Stability Lost: Implications for Consumers and the Individual Insurance Market Under the Senate Proposal

July 21, 2017

Highlights

- Tying the tax subsidy to the "benchmark level" of 58 percent Actuarial Value would significantly lower subsidy amounts for consumers to the point where insurance would provide little to no value for the vast majority of Americans — with a $13,000 deductible for an individual and a deductible of $26,000 for a family, the only lower income people who would likely opt for coverage would be those needing high cost care. This would both mean far fewer get coverage at all, and would guarantee a bad risk mix and higher costs for remaining insureds with and without subsidies.
- The current amount of risk-stabilization funding is not enough to offset the significant negative effects of the law. The funding for 2022 and thereafter would need to be several times higher than proposed in order to maintain stability in the individual market – requiring tens of billions of dollars, instead of the $6.4 billion provided.
- Even absent the elements of the "Cruz Amendment," the proposed changes in the Better Care Reconciliation Act (BCRA) would make the individual markets far less stable than they are today, and cause increases in premiums for lower income and middle income Americans — caused by the combined effect of removing the mandate, worsening of risk mix from reducing the subsidy and cutbacks to Medicaid. These changes would have the greatest negative impact on older Americans and those who live in relatively high cost areas. If the "Cruz Amendment" were included, the BCRA would dramatically destabilize the individual insurance markets, with the individual market likely to collapse in virtually every state in a short period of time due to the removal of common risk structures.

Introduction

Many states have seen their individual markets stabilize in the past few years and millions of Americans have benefited from the ability to have access to health care coverage that provides real protection in the event they become sick. This has been especially true in California's individual market, where health plans actively compete for the people's business, resulting in more covered members through its marketplace in 2016 than in any other state.

Two indicators of the increasing stability of the individual markets can be found in the recent report from the Centers for Medicare and Medicaid Services (CMS) on the national risk-adjustment program for 2016, which demonstrate that both on- and off-exchange risk scores have remained the same in spite of longer average enrollment

and improved data collection and reporting by issuers.[1] The second indication comes from recent analysis of the first quarter 2017 profit margins reported by health plans in the individual market: Nearly all plans have reached breakeven or modest profit levels as of the first quarter, which bodes well for the full 2017.[2] For the first quarter 2017, the Kaiser Family Foundation analysis indicates that the Medical Loss Ratio averaged 75 percent (which will increase as the year progresses), which they find is, "a sign that individual market insurers on average are on a path toward regaining profitability in 2017."

This issue brief, "Stability Lost: Implications for Consumers and the Individual Insurance Market Under the Senate Proposal," assesses the potential impacts of the Senate's proposed Better Care Reconciliation Act on both the individual market and on consumers, grounded in Covered California's experience serving that market for the past four years.

Principles for Reform to Improve Stability and Access to Quality Coverage

The promise of reforms to the current structure of insurance rules and financial assistance is that they will make improvements on two fronts: stabilize the market and improve access to quality health coverage. To stabilize the individual market, incentives need to be aligned to ensure health plans are competing for consumers by offering products of value. To improve access to quality coverage, reforms must ensure a real choice of quality products that will meet consumers' health care needs if they become sick. For many consumers, this means providing financial assistance, which is what employers are encouraged to provide through the tax benefits the vast majority of Americans under 65 benefit from that is the foundation of employer-sponsored insurance.

The updated version of the Better Care Reconciliation Act (BCRA), introduced in the U.S. Senate on July 13, 2017, makes an array of significant changes to the existing size and structure of how consumers may be able to get financial assistance to pay for their health care. Some of these changes are very complex and difficult to predict. Others are relatively straightforward. While it is unclear which specific provisions of reform may be considered by the Senate, the BCRA provides indications of major policies that may be considered.

Even before its recent revisions, the BCRA would have made insurance markets less stable. It would have increased prices so dramatically that millions would be priced out of coverage altogether, and would have offered a benchmark level of coverage (at 58 percent actuarial value) that could not meet the basic needs of most Americans.

The recent revisions, and in particular the potentially added Title III, put the individual market on the path to a "death spiral," potentially leading to a collapse of the individual market. We believe the disruption to the individual market would occur even in states

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

[2] http://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-early-2017/

like California that have had a robust competitive individual market that has become more competitive in the past five years.

This issue brief seeks to shed light on the more significant elements of the BCRA that would affect insurance market stability and consumer coverage, including: (1) the change of “benchmark plan” to a 58 percent actuarial value level and other policies affecting the risk mix of the individual market; and (2) the establishment of two “stabilization funds,” with various short-term, long-term and dedicated elements. (3) the potential addition of Title III to the BCRA that could encourage the segregation of consumers into isolated risk pools in which;[3] These elements would each have direct and powerful impacts on the operation and viability of an exchange, but more important, they are central to the extent to which millions of Americans would or would not have access to coverage and care.

Major Changes to Medicaid by the BCRA Would Also Affect the Individual Market, but Are Beyond Scope of This Analysis

While this Issue Brief focuses on the impact of the individual market, the major changes to Medicaid funding would have significant direct impacts on the millions of Americans who would lose coverage and very big indirect impacts on the individual markets — the shape and nature of which are hard to predict with great accuracy.

Based on the earlier Senate bill, reductions in Medicaid funding result in fewer individuals eligible for Medicaid and a national reduction in coverage of 15 million by the year 2026. At the same time, depending on states’ actions, many individuals may become eligible for subsidies in exchanges. The Congressional Budget Office (CBO) noted that instead of there being a dramatic growth in coverage through the individual market with the rollback of Medicaid, 7 million fewer people would enroll in individual coverage in 2026 since the subsidies themselves and the new benchmark plan would make signing up not worthwhile. Even if all of a state’s proposed stabilization funds were applied to increase the level of coverage provided by the benchmark plan, our analysis finds that the funds are insufficient to meaningfully alter the estimates predicted by the CBO.

The Consumer and Market Impacts of the Change in the Benchmark Plan Value

The Senate proposes creating a new, lower “benchmark plan” with a 58 percent actuarial value (AV) as the standard coverage option that the law would help consumers afford. Consumers would bear additional costs in the form of higher deductibles, copayments, and coinsurance compared to the current average employer plan or the current 70 percent AV Silver benchmark plan (see Table 1: Comparing the Impact to Consumers of Employer Coverage to Current and Proposed “Benchmarks”).

