BIPARTISAN POLICY CENTER

Stabilizing the Individual Insurance Market: What Happened and What Next?

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In August 2017, members of the Bipartisan Policy Center's **Future of Health Care** initiative proposed a two-stage approach to health care reform that would first stabilize the individual health insurance market and then work expeditiously to address the more fundamental structural challenges in America's current health care system. **Since that release, there have been significant changes in both the political landscape and in the individual insurance markets.**

Since the release of the expert panel recommendations, the Trump administration announced that the government would no longer make cost-sharing reduction (CSR) subsidy payments to insurers unless Congress provided an explicit appropriation for CSR subsidy payments. Congress repealed tax penalties that are assessed against individuals who fail to comply with the Affordable Care Act's (ACA's) "individual mandate" coverage requirement, as a part of the Tax Cuts and Jobs Act of 2017. In the recent insurance open enrollment period, several new trends have emerged, including higher premiums being "loaded" onto "silver-level" plans. This "silver loading" resulted larger premium tax credits for consumers, as well as more availability of zero-premium and low-cost "bronze-level" plans. This paper reexamines how to address the short-term objective of stabilizing the individual insurance market in light of these major changes.

This issue brief provides background on what has happened since September 2017, followed by policy options.

BPC's Future of Health Care leaders have examined a series of policy options, recognizing that there is much more to be done. More sweeping changes have been supported by Democrats and Republicans alike. The proposals listed below are intentionally limited in scope and are intended to address problems in the near term. This spring, insurers will be making decisions about individual market participation for 2019 and submitting proposed 2019 premium rates for review by state regulators. Given this timeframe, action is needed now to impact premiums and market competition in the individual market for 2019.

Background on Developments Since September 2017

The individual health insurance market has long faced challenges in attracting sufficient numbers of younger and healthier individuals to ensure that premiums and cost-sharing are affordable for all served by this relatively small market. Currently, in the non-group or individual health insurance market, insurers are required to meet minimum federal standards for benefits, premium rating, actuarial value, marketing, and other requirements. Health insurance policies can be offered through state and federal "exchanges" where consumers can receive tax credit assistance to cover premium costs, as well as through "off-exchange" plans that are offered outside of the marketplaces. The same benefit standards and market reform rules discussed above apply to both marketplace plans and off-exchange plans. Both on-exchange plans and off-exchange are part of the same "single risk pool" under the ACA, which requires risk adjustment transfer payments from plans that have healthier-than-average enrollees to other plans in the risk pool that have sicker-than-average enrollees. Health plans offered both on the exchanges and off-exchange must fall into one of five basic "metal levels" (platinum, gold, silver, bronze, or catastrophic) that are determined based on the plan's actuarial value. Under the single risk pool requirement, insurers that offer plans both on the exchanges and off-exchange must set premiums at the same level for their exchange plans and off-exchange plans, when the plans have the same metal level and benefit design.

To make insurance coverage more affordable, individuals with income between 100 percent and 400 percent of the federal poverty level (FPL) are eligible for sliding scale premium tax credits to offset the costs of premiums for exchange plans. The amount of the tax credit varies based on income, but is tied to the cost of the second-lowest cost premium for silver-level plan coverage in the exchange. As a result, when silver plan premiums increase, the value of the tax credit increases.

Individuals with income below 250 percent of FPL are also eligible for "cost-sharing reduction" (CSR) assistance to reduce coinsurance and deductibles. Insurers are required to provide this CSR assistance for individuals with income below 250 percent of FPL only when the individual enrolls in a silver metal level plan. For the first four years of ACA implementation, the federal government made CSR subsidy payments to insurers to offset the cost borne by the insurers in providing the CSR assistance to enrollees.

CSR Payments Stopped

Beginning in October 2017, the Trump Administration announced that the government would no longer make CSR subsidy payments to insurers unless Congress provided explicit appropriations for CSR subsidy payments. As a result, for plan year 2018, insurers incorporated the expected costs of CSR assistance (which they were still legally required to provide) into plan premiums.

In 38 states, state insurance regulators directed insurers to "load" the expected cost of CSR assistance only onto silver-level plans. In eight states and the District of Columbia, regulators required that insurers load the cost of CSR assistance across plans at all metal levels.

In a few states, such as California and Pennsylvania, regulators took additional steps to help ensure that CSR-related costs were only loaded onto on-exchange silver-level plan premiums in order to protect non-subsidized off-exchange consumers from premium hikes on off-exchange silver-level plans (which do not have to provide CSR assistance to enrollees). Other states, such as Tennessee, instructed insurers to apply the "silver load" to both on-exchange silver-level plan premiums and to off-exchange silver-level plans, out of concern that loading CSR-related costs only onto on-marketplace silver-level plan premiums would violate the current law single risk pool requirements for premium pricing.

