continued moratorium of the Section 9010 health insurance tax (HIT), funding for cost-sharing reductions (CSRs), and additional flexibility for states to manage their individual markets.

With the deadline for health plans to make final decisions about participation in the exchanges for 2018 rapidly approaching and Open Enrollment less than two months away, any legislative or regulatory initiatives have limited time to influence 2018 market dynamics. In particular, for any proposal to impact 2018 premiums, Congress would not only need to approve the applicable policies, but plans would need to be permitted to refile 2018 rates.

America's Health Insurance Plans (AHIP) requested that Avalere model a package of market stability proposals and their potential impact on the individual market for the 2018 benefit year. Specifically, the policies modeled would:

1. Guarantee funding for cost-sharing reduction payments
2. Create a $10B to $15B premium stabilization program or reinsurance fund to help stabilize premiums
3. Continue the moratorium of the HIT
4. Provide states additional flexibility to manage their individual insurance markets

Importantly, while this analysis is focused on the impact to premiums and coverage for 2018, some of the current legislative discussions are proposing multi-year stabilization efforts. Many of these policies, particularly longer-term CSR and reinsurance funding, would have market stabilizing effects beyond 2018.

Executive Summary

Assuming the package of proposals outlined above were approved by Congress and issuers were permitted and willing to refile rates for the 2018 plan year, Avalere found that a combination of these policies may lead to:

- Reduction of individual market premiums—as compared to current law--by 13% to 17% for 2018, driven primarily by the reinsurance program as well as the continued HIT moratorium
- An additional 200,000 – 300,000 individuals enrolled in coverage (and subsequently a comparable amount fewer uninsured)
- A decrease in risk scores from 1.34 to 1.33 due to the enrollment of some younger, healthier individuals
- Increased government spending compared to current law between $18.6B and $21.8B, depending on the size of the stabilization investment.

Figure 1: Overview of Stabilization Package Findings for 2018

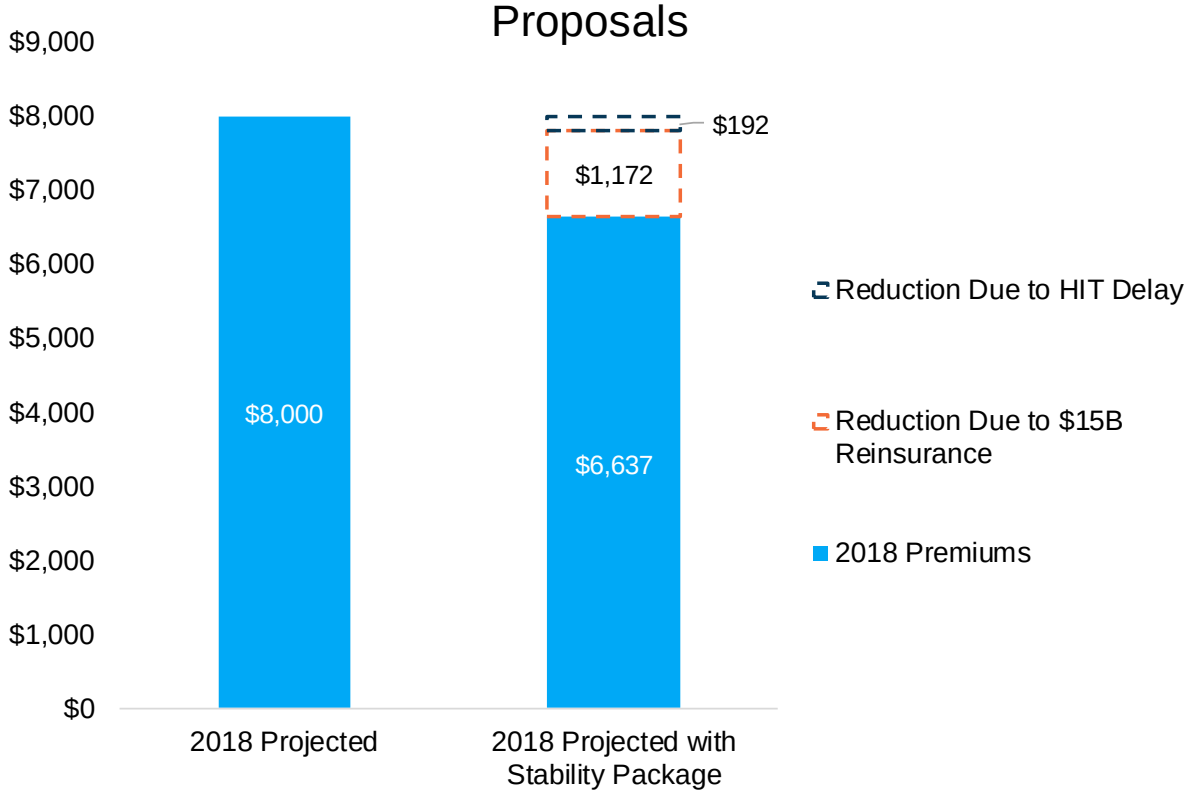
Stabilization Package Modeling, 2018	Average Individual Market Yearly Premiums	Premium Impact of Stabilization Package	Average Individual Market Risk Score	Individual Market Enrollment	Change in Federal Spending and Foregone Revenues
Current Law	$8,000	-	1.34	18,300,000	-
Stabilization Package: Reinsurance Funded at $15B	$6,637	-17%	1.33	18,600,000	$21.8B
Stabilization Package: Reinsurance Funded at $10B	$6,971	-13%	1.33	18,500,000	$18.6B