For consumers, the cost of their health care is divided into two core components: what they pay for their premium and what they pay out-of-pocket. The “actuarial value” of a health insurance product seeks to capture this in gross terms — with the AV of 70 percent meaning that the insurance coverage paid for in premiums and subsidies for

[3] Note that potential changes to BCRA related to the Cruz amendment are a constantly moving target. This Issue Brief addresses the concepts as described in their original proposal.

consumers covers 70 percent of the health care costs, while the consumer pays the remaining 30 percent out of pocket. Out-of-pocket spending can take the form of copays or coinsurance paid at the time services are delivered, or those payments made prior to coverage taking effect required to meet deductibles. The fact that lower-income individuals will not see or receive any value of coverage that requires high out-of-pocket expenses — when they do not have money in their pocket — is recognized in the cost-sharing reduction (CSR) program that lowers out-of-pocket expenses to those who make less than 250 percent of the federal poverty level.

Table 1
Comparing the Impact To Consumers of Employer Coverage To Current and Proposed "Benchmarks"

	Average Employer Coverage 82% AV[1]	**Current Benchmark Silver Plan** 70% AV[2]	**Proposed Senate Benchmark Plan** 58% AV[3]
Single Person Deductible	$1,478	$2,500	$13,000
Family Deductible	$2,966	$5,000	$26,000
Maximum Out-of-Pocket	Various Levels	$6,800 individual $13,600 family	$13,000 individual $26,000 family
Services Covered WITHOUT Needing to Satisfy Deductible	• Primary Care Visits • Specialty Care on outpatient basis • Mental Health Care (non-hospital) • Prescription drugs • Tests (x-ray, MRI, CT-Scan) • Telehealth	• Primary Care Visits • Specialty Care on outpatient basis • Mental Health Care (non-hospital) • Prescription drugs • Tests (x-ray, MRI, CT-Scan) • Telehealth	NONE

[1] Data on employer coverage is from the Kaiser Family Foundation 2016 Employer Benefits Survey available at: http://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/. Actuarial value for employer coverage is reported here: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf

[2] The Silver Plan is based on Covered California's benefit design, available at: https://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf. The designs do not reflect the richer benefits received by those eligible for Cost Sharing Reduction subsidies, which are about 55% of enrollees.

[3] There is no benefit design description in the Senate bill, the design reflects having the lowest possible deductible. To the extent some services were not subject to the deductible, the deductible would increase. The $13,000 deductible would be higher than the current law allows for maximum out of pocket expenses.

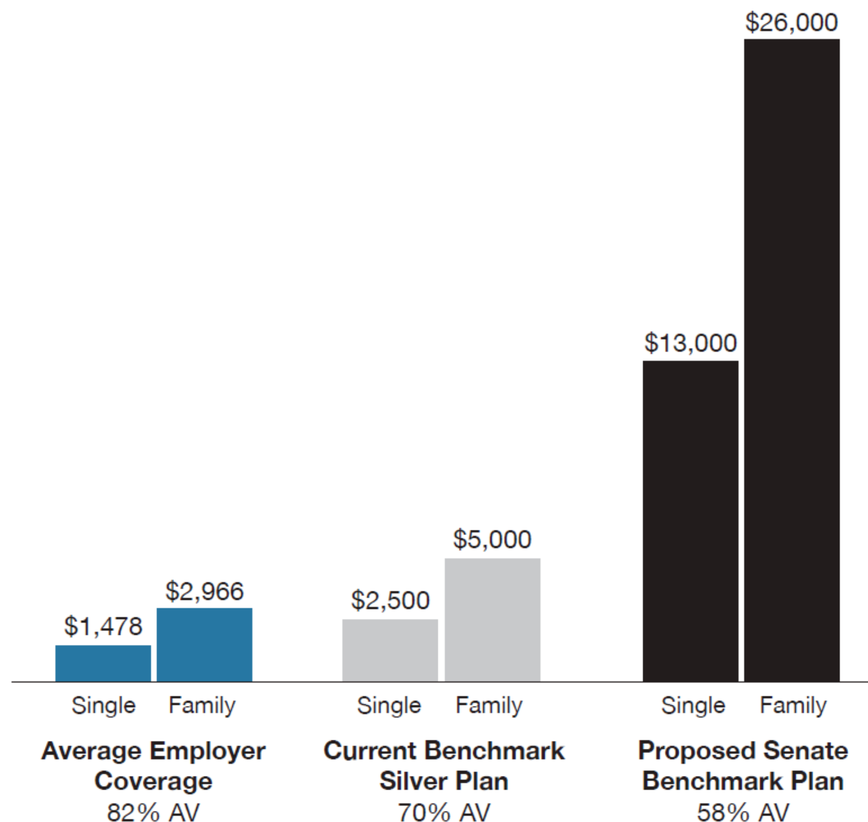
In addition, under both the typical employer plan and the current 70 percent AV Silver benchmark plan, several services, such as primary care visits, specialist visits, prescription drugs, outpatient mental health and substance use treatment, are excluded

from the deductible. Excluding benefits from the deductible means that consumers have immediate access to the benefit but need to pay the plan copay or coinsurance.

A recent analysis by the National Academy for State Health Policy, "Barely Covered: Initial Analysis of Coverage and Affordability Impacts to Consumers Under the Proposed Better Reconciliation Act," compared the benefits, deductibles and maximum out-of-pocket of Silver plans offered in California, Ohio and Pennsylvania for 2017 to a benefit design that would meet the benchmark plan value proposed in the Senate bill. When compared to current law, the analysis found the Senate proposal would result in:

- **Higher Deductibles —** The Congressional Budget Office estimates that a plan with a 58 percent AV would have a deductible of $13,000 for an individual[4], which would correspond to $26,000 deductible for a family. These new deductibles would be four to five times higher than the benchmark deductibles currently offered at the benchmark level in the selected Silver plans offered by the three states (see Figure 1: Benchmarking Consumer Impact of Plan Design Deductibles).

Figure 1
Benchmarking Consumer Impact of Plan Design Deductibles



[4] https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf

- **Less Coverage —** Consumers currently enrolled in a benchmark plan in California, Ohio and Pennsylvania can access numerous services without being subject to a deductible. This includes primary care visits, specialist visits and outpatient services for mental health and substance abuse.

  However, under the BCRA's benchmark plan, those services would likely need to be included in the deductible, requiring consumers to pay 100 percent of their medical expenses for these services until their $13,000 deductible is met.