Premium Increases and other Responses to the CSR Subsidy Change and "Silver Loading"

The prevalence of silver loading resulted in silver-level plan premiums rising by 32 percent in 2018, while premiums for gold-level plans rose by 18 percent, along with an increase in bronze plan premiums of 17 percent.[1] Since premium tax credits rose correspondingly with the jump in silver plan premiums, some of the silver loading pricing distortions that benefitted lower-income consumers, making it advantageous for them to shift from silver-level plans to gold-level plans with lower premiums or bronze-level plans that in many cases required no additional premium beyond the premium tax credit.

Jumping Down to Bronze

"Zero premium" bronze-level plans (which require no premium from the enrollee beyond the premium tax credit which the enrollee is eligible) became more widely available in 2018. For instance, based on aggregate information at the national level, in 2017, a 40-year-old would need to have income below 158 percent of FPL in order to qualify for a zero-premium bronze-level plan. In 2018, a 40-year-old with income below 209 percent of FPL would qualify for a zero-premium bronze-level plan. In some states, the market saw substantial shifts from silver- to bronze-level plans. In Idaho, enrollment in silver-level plans dropped from 69.6 percent of the market to 50 percent of market enrollment, while bronze plan enrollment grew from 25.3 percent of the market to 40 percent of the market. Similarly, silver plan enrollment in Connecticut dropped by 8.3 percent, while bronze plan enrollment increased by 9.8 percent.

Jumping Up to Gold

At the same time, the faster increase in premium tax credit growth (as result of silver loading) relative to the slower increase in gold plan premiums resulted in gold plan coverage becoming available to many enrollees for a minimal premium after accounting for tax credits. In some states for which data is available, enrollment migrated from silver-level plans to gold-level plans in 2018—in what appears to be a consumer response to the pricing distortions that result from silver loading. For instance, in Maryland, enrollment in gold-level plans jumped from 4.7 percent of the market in 2017 to 19.1 percent of the market in 2018, all while silver-level plan enrollment dropped by 17 percent and bronze plan enrollment grew by 2.8 percent. Likewise, in California, silver plan enrollment dropped from 63 percent of total enrollment to 49 percent of the market in 2018, while gold plan enrollment grew from just 4 percent to 15 percent of market enrollment.

However, in most instances higher-income consumers who were not eligible for premium tax credits were required to bear the full cost of the elevated premiums. As noted above, some states were able to partially address this issue by allowing for insurers to load CSR-related costs solely onto on-exchange premiums, which minimized the premium impact of the CSR issue for off-exchange products and provided an off-exchange alternative for higher-income consumers.

Federal Costs of Silver Loading

The Congressional Budget Office (CBO) projected that if CSR subsidy payments to insurers are permanently eliminated (while insurers are still required to provide CSR assistance to low-income consumers), the impact of silver loading of CSR-related costs on silver-level plan premiums (and the corresponding effect on premium tax credits) would increase net federal outlays by $194 billion over the following decade.

Individual Mandate Tax Penalties Repealed

While the CSR subsidy payment change impacted premiums in 2018 and could continue to impact premiums in future years, the repeal of the ACA's individual mandate penalties is still new. Its full effects have not yet been felt and could first start to have a more pronounced impact on premiums and enrollment in 2019. In December 2017, as a part of the Tax Cuts and Jobs Act of 2017, Congress

repealed the tax penalties that are assessed against individuals who fail to comply with the ACA's individual mandate coverage requirement, which requires that consumers obtain qualified health insurance coverage. The repeal of these individual mandate tax penalties will go into effect in 2019. The Trump Administration projects that this policy change will reduce exchange enrollment by roughly 3.4 million consumers in 2019 and increase exchange plan premiums by 10.5 percent.[2]

Changes in Response to Repeal of Individual Mandate Tax Penalties

Many insurers predict that the repeal of the individual mandate's tax penalties will have a negative impact on the health of the individual health insurance market risk pool, by removing a key incentive for younger and healthier consumers to enroll in and retain coverage. Previous estimates from the CBO project that individual market premiums would rise by 10 percent as a result of the repeal of the individual mandate tax penalties, via the corresponding impact that repeal would have on the underlying health of the risk pool. Anecdotal evidence suggests that some insurers elevated premiums for the 2018 plan year in anticipation of the possibility that the individual mandate could be repealed or no longer enforced by the Trump Administration. However, to date, it is unclear how prevalent that pricing strategy was, across the entire market. Given this uncertainty surrounding the impact of the repeal of the individual mandate tax penalties, one could expect additional premium increases in 2019 that are attributable to the repeal action. Insurers are already making decisions about their participation and rates for the 2019 plan year, and rates will be filed and finalized this spring and summer for the next open enrollment period in the fall.