Source: Avalere proprietary model of individual market health insurance coverage. Additional methodology and sourcing information available in the Methodology.

Avalere's analysis finds that near-term action on these proposals could create downward pressures on premiums, lead to greater enrollment and better average risk, and establish more certainty for health plans in the individual market for 2018 compared to current law. Concurrently, the proposal would increase federal spending as a result of the reinsurance program and continued delay of the HIT, though some of the costs would be offset by lower federal spending on advance premium tax credits.

With the deadline for health plans to make final decisions about participation and sign their contracts for 2018 currently slated for September 27, action by Congress and/or the Administration must occur quickly to have the potential to impact the market for 2018. Importantly, while health plans were required to submit final individual market rates on September 5, CMS and states have the authority to extend this deadline to allow health plans to respond to market stability legislation prior to open enrollment. Regardless of this flexibility, the deadline for implementing a stabilization package is rapidly approaching.

Figure 2: 2018 Average Yearly Premiums, Potential Reductions Due to Stabilization Proposals



Stabilization Package Proposals

Funding for Cost-Sharing Reduction Payments for 2018

Much of the uncertainty in the market for 2018 has been driven by the lack of commitment from the Administration and Congress to continue paying CSRs to health plans. The ACA requires health plans to reduce cost-sharing (e.g., deductibles, coinsurance, co-payments) for individuals with incomes between 100% and 250% of the federal poverty level. Health plans are reimbursed for these reductions through CSR payments from the federal government. Amidst an ongoing legal battle, the Administration and Congress have not committed to fully funding these payments for the 2018 benefit year.

Health plans have responded to this uncertainty in various ways, including increasing 2018 silver plan premiums to account for the uncertainty of CSR compensation or by submitting two sets of rates to account for scenarios under which the CSRs are and are not funded. For 2018,

the CBO estimates that premiums would be 20% higher, on average, for silver plans, if CSRs were not paid to plans in the market. CBO also estimated that ending payments for CSRs would lead to increased federal deficits of $194B over 10 years and a 25% increase in silver plan benchmark premiums in 2020 and subsequent years compared to current law.[1] Based on Avalere analysis of expected 2018 premiums, failing to fund CSR payments while maintaining the requirement for on-exchange health plans to offer CSR variations of their silver plans could increase on-exchange 2018 silver plan premiums by approximately $1,600 per year.