  Any consumer who does not want a high deductible plan would have to pay the premium difference between the benchmark plan and a plan that provides some coverage prior to meeting the deductible.

- **High Prescription Drug Costs —** California's Silver plan offerings in 2017 contain a $250 drug deductible that is separate and lower than the deductible for other services. Consumers pay $15 for a generic prescription, which is not subject to the deductible, while other drug tiers have a flat-dollar copay after meeting the deductible, and their specialty drug costs are capped at $250 per prescription per month.

  Comparison plans in Ohio and Pennsylvania also offer generic prescriptions for $15 outside of consumers' combined medical and pharmacy deductible and offer benefit features that cap consumers' financial exposure to specialty drug costs. However, a 58 percent benchmark plan would likely require placing prescription drug costs under the deductible.

To the extent services were covered prior to the deductible being met, the amount of the deductible would need to increase. Consumers who do not want higher out-of-pocket costs would have to pay additional premium costs for upgrading to a plan that covers services prior to meeting the deductible. For those consumers who could not afford to buy richer coverage, many would be likely to forego coverage rather than purchase these products — even with a subsidy.[5] The fact that the benchmark plan is so thin that lower income Americans would not see the value of getting covered should come as no surprise. With a family deductible of $26,000, the only people who would see any value in getting coverage are either those who are already facing very high health care costs or high-net-worth individuals who see the value of a very high deductible plan in protecting their assets. This deductible represents more than half of the average Covered California family policyholder's annual income (approximately $46,000).

The fact that far fewer low-income individuals would enroll with a lower value benchmark plan would also have direct impacts on premiums for those who remain. Estimating the specific premium impacts, however, requires micro-simulation modeling that we were not able to complete in the short time since the BCRA proposals were made public.

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[5] See Congressional Budget Office, June 26, 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf. "The deductible for a plan with an actuarial value of 58 percent would be a significantly higher percentage of income—also making such a plan unattractive, but for a different reason. As a result, despite being eligible for premium tax credits, few low-income people would purchase any plan, CBO and JCT estimate."

While the change in benchmark plan would likely lead to a decrease in coverage for millions of consumers, the state-administered stabilization funds could potentially offset their effect. The extent that they would be sufficient to meet those needs requires adequate funding and states being given the flexibility to act. Additional analysis on this issue follows below.

Before assessing the extent to which the funds in the BCRA are adequate, however, it is important to understand the other changes that stabilization funds need to address. These are outlined in the next section.

Need for Stabilization Funding Beyond the Reduction in the Benchmark Plan

Beyond the potential major structural changes to the market landscape that would allow for insurance products of all varieties, potentially creating separate risk pools and the changes to the benchmark plan, the BCRA would also significantly alter the financial support structure, insurance rules and Medicaid coverage, which would likely have substantial impacts on individual market coverage. What follows is a review of some of the major elements and their respective potential impacts on consumers or the individual market, or both:

- **Repeal the cost-sharing reduction program that lowers the cost of care for individuals earning less than 250 percent of the federal poverty level**. In California, about 48 percent of the 1.4 million Californians with coverage on the exchange receive cost-sharing reductions (CSRs) that lower the out-of-pocket cost for consumers when they need to use coverage and receive care.[6] The level of the CSR is adjusted based on the income of the individual or family, with lower-income individuals paying less when they get care. For example, a family of four making $35,000 would have an annual deductible of only $150 and have an office-visit copay of $5. (See "How Cost Sharing Reductions Work and the Critical Role They Play in the Individual Market." http://hbex.coveredca.com/data-research/library/CoveredCA_CSRs_and_the_Individual_Market-7-21-17.pdf)

  Already the lack of clear guidance to health plans on the federal funding of CSRs is causing destabilizing effects, with some health plans deciding to leave the individual markets because they are faced with this uncertainty, and with others pricing for the uncertainty for 2018. The BCRA would provide federal funding for the CSR program through 2019 and then eliminate the program effective 2020. The result for 670,000 Californians and an additional 5 million Americans in other states is that absent some form of substitute funding, the value of their coverage would be dramatically reduced overnight. To the extent a mechanism and funding similar to the CSR is not put in place, many of those who now get coverage would stop getting insurance. Those who kept their insurance would be more likely to be less healthy, raising premium costs to the remaining subsidized and unsubsidized insureds.

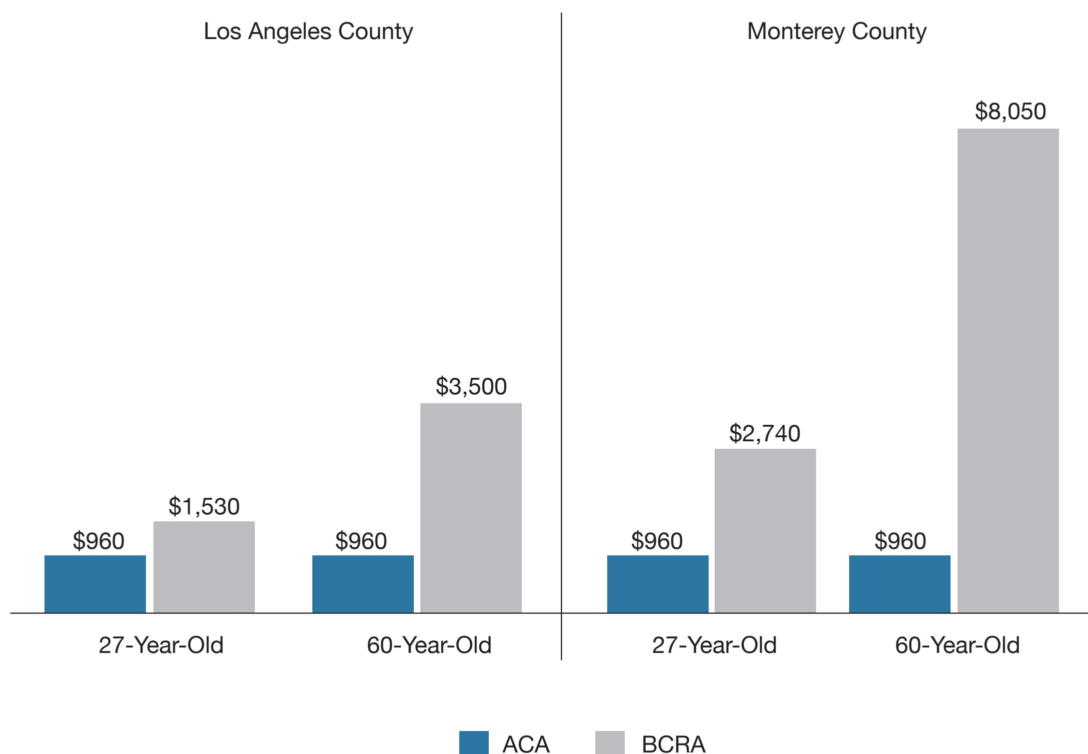
[6] http://hbex.coveredca.com/pdfs/Bringing_Health_Care_Coverage_Within_Reach.pdf