Policy Options to Address Issues in the Changing Individual Insurance Markets

Reinsurance Solutions to Help Drive Down Premiums and Improve Insurer Participation

To help mitigate the premium impact of uncertainty surrounding high-cost claims from individual market enrollees, as well as the impact of the repeal of the individual mandate" tax penalties, policymakers could establish permanent or temporary (e.g., three-year) funding for state-based reinsurance programs. This policy would result in premium reductions across multiple segments of enrollees—for lower-income individuals who receive premium tax credit assistance, but also for higher-income consumers who are not eligible for tax credits and bear the full cost of individual market plan premiums.

For example, under a reinsurance program, the program's appropriated funding of at least $10 billion annually[a] would be used to pay for a portion (e.g., 75 percent) of claims costs that exceed a specified attachment point (e.g., $50,000), up to a certain reinsurance cap (e.g., $350,000), above which the insurer would resume sole responsibility for covering claims costs. For states that fail to establish their own reinsurance program, using the federal dollars provided, policymakers could establish a federal fallback reinsurance program through which insurers in those states could participate. State-by-state allocations of reinsurance dollars could be based on overall enrollment and on the relative health of the state's individual market risk pool. In establishing their reinsurance programs, states could

[a] Based on recent analyses indicating that 50 to 66 percent of the cost of reinsurance appropriations can be offset by reductions in on-exchange plan premiums and corresponding reductions in premium tax credits, one could expect that a $10 billion annual appropriation could amount to just $3.3 billion to $5 billion in net annual federal budgetary costs.

elect to require that as a condition of eligibility for reinsurance payments, insurers must establish care management programs to be offered as an optional additional benefit to enrollees whose claims costs exceed the attachment point for the reinsurance program.

A variety of analyses suggest that between one-half and two-thirds[3] of the cost of appropriated dollars for a reinsurance program would be offset by reduced premium tax credit outlays that stem from premium reductions driven by the reinsurance program. Having such premium reductions that result from reinsurance could help to offset increased premiums resulting from repeal of the individual mandate tax penalties.

State approaches to reinsurance from Alaska and Minnesota have already yielded results, with an approximate 20 percent decrease in premiums.[4] Other analyses suggest that premium reductions of a magnitude of 10 to 20 percent are possible depending on program design and the circumstances of individual state markets.[5] The availability of a reinsurance program is also likely to make individual market participation more attractive for insurers and, in doing so, promote competition in the individual market.

Dedicating Existing Resources to Exchange Outreach and Enrollment Activities

Prior to 2018, the Centers for Medicare and Medicaid Services (CMS) implemented an exchange "user fee" that was assessed against Federally-facilitated Exchange-participating health insurers to fund the operating expense of the Federally-facilitated Exchanges. CMS used these user fees to, among other things, fund the costs of advertising and other outreach efforts conducted during the open enrollment period. In each year, the user fee assessed against health insurers is equivalent to 3.5 percent of the premiums received by the insurer for covered individuals on Federally-facilitated Exchanges. Federally-facilitated Exchange user fee revenues amounted to roughly $1.5 billion in 2017. For plan year 2018, the Trump Administration reduced funding for advertisements for 2018 open enrollment by 90 percent and reduced funding for health insurance navigator programs and other enrollment assistance by 41 percent. At the same time, the CMS continued to collect the 3.5 percent exchange user fee from participating health insurers. Given that the repeal of the individual mandate's tax penalties will go into effect in 2019 (and the fact that the number of regulatory changes around the availability of plans not compliant with current-law requirements could create confusion amongst consumers), there is likely to be a heightened need for outreach, marketing, and enrollment investment for the 2019 open enrollment period and for future years. Such confusion is most likely to cause healthier clients to drop coverage. While opinions vary as to the amount needed for outreach and enrollment, there is agreement that amounts should be evidence-based. California, for example, spent $111 million, which amounted to 33 percent of the 4 percent user fee that the state assessed.[6] California officials estimate the investment had a 255 percent return on investment. Clearly, outreach and enrollment needs will vary state to state, and more information is needed.

To address the effects of the repeal of the individual mandate tax penalties and other issues, policymakers could codify the current 3.5 percent user fee for Federally-facilitated Exchanges, and require that CMS allocate at least 20 to 25 percent of the user fees collected toward third-party grantee-organized outreach, enrollment, and marketing activities.