Importantly, CBO also projected that eliminating CSR compensation would lead to short term plan exits from the insurance market. According to their analysis, 5% of individuals would live in an area without any insurer participation in 2018 if CSR compensation were eliminated. As such, funding CSRs not only leads to lower premiums, but also retains health plans in the market and provides access to enrollees.

Market stabilization legislation could include a proposal to fully fund CSRs to ensure continued payment to health plans. The Avalere model described above is based on current law and assumes, despite the current lack of clarity, that CSRs would be made available for 2018. However, the expected growth in 2018 premiums takes into account that plans' proposed 2018 premiums have priced in the uncertainty around the future of CSRs in the market through higher rates.

Importantly, were CSRs not paid for the 2018 plan year, Avalere expects that states that allowed two sets of rate filings would honor the higher rates that account for lack of CSR funding and that health plans would take significant premium increases, to the degree they were permitted by the state. In addition, participation in the market would likely decrease, potentially leaving some counties without any plans offering coverage.

Federal Premium Stabilization Program

The Affordable Care Act (ACA) included funding for a transitional reinsurance program for the 2014-2016 benefit years to help offset the costs of high-cost enrollees during the first years of the law's implementation. The reinsurance program placed downward pressure on premiums in the initial years, while the phase-out of the program was shown to be a key factor in higher premiums in 2017.[2] Market stability legislation could provide funding for a one-year premium stabilization program that operates like a reinsurance program, leading to more certainty for health pans around risk and placing downward pressure on rates by offsetting the costs associated with individuals that have extensive healthcare needs. A one-year reinsurance program such as this would provide a limited administratively burdensome approach for health plans and effectively stabilize the market, however it would require federal funding, which would have implications for government spending.

1 [1] CBO. August 2017. The Effects of Terminating Payments for Cost-Sharing Reductions. Link: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

2 [2] American Academy of Actuaries. 2016. Drivers of 2017 Health Insurance Premium Changes. Link: http://www.actuary.org/files/publications/IB.Drivers5.15.pdf

While it would be extremely challenging to operationalize and incorporate a reinsurance program into 2018 premiums at this late date, Avalere's analysis found that a reinsurance program, funded at $15B for 2018, could lead to an average yearly premium decrease of $1,172, or 15%, for individual market enrollees in 2018. Importantly, because of the way advance premium tax credits (APTCs) are calculated in exchanges, funding a reinsurance program has the added benefit of reducing federal spending on APTCs by lowering underlying premiums. As such, the full federal cost of a reinsurance program is lower than the allocated funding. Indeed, approximately 40% of the cost is offset by lower APTC spending due to the reinsurance funding.

Additional One-Year Moratorium of the Health Insurer Tax

Section 9010 of the ACA established a health insurance tax (HIT) charged to entities that provide health insurance coverage, based on a company's share of net premiums written nationally for the previous year. The Consolidated Appropriations Act of 2016 suspended the fee for payments due in 2017. CMS estimated that the amount collected from this fee in 2017 would have been $13.9B had it not been suspended.[3] Because the fee is an administrative cost for plans, it would be incorporated into a health plan's premiums during the year it is collected and passed onto consumers. Absent future legislation, the HIT will be reinstated in 2018. The HIT is projected to contribute 2.6% to premiums in 2018 without other action.[4] Market stabilization legislation could repeal or further delay the HIT, lowering premiums by relieving the administrative expense.

If the fee is collected in 2018, the federal government is projected to receive $14.3B.[5] Avalere found that extending the current moratorium on the HIT would lead to an approximate $192 reduction, or 2.6%, in 2018 average yearly individual market premiums. As with the investment in reinsurance, this premium reduction would also lower costs for APTCs. However, the impact is significantly smaller than with reinsurance because the HIT also applies to fully-insured plans in Medicare, Medicaid, and the group market. Conversely, the extension of the current moratorium on the HIT is the largest driver of increased federal spending of this proposal.