- **Eliminate the mandate for coverage, replacing it with a "waiting period" before which consumers cannot get coverage**. The Congressional Budget Office estimates that the removal of the penalty could raise premiums by 15 to 25 percent relative to those under current law.[7] The BCRA proposes to immediately and retroactively eliminate the penalty for not getting coverage and "replacing it" with s six-month waiting period during which consumers would need to wait for getting coverage. The American Academy of Actuaries indicates this proposal might increase enrollment modestly, but would primarily only temporarily shield the risk pool from these high-risk enrollees.[8] In short, the policy would temporarily keep high-need consumers from getting the care they need, rather than spread the risk of being a high-need case across a diverse group of enrollees.

- **Add age as a premium-contribution factor and increase the maximum contribution from 9.5 percent of income today to over 16 percent of income for individuals 59 and older**. As analyzed by the Kaiser Family Foundation, this change would dramatically alter the affordability calculation for older consumers.

Figure 2

Comparison of Estimated Annual Consumer Premiums*Under ACA and BCRA in a Low and High Cost County in the State



Notes: Data from Kaiser Family Foundation, "Premiums and Tax Credits under the Affordable Care Act vs. the Senate Better Care Reconciliation Act: Interactive Maps" (updated June 23, 2017) http://kaiserf.am/2uRff6e

[7] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf

[8] Sen. Aditi and Thomas DeLeire. "The Effect of Medicaid Expansion on Marketplace Premiums." Sept. 6, 2016. https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf

Additionally, the higher 16 percent of income maximum individual-responsibility requirement for consumers 59 and older could become a tremendous burden, as illustrated in Figure 2: Comparison of Estimated Annual Consumer Premiums Under ACA and BCRA in a Low and High Cost County in the State, showing the proposed impact on premium costs for lower-income consumers earning $20,000 per year.

- **Reduce the ceiling for receiving subsidies from 400 percent to 350 percent of the federal poverty level.** For those making more than 350 percent of the federal poverty level, this moves them to the "wrong side of the cliff," making them ineligible for any subsidy, irrespective of how much health care costs as a percentage of their income. In California, many middle class Americans who today make more than the current "subsidy cliff" of 400 percent struggle to meet the coverage costs. Lowering the ceiling would mean that on average healthier people in this income bracket would be more apt to go without coverage, while those facing known health care needs would avail themselves of the comprehensive coverage of the essential health benefits and other consumer protections provided under "full" coverage.

- **Reduction of Medicaid coverage and increased uncompensated care.** The BCRA proposes to make dramatic reductions in payment to support states in their provision of Medicaid benefits. The direct effect of these reductions, based on Congressional Budget Office analysis of the earlier Senate bill, is that there would be a national reduction in coverage of 15 million by the year 2026. Beyond those direct effects, there are potential indirect effects on the individual market.

  The first indirect impact relates to the potential change in the risk mix of the individual market that could occur to the extent a state reduces its Medicaid coverage down from 138 percent of the federal poverty level to 100 percent. The risk mix ramifications of this eligibility change are difficult to forecast without more Medicaid data and simulation modeling. Recent findings from the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE), in a study assessing the relationship between Medicaid expansion and marketplace premiums, indicate that Medicaid expansion is associated with a 7 percent reduction in marketplace premiums.[9] The actual impact could be greater or less, depending on the number of consumers who take up and their relative risk profile — but the potential for significant upward pressure on rates is very real.

  An additional potential indirect impact of the reduction in coverage would be a dramatic reduction in uncompensated care in hospitals. In the years since the implementation of the Affordable Care Act, sources report that uncompensated care in hospitals has fallen by at least 40 percent.[10]

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[9] Sen, Aditi and Thomas DeLeire. 2016. "The Effect of Medicaid Expansion on Marketplace Premiums." September 6, 2016. https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf.

[10] D. Dranove, C. Garthwaite, and C. Ody, The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal, The Commonwealth Fund, May 2017: http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medicaid-expansion-hospital-uncompensated-care

Greatly reducing Medicaid funding and "spilling" those recipients back into uninsured status would result in a return to much higher uncompensated care, which would likely cause hospitals to increase rates across the board for hospitals' entire commercial lines of business. This means that both employers and the individual markets would be directly and negatively affected, placing additional upward pressure on premiums — estimated at 1 to 2 percent.[11]

Taken together, these factors would increase premiums and cost sharing dramatically, particularly for many low-income and older consumers, which would lead to a greater proportion of healthy consumers dropping their coverage (particularly with the proposed elimination of the tax penalty for not maintaining coverage). The newly proposed Title III of the BCRA and its move to "skinny" benefit products would in turn result in a further increase in premiums for those who remain in full essential health benefit coverage that would likely totally destabilize individual markets. Even without that policy, large amounts of stabilization funding would be critical to mitigate the market instability and encourage healthy consumers not to drop coverage that would be the product of the collective policies in the BCRA as proposed. (As is summarized in "Table 2: Stabilizing Individual Markets: Demands and Potential Implications," the need for risk-stabilization funding is real and significant).

The Impact of Encouraging Carriers to Offer Alternate Products: Negative Impacts to Individual Markets and the Risk of Return to Coverage in Name Only

The amendment to the Senate bill on July 13 included a provision that would encourage carriers to offer off-exchange products that do not cover essential health benefits or to provide other protections under current law. While the provision, better known as the Cruz Amendment, was not included in the revised Senate bill submitted on July 20, it could be reintroduced at a later date.

The structural impact on the individual market would be to divide the risk pool into those who believe they are healthy and should seek cheaper coverage off the exchange, and those who want the assurance of receiving full and known coverage.