Options to Help Blunt the Impact of Repeal of Individual Mandate Tax Penalties

To help address concerns around adverse selection resulting from the elimination of the individual mandate tax penalties, policymakers could establish state-based options for replacing the federal tax penalties with state-based requirements for the purchase of health insurance coverage or forms of automatic enrollment for uninsured consumers who qualify for zero-dollar premium bronze-level plans. The Department of Health & Human Services (HHS) and the Internal Revenue Service (IRS) could provide necessary information to states to facilitate a state-based approach to maximizing enrollment in the individual health insurance market. HHS and the IRS would,

at a state's request, provide data and technical assistance to help states in the development of an automatic enrollment process for uninsured consumers or a state-based individual mandate or premium surcharge policy for lack of continuous coverage.

These options would likely draw more healthy enrollees with low annual claims costs into the individual market risk pool, reduce premium growth, and promote insurer participation in the markets.

CSR Subsidy Issue

Throughout 2017, questions surrounding the legality of the federal government reimbursing insurers for CSRs (as well as ongoing legislative action on repealing significant portions of the ACA) prompted insurance plans and state regulators to contemplate premium pricing responses to the possibility that CSR subsidy payments to insurers were no longer be provided in 2018. Many plans engaged their state regulators on an ongoing basis and, for plan year 2018, incorporated the expected costs of CSR assistance (which they were still legally required to provide) into plan premiums. As a result, individuals eligible for CSRs did not experience an increase in out-of-pocket costs in states that allowed CSRs to be loaded into silver-level plan premiums. This result was not wholly unexpected, and in fact it was aligned with analysis that the Congressional Budget Office released in August of 2017. Without a legislative change or administrative action, it is likely that most if not all states would load the cost of CSRs onto silver-level plans, and individuals receiving premium tax credits would largely be shielded from the impact of not paying CSRs, while non-subsidized consumers could continue to bear the full cost of higher premiums resulting from non-payment of CSR subsidies by the federal government. Making CSR subsidy payments to insurers (to cover the cost of CSR assistance to consumers) is likely to reduce premium growth by 10 percent in 2019, although the impact on net premiums owed (after accounting for reduced premium tax credits) could vary greatly across consumers at different income levels.

Policymakers differ on whether there is a need to make any legislative changes related to CSR issues. The changes resulting from silver loading can provide the benefit of improved affordability for lower-income consumers, but also create spending implications for the government, as well as out-of-pocket concerns for bronze plan enrollees and premium impact issues for individuals who are not eligible for premium tax credits.

If policymakers determine that there is a need to address CSR issues via legislation, one option would be to direct CMS and the Treasury Department to make CSR subsidy payments to insurers.

In either scenario, to help address high out-of-pocket costs for low-income consumers who choose to enroll in zero-premium bronze-level plans (which require no additional premium beyond the tax credit to which the enrollee is eligible), policymakers could allow enrollees in bronze-level products to retain the difference between the silver plan-based premium tax credit and the Bronze plan premium. This difference would be deposited in a Health Savings Account (HSA) for the enrollee that is established on the enrollee's behalf by the exchange.

Endnotes

[1] Premium changes for a 40-year-old nonsmoker between 2017 and 2018 premiums. Source: Ashley Semanskee, Gary Claxton, and Larry Levitt, "How Premiums Are Changing in 2018," Kaiser Family Foundation, November 29, 2017. Available at: https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/.

[2] Treasury Department, Department of Labor, and Department of Health & Human Services, "Short-Term, Limited-Duration Insurance," Joint Proposed Rule, Regulatory Impact Analysis, "Table 2: Estimated Effect on Individual Market Exchanges in 2019," February 20, 2018. Available at: https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance.

[3] *See* Christine Eibner and Jodie Liu, "Options to Expand Health Insurance Enrollment in the Individual Market," RAND Corporation, microsimulation performed on behalf of the Commonwealth Fund, October 2017. Available at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2017/oct/eibner_options_expand_hlt_ins_enrollment.pdf.

See also: Covered California, "Funding Reinsurance to Support Risk Stabilization and Potentially Reduce Federal Spending on Advanced Premium Tax Credit," Covered California Research Analysis, July 21, 2017. Available at: http://hbex.coveredca.com/data-research/library/CoveredCA_Risk_Stability-Funding_Reinsurance-7-21-17.pdf.

[4] Centers for Medicare and Medicaid Services, "Alaska: State Innovation Waiver under section 1332 of the PPACA,", July 22, 2017. Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf.

[5] Covered California, "Funding Reinsurance to Support Risk Stabilization and Potentially Reduce Federal Spending on Advanced Premium Tax Credit," Covered California Research Analysis, July 21, 2017. Available at: http://hbex.coveredca.com/data-research/library/CoveredCA_Risk_Stability-Funding_Reinsurance-7-21-17.pdf.

[6] Covered California, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," September 2017. Available at: http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

Expert Panel on the Future of Health Care

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