Additional State Market Flexibility Granted to States

Under Section 1332 of the ACA, states are permitted to apply for waivers that offer flexibility in providing health coverage to residents in their state that is at least as generous and affordable as the coverage provided under current law. For instance, under current law, states are able to seek waivers to modify premium tax credit and cost-sharing reductions, individual and employer mandates, rules regarding what plans can be offered on the exchange, and rules around

3 [3] CMS. February 2016. Frequently Asked Questions on the 2017 Moratorium on Health Insurance Provider Fee. Link: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL_9010_FAQ_2-29-16.pdf

4 [4] Oliver Wyman. August 2017. Analysis of the Impacts of the ACA's Tax on Health Insurance in 2018 and Beyond. http://www.stopthehit.com/wp-content/uploads/2017/08/Oliver-Wyman-2018-HIT-Analysis%E2%80%8E-August-8-2017.pdf.

5 [5] IRS. Affordable Care Act Provision 9010 ---- Health Insurance Providers Fee. https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

coverage, including essential health benefits, annual out-of-pocket limits, and actuarial value. Many of the states that have submitted waiver applications (Alaska, Minnesota, and Iowa) have sought to establish high-risk pool funding or reinsurance programs for high-cost enrollees. Alaska's waiver was approved on July 7 and the state reported the program contributed to a decrease in requested premium increases for the 2017 plan year from 42% to 7%.[6] Market stability legislation could provide additional options for states to manage their markets or alter the waiver process by shortening the required time for CMS to review and approve applications.

Streamlining the process for 1332 approval (i.e. reducing the amount of information required for the 1332 application process, reducing the waiting period for approval, and shifting from an application process to a letter request) could potentially make waivers more attractive to states and allow state officials to tailor solutions to the needs of their specific markets. While some changes implemented through 1332 waivers (i.e. reinsurance) have the potential to enhance market functionality, other changes could impact consumer access to care. For example, should states choose to narrow the scope of Essential Health Benefits (EHB), patient out-of-pocket spending could increase for some services.[7]

Given timing for plan submissions, it is unlikely that providing additional state flexibility will have any impact on the 2018 benefit year. Instead, the effects of additional state flexibility are likely to lead to later year impacts as states submit waivers and implement changes in their market.

As a result, Avalere's analysis did not find a significant impact of including additional state flexibility in 2018. This is largely a result of the time required for states to take advantage of the flexibility. However, implementing additional state flexibility could have an impact on the market in future years.

Methodology

The modeling results are the output of Avalere's proprietary model of individual market health insurance coverage. The underlying data in the model is drawn from the American Community Survey (ACS), Centers for Medicare & Medicaid Services (CMS) exchange enrollment reports, and general exchange market demographic data released by the United States Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). In addition, Avalere utilizes Inovalon's proprietary MORE² claims database of individual market enrollees. This allows the model to take into account underlying risk, for purposes of calculating risk scores and modeling behavior, as well as risk selection by metal level, age, and gender.

6 [6] State of Alaska Department of Commerce, Community, and Economic Development Division of Insurance. https://www.commerce.alaska.gov/web/Portals/11/Pub/Alaska-1332-Waiver-Application-with-Attachments-Appendices.pdf?ver=2017-01-05-112938-193

7 [7] CBO. May 24, 2017. CBO estimate of the H.R. 1628, American Health Care Act of 2017. Link: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf

For purposes of this analysis, Avalere assumed an expected average premium increase of 18% for 2018. Avalere did not assume any counties in the country without health insurer coverage, regardless of scenario modeled. Importantly, the reinsurance funding is assumed to be evenly distributed across the states and effectively removes that dollar value of funding from the claims cost of the individual market population for 2018, lowering average premium costs. For purposes of calculating premiums, Avalere assumes health plans price perfectly, matching the medical loss ratio requirements with expected claims costs of beneficiaries. Finally, the HIT impact on premiums is assumed to be 2.6%, as calculated by a recent Oliver Wyman analysis. This August estimate represents a midpoint of other publicly available assumptions around the impact of the HIT on premiums.

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