For the market broadly, almost immediately, the impact on the risk mix of the individual market as a whole would likely be devastating — with low-risk individuals migrating to very "thin" but cheap benefit products, while those who need comprehensive coverage would stay on the exchange. The Brookings Institute says, "The loss of healthier enrollees from ACA-compliant plans would put significant upward pressure on premiums for ACA-compliant plans. The rise in ACA-compliant premiums would, in turn, shift costs toward sicker enrollees and drive up the federal government's cost of providing premium tax credits."[12]

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[11] Since on average hospitals get half of their revenue from Medicare and Medicaid, unit prices for other payers could be anticipated to rise by over 3 percent (two times the 1.6 percent reduction in operating costs identified by Dranove, et al.). Since hospital costs are roughly 40 percent of premiums, a 3 percent increase in hospital rates would translate into a between a 1 and 2 percent increase in employer-sponsored insurance and individual market premiums. Medicare would be largely insulated from impact by its administered prices.

[12] https://www.brookings.edu/blog/up-front/2017/07/20/requirement-to-maintain-a-single-risk-pool-would-not-contain-effects-of-cruzs-proposal/

While some of those premium increases might be offset for some carriers, the American Academy of Actuaries[13], insurance commissioners[14] and advocacy groups[15][16] have declared the amendment will lock many consumers out of coverage and destabilize the markets. In addition, two of the most prominent names in the insurance industry have called the amendment "unworkable in any form."[17]

As a result, carriers offering the combination of full essential health benefit products alongside "skinny" benefit products would likely want to quickly exit from the remaining full essential health benefit product market. A consequent event would be that those carriers would no longer be eligible to offer "skinny" benefit products under the BCRA. Covered California believes that the individual market as a whole in most regions would be at high risk of a "death spiral" within a few years, and there would be no individual product market at all in many states.[18]

Even in California — which had a robust individual market prior to the Affordable Care Act, and over the past five years has fostered even greater competition and expanded coverage — the individual market could be at risk of collapse in the three to five years.

One element of the BCRA that is proposed to ameliorate the negative impacts to the risk pool is the establishment of a special $70 billion fund that can be used over six years. That fund, however, both in design and in funding level, would be inadequate. The fund is structured such that those plans that offer such off-exchange products would be given priority over other carriers to receive special federal funding administered by the Secretary of Health and Human Services. Yet this federal government-to-issuer payment system would not be nearly adequate to overcome the "death spiral" premium increases, where premium reductions possible with the fund would decrease each year, and would not remedy the underlying risk dynamics driving the death spiral.

The likely consumer experience under the proposed Title III is clear: In the best case consumer scenario, for those who choose to purchase "cheap" coverage off exchange, this would mark a return to an era of insurance products with poorly understood gaps in coverage that surprise consumers when they need care. Health plans would be able to price these products differently based on the health status of individuals and they would "win" by constructing benefit designs that do not cover higher-cost coverage for which consumers do not understand the value when they make their purchase decision.

Today, in California, consumers with and without subsidies actively shop and make choices based on the factors that matter most to them: the premium they pay; broad

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[13] http://www.actuary.org/files/publications/RiskPoolingFAQ071417.pdf

[14] http://www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=258

[15] http://www.kff.org/health-reform/issue-brief/how-the-cruz-amendment-might-affect-the-marketplace-applying-different-rules-to-competing-health-plans/

[16] http://familiesusa.org/press-release/2017/cruz-amendment-resurfaces-radical-and-dangerous-amendment-radical-and-dangerous

[17] https://www.ahip.org/wp-content/uploads/2017/07/Joint-AHIP-BCBSA-Consumer-Freedom-Option-Letter-FINAL-071417.pdf

[18] The closest example of a similar policy was the decision in the 1990s by Washington state and Kentucky to offer guaranteed issue policies without a mandate fee or any effective insurance requirements, which resulted in a complete withdrawal of insurers from their markets (until the laws were rescinded).

ranges in the scope of coverage (whether they want higher or lower risk); which doctors, hospitals and other providers are in their network; and the approach to care of the health plan they are selecting. Health plans today do not compete on how cleverly they limit certain types of expensive care that will not be covered when it is needed, as was too often the case in years past. Today, they compete on what matters to consumers: price, provider network and quality.

Table 2
Stabilizing Individual Markets: Demands and Potential Implications[19]

BCRA Policy	Potential Impact or Stabilization Funding Requirement	Projected Funding Needed to Mitigate Impacts in Years 2022 to 2026[20] (See Table 4 for Details)
Allow for health plans to offer "thin" coverage off exchange	The impact would be to fundamentally restructure the risk pools, which over time would likely result in the on-exchange, "full" coverage functioning as a high-risk pool.	Anticipate that the instability caused by the market dynamics would not be mitigated by more funding.
Eliminate cost-sharing reduction Program	Cost of reducing cost sharing for lower-income consumers: on par with existing CSR program.	$12 billion to $15 billion per year
Eliminate penalty for not purchasing "affordable" coverage	Increase premiums by 15 to 20 percent for all consumers.	$ 20 billion to $26 billion per year
Lowering benchmark plan to 58 percent actuarial value (AV)	Cost of increasing the level benchmark plan for subsidy from 58 percent to 70 percent AV.	$ 9 billion to $12 billion per year
No specific funding for reinsurance	Funding at the level of the first two years of the Affordable Care Act lowered premiums by approximately 10 percent by the federal government.	$ 8 billion to $11 billion per year
Reduce Medicaid coverage and increase uncompensated care	Potential individual market increase of 7 percent for worse risk mix and 1 to 2 percent for cost shift from uncompensated care in hospitals.	$ 7 billion to $10 billion per year

[19] The impacts of some policies are on discrete populations, while others are market-wide. In addition, because of interaction effects between the various dynamics, without a microsimulation model, it is not feasible to simply sum up the individual dynamics to provide an estimate of the funding needed to ensure a baseline of stability and access in the market.

[20] These are best estimates available at the time of publication. In some cases, the estimates would be improved by more sophisticated modeling, including microsimulations. Covered California continues to refine these estimates and will produce revised figures as they become available.

Are Stabilization Funds Proposed Sufficient to Maintain Stability in the Individual Market?

The potential demands on stabilization funds are significant. Without a sufficient amount of annual stability fund dollars, insurers will conclude that the individual market, both on and off exchange, is too difficult to price and manage.

Our preliminary modeling, explored in more detail below, shows the need for significantly more stability funds. For the most part, the potential need for "stability funding" described in Table 3 is not to address any *existing* instability; rather, it would be required to address fundamentally new instability created by the policy changes in the BCRA. The current BCRA proposes an annual State Administered Stability Fund of $6.4 billion as of 2022 (assuming all states participate and provide matching funds; see next section). It is clear that such a level of funding would be insufficient to even partially address the significant negative impacts on the individual markets across the nation and the approximately 14 million Americans who now receive coverage through those markets.

It is unclear what level of stability funding would be adequate, but if the goal were to provide sufficient funding to have individual markets reflect a balanced risk mix and have premium increases that are driven only by underlying health care cost increases, the stability funding from 2022 on would need to be at least several times the level currently proposed, or $40 to $50 billion annually.

The Mechanics and the Potential Impact of the Stabilization Funding Provided

The Mechanics of the Proposed Risk-Stabilization Funding — The current Senate bill would create two distinct stability-funding programs: a State Stability and Innovation Program and a Long-Term State Stability and Innovation Program, which has two elements. The State Stability and Innovation Program would provide funding to the Administrator of the Centers for Medicare and Medicaid Services to fund arrangements with health insurance issuers to address coverage and access disruption and to respond to urgent health care needs within states. The bill appropriates $50 billion for the programs ($15 billion for calendar years 2018 and 2019, and $10 billion for calendar years 2020 and 2021.) See Table 3: Summary of Proposed Better Care Reconciliation Act of 2017 Stability Funding.

Table 3:
Summary of Proposed Better Care Reconciliation Act of 2017 Stability Funding

	Federally Administered		Federally Administered	State Administered Funds			
Year	**Short-Term Stability Fund:** Payments for Issuers from HHS[1]	**Long-Term BCRA Stability Fund**[2]	**Long-Term Stability Fund:** Potential Allocation of BCRA Title III Payments to Issuers[3]	**Long-Term BCRA Stability Fund:** Estimated Amount Remaining to Allocate for State Use[4]	**Long Term BCRA Stability Fund:** State Match[5]		**Estimated Total Funds for State Use Including State Match**[6]
2018	$15 billion				%	$	
2019	$15 billion	$8 billion		$8 billion	0%	$0	$8 billion
2020	$10 billion	$14 billion	*	$14 billion	0%	$0	$14 billion
2021	$10 billion	$14 billion	*	$14 billion	0%	$0	$14 billion
2022		$19.2 billion	$13.2 billion	$6 billion	7%	$400 million	$6.4 billion
2023		$19.2 billion	$13.2 billion	$6 billion	14%	$800 million	$6.8 billion
2024		$19.2 billion	$14.2 billion	$5 billion	21%	$1.1 billion	$6.1 billion
2025		$19.2 billion	$14.2 billion	$5 billion	28%	$1.4 billion	$6.4 billion
2026		$19.2 billion	$15.2 billion	$4 billion	35%	$1.4 billion	$5.4 billion
Total	$50 billion	$132 billion	$70 billion	$62 billion		$5.1 billion	$67.1 billion

[1] The short-term stability fund does not require state-matching funds and is paid directly to health insurance issuers to address coverage and access disruption and respond to urgent health care needs within states. The total in this column does not reflect a decrease of 1% of total funding – $150 million in 2018 and 2019 and $100 million in 2020 and 2021 – for each calendar year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75% higher than the national average.

[2] For years 2019-2021, the CMS Administrator shall ensure that at least $5 billion of the amounts appropriated for each such year are used by States for the purposes of stabilizing premiums and promoting State health insurance market participation and choice in plans offered in the individual market. State-matching funds are required beginning in 2022.

[3] $70 billion of the total long term stability fund as appropriated from 2020-2026 will be paid directly by the Secretary of HHS to issuers to assist in covering high risk individuals enrolled in QHPs. To enable the calculations in this issue brief, here we display potential annual allocations of this fund for years 2022 through 2026. We note that the proposed legislation does not specify an annual allocation of the $70 billion. This $70 billion does not require state-matching funds.

[4] This column estimates the amount of long-term stability funding that would remain for state use after appropriation of the $70 billion for BCRA Title III payments to issuers. The total in this column does not reflect a decrease of 1% of total funding for each calendar year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75% higher than the national average.

[5] State match applies to funding allocated for state application for use of long-term BCRA stability funds.

[6] This is based on an assumption as allocation formula has not been released.

* This funding will be available to the Secretary of Health and Human Services to use in these years.

The Long-Term State Stability and Innovation Program would provide funding to the Administrator for two purposes. First, it would provide allotments to the states for one or more of the following purposes: (1) to establish or maintain a program to help high-risk individuals; (2) to establish or maintain a program to enter into arrangements with issuers to assist in the purchase of health benefits coverage by stabilizing premiums;

(3) to provide payment for health care providers; or (4) to provide health insurance coverage by funding assistance to reduce out-of-pocket costs. The bill would appropriate $62 billion ($8 billion for calendar year 2019; $14 billion for calendar years 2020 and 2021, $6 billion for calendar years 2022 and 2023, $5 billion for calendar years 2020 and 2025, and $4 billion for calendar year 2026.). The funding for calendar years 2022 through 2026 is subject to the requirement that states contribute additional matching funds, which start at 7 percent in 2022 and increase to 35 percent by 2026, with the total match required of states totaling $31.1 billion.

The second element of the Long-Term State Stability and Innovation Program was added by amendment on July 13, 2017. The amendment added $70 billion to the program (increasing the amount of funding to $19.2 billion each year for calendar years 2022 through 2026), with the requirement that these funds be administered by the Health and Human Services (HHS) Secretary and paid directly to carriers instead of being made available to states. The amendment would create a new Title III, Section 301, which would allow issuers to offer plans off the exchange that do not comply with the essential health benefit requirement and other current requirements as long as they offer one Gold, one Silver, and one benchmark health plan through the exchange, and if allowed, under state law. The amendment transfers $70 billion of the funds appropriated to the Long-Term State Stability and Innovation Program to the HHS Secretary to use for years 2020 through 2026 to make payments to assist issuers in covering high-risk individuals enrolled in health plans through the exchange. The HHS Secretary would be required to prioritize the allocation of the funds based on the percentage of rating areas in the state that have plans that meet the current law, and to health plans that offer both full essential health benefits and other current requirements, and also offer off-exchange plans that do not meet the essential benefits standards and other elements of the current law.

Both the Short-Term Stability Fund and the state-administered portion of the Long-Term Stability and Innovation Fund include a 1 percent withhold, worth $1.1 billion, in states where the cost of insurance premiums are at least 75 percent higher than the national average, for which Alaska is the only qualifying state.

The new Section 301 would also appropriate $2 billion for the period beginning Jan. 1, 2020, and ending on Dec. 31, 2026, for the purpose of providing allotments to states to offset costs attributable to the state's regulation and oversight of off-exchange non-Affordable Care Act-compliant plans.

Below we model various uses of the portion of the Long-Term State Stability Fund allocated for state use. We note that, despite the naming of each of the stability funds, most of the funds appear to be earmarked for direct payment to issuers rather than states. This approach makes it difficult for a state to determine what portion, if any, of the total funds would actually flow to the state. Without knowing the total amount of funding or having control of its application, a state cannot accurately estimate the impact of the stability funds for their intended purpose — stabilizing the individual market under the BCRA.

Modeling of Potential Impacts of Stabilization Funding — The purpose behind risk-stabilization funds — bringing stability to the individual markets — is met by encouraging more consumers to enroll and stay enrolled in coverage. The two primary financial vehicles for promoting coverage are: (1) lowering the cost of the coverage and increasing affordability for consumers; or (2) increasing the value of the coverage offered by expanding the scope of coverage, making consumers more likely to get and keep coverage. Those two pathways can be pursued by an array of tactics. Cost of coverage can be lowered by programs such as high-risk pools or a reinsurance fund that lowers premiums to all insureds, or by targeted subsidies that are adjusted for age, income or region. Increasing the value of coverage can be done by funding out-of-pocket costs, as the current cost-sharing reduction program does for approximately 55 percent of subsidy-eligible consumers. The Senate bill anticipates that the Long-Term Risk Stabilization Funds available to states could be used for just these sorts of purposes.[21]

For the years 2018 and 2019, the Senate bill proposes that the current structure of tax subsidy and cost-sharing reductions are kept in place and the Short-Term Stability Fund administered by the HHS would be funded at $15 billion, with an additional $8 billion in Long-Term Stability Funding that would be state administered available in 2019. In those years, the potential premium increase caused by the elimination of the penalty could be largely offset if the respective stabilization funding were used for reinsurance.[22] (The CBO estimates the repeal of the mandate penalty could raise premiums by 15 to 20 percent.)

In 2020, the first year that the new lower-benchmark plan and the other changes to subsidies take effect, the Short-Term Stability Fund provides $10 billion to be administered by HHS and $14 billion to be administered by states. The same funding is provided for 2021. During these years, the CMS administrator is to ensure that at least $5 billion is used by states to stabilize premiums and ensure participation by issuers and choice of plans offered in the individual market. As noted above, this restriction makes it very difficult for a state to model its share of the fund. It also makes it unclear whether a state would have the flexibility the BCRA seems to determine how the money will be allocate to each of the four permissible uses of the fund. Due to this uncertainty, years 2020 and 2021 are not modeled below.

To model the potential impact nationally of the application of Long-Term Risk Stabilization Funds, this report considers three scenarios. These scenarios look only at the 2022 through 2026, after the termination of the Short-Term Stability Fund, and do not consider the federally administered $70 billion fund, which is designed to offset anticipated impacts of health plans offering new designs that cost less than standard

[21] Importantly, differences in the approaches to achieving the goals of stability and access will have different outcomes for different kinds of consumers: for example, restoration of benchmark coverage to 70% benefits subsidized, low-and moderate income consumers who are receiving tax credits, while reinsurance largely benefits consumers over 350% FPL who are not receiving subsidies (for subsidized consumers, reinsurance principally acts to reduce the size of their tax credits – accruing a savings to the federal taxpayer).

[22] In previous analysis we estimated that $15 billion invested in reinsurance would reduce premiums in ACA-compliant on and off-exchange plans by from 12 percent to 15 percent which would generate $10 billion in savings in federal premium tax credit expenditures. http://hbex.coveredca.com/data-research/library/RiskStabilization-FederalSpendingImpact-04-14-17-Final.pdf

on-exchange offerings because they do not offer the full essential health benefits or meet other elements of existing law.

Each of these scenarios assumes that all states participate in the matching-funding requirement to have the stabilization funds available. In reality, it is very likely that some states would not opt to participate in the stabilization funding given the required matching costs, which over the five years would total $5.1 billion nationally.

Critically, these scenarios assume that the entire allocation of Stabilization Funds are used by a state to mitigate the instability addressed by the scenario. In fact, states would need to confront all of the impacts these scenarios address, together, with a single allocation. As indicated in the modeling results, the proposed Stabilization Funds are not adequate to support even one of the scenarios fully, even if fully committed to that scenario. A state that seeks to address multiple instability concerns at once (e.g. premium increases due to mandate repeal and reduction of out-of-pocket costs for lower income consumers) would find the Stabilization Funds able to cover an even lower percentage of the needed resources to mitigate the instability than shown in each scenario.

Those scenarios are detailed in Table 3: Modeling Impacts of BCRA State-Administered Stabilization Funds, 2022 to 2026. The scenarios and the major observations about them follow:

- **Scenario 1: Reduce out-of-pocket costs for consumers who earn under 250 percent of the federal poverty level to current levels provided through cost-sharing reductions (CSRs).** This scenario uses the current level of financial support to lower out-of-pocket costs for lower-income consumers, which would have the effect of increasing the actuarial value of the plans those individuals selected to 85 percent. The cost of increasing the value of insurance products above the proposed benchmark value of 58 percent would be $12 billion in 2022, increasing to $15.8 billion by 2026. The stabilization funding available over the five years would range from $5.4 billion to $6.8 billion, assuming all states contribute their matching funds. This would mean the at most the stabilization fund could cover 53 percent of the needed amount, leaving a $5.6 billion shortfall (in 2022) and cover only 34 percent of the costs, and leave a $10.4 billion shortfall in 2026.
- **Scenario 2: Provide stability funding sufficient to cover the increased premium costs of removing the individual mandate (penalty).** This scenario would target funding (that could be administered as reinsurance, which would spread the beneficial impact across both those who do and do not receive subsidies) to offset the impact of premium increases resulting from the elimination of the penalty. For the purpose of this modeling, we used the CBO estimates 20 percent - which would mean that the cost of lowering premiums to the level that they would have been otherwise as of 2022 would be $20.1 billion, increasing to $26.4 billion in 2026.[23] The stabilization funding available over the

[23] Recent estimates include: Congressional Budget Office. 2017. "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums," at page 2: https://www.cbo.gov/system/files/115th-congress-2017-

five years would range from $5.4 billion to $6.8 billion, assuming all states contribute their matching funds. This would mean the at most the stabilization fund could cover 32 percent of the needed amount, leaving a shortfall of $13.7 billion (in 2022) and cover only 20 percent of the costs and leave a shortfall of $21 billion in 2026.

- **Scenario 3: Increase benchmark used for tax credits to consumers earning less than 350 percent of the federal poverty level to the 70 percent Silver plan of current law (from proposed benchmark of 58 percent).** The cost of increasing the subsidy from the proposed benchmark value of 58 percent to a value of 70 percent would be $8.9 billion in 2022, increasing to $11.7 billion by 2026. The stabilization funding available over the five years would range from $5.4 billion to $6.8 billion, assuming all states contribute their matching funds. This would mean the at most the stabilization fund could cover 72 percent of the needed amount, leaving a $2.5 billion shortfall (in 2022) and cover only 46 percent of the costs and leave a $6.3 billion shortfall in 2026.
- **Scenario 4: Reduce premiums through reinsurance.** The value of reinsurance is reflected in premiums being lower than they would have been absent the funding, spread across all insureds. Because tax credits for lower-income consumers are based on income, the primary consumers who would benefit from this scenario are those consumers over 350 percent of the federal poverty level who are not receiving tax credits (whether they receive coverage on- or off-exchange). In a scenario that establishes a reinsurance pool at the same level as was provided in the first year of the Affordable Care Act, which reduced premiums by an average of 10 percent, the cost would be $10.1 billion in 2022, increasing to $13.2 billion by 2026. The stabilization funding available over the five years would range from $5.4 billion to $6.8 billion, assuming all states contribute their matching funds. This would mean the at most the stabilization fund could cover 64 percent of the needed amount, leaving a $3.6 billion shortfall (in 2022) and cover only 41 percent of the costs and leave a $7.8 billion shortfall in 2026.

These scenarios show that the proposed risk-stabilization funds are not only inadequate in addressing the multiple interrelated policies in the BCRA that will create new instability, but they are also inadequate in even partially addressing any one of the single major elements.

2018/reports/52371-coverageandpremiums.pdf; "Repeal the Individual Health Insurance Mandate." https://www.cbo.gov/budget-options/2016/52232; Congressional Budget Office. 2017. Letter to Senator Mike Enzi, at page 5: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.

Table 4:
Modeling Impacts of BCRA State-Administered Stabilization Funds, 2022 to 2026[24]

Use of Funds To Lower Costs *(in billions)*	**2022**	**2023**	**2024**	**2025**	**2026**
Total Stabilization Funds Available To States (includes federal funds and state match)	$6.4	$6.8	$6.1	$6.4	$5.4
SCENARIO 1 — Reduce < 250% FPL Consumers Out-of-Pocket to CSR Levels (85% AV)					
CSR backfill cost	$12.0	$12.9	$13.8	$14.7	$15.8
Are funds sufficent to reduce out-of-pocket costs for all consumers < 250% FPL?	No 53%	No 53%	No 44%	No 43%	No 34%
Remaining Funds (or shortfall)	-$5.6	-$6.0	-$7.7	-$8.3	-$10.4
SCENARIO 2 — Offset Premium Increases Due to Loss of Requirement to Carry Coverage (Individual Mandate Repeal)					
Cost to offset 17.5% premium increase	$20.1	$21.5	$23.0	$24.6	$26.4
Are funds sufficiento to reduce premiums by 20%?	No 32%	No 32%	No 26%	No 26%	No 20%
Remaining funds (or shortfall)	-$13.7	-$14.7	-$17.0	-$18.2	-$21.0
SCENARIO 3 — Raise Benchmark Plan for Consumers < 350% FPL to Silver (70% AV)					
Cost to add to APTC to afford 70% AV benchmark	$8.9	$9.5	$10.2	$10.9	$11.7
Are funds sufficient to improve benchmark plan to Silver plan for all consumers < 350% FPL?	No 72%	No 72%	No 59%	No 59%	No 46%
Remaining funds (or shortfall)	-$2.5	-$2.7	-$4.1	-$4.5	-$6.3
SCENARIO 4 — Reduce Premiums Through Reinsurance					
Cost to fund reinsurance similar to 2015 levels (10% premium reduction)	$10.1	$10.8	$11.5	$12.3	$13.2
Are funds sufficient to reduce premiums by 10%? Note: primarily lowering net premiums for consumers > 350% FPL and off-exchange)	No 64%	No 64%	No 53%	No 52%	No 41%
Remaining funds (or shortfall)	-$3.6	-$3.9	-$5.5	-$5.9	-$7.8

[24] **Assumptions:** These estimates rely on 2016 actuals for individual market premiums, tax credits, and cost sharing as reported by CMS (https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf and https://aspe.hhs.gov/health-insurance-marketplace-cost-sharing-reduction-subsidies-zip-code-and-county-2016, respectively). The scenarios assume a straight 7 percent medical trend for premium inflation beyond 2016. This means the estimates do not account for factors in BCRA that will likely cause premiums to change, including:

1. Changes in affordability from reduced tax credits to many consumers from the change in a benchmark plan to 58 percent actuarial value.
2. Changes in the risk mix from changes to the requirement to carry coverage (individual mandate).
3. Change in the risk mix from availability of coverage with less comprehensive benefits (e.g., off exchange under the amendment proposed by Senator Cruz).

Sources:

BCRA bill text:
http://www.budget.senate.gov/imo/media/doc/BetterCareJuly13.2017.pdf

CMS data for market premiums:
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

CMS data for APTC and CSR amounts:
https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

ASPE Data on cost-sharing reduction summaries:
https://aspe.hhs.gov/health-insurance-marketplace-cost-sharing-reduction-subsidies-zip-code-and-county-2016

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4. Changes to premiums (likely significant increases) due to segregation of risk pools and the reintroduction of health-based rating under the Cruz amendment.
5. Change to premiums and take-up from shift to five-to-one age rating curve.

For stabilization funding available, these estimates focus only on the funds dedicated to state stability and innovation.