

Cost-Sharing Assistance and Alternatives

Report to House Committees on Appropriations and on Health Care and Senate Committees on Appropriations, Health and Welfare, and on Finance Pursuant to Act 11, Section E.306 (2018)

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January 14, 2019



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Background

Act 11 (Special Session 2018) Section E.306¹ directs the Agency of Human Services (AHS) to research, analyze, and recommend alternatives to the cost-sharing assistance established in 33 V.S.A. §1812. In response, AHS's Department of Vermont Health Access (DVHA) drafted this report in coordination with the Office of Health Care Reform.

In brief, AHS recommends maintaining Vermont cost-sharing assistance in light of federal uncertainty.

Cost-sharing assistance

The Affordable Care Act (ACA) established an income-based cost-sharing assistance benefit (also known as cost-sharing reduction, "CSR") for individuals and families. This benefit reduces out-of-pocket costs for those enrolled in qualified health plans (QHPs) through the health insurance exchange (Vermont Health Connect or "VHC"). Federal CSR eligibility is based on income between 100 and 250 percent of the federal poverty level (FPL).

Vermont established additional cost-sharing assistance at 33 V.S.A §1812(b). The section provides that an individual or family with income at or below 300 percent of the FPL shall be eligible for cost-sharing assistance, including a reduction in the out-of-pocket maximums established under the ACA. The section establishes a sliding scale based on modified adjusted gross income (MAGI) for eligible individuals and families and states that the assistance shall be administered using the same methods as set forth in the ACA to the extent practicable. Vermont cost-sharing assistance is known as "VCSR."

In order to receive VCSR, customers must enroll in a silver-level QHP. Customers who are eligible for VCSR based on their income are automatically enrolled into an enhanced version of the baseline silver plan they select. The enhancement of the plan to result in reduced cost-sharing for enrollees is quantified in the plan's actuarial value (AV).

Baseline silver is 70% AV. The CSR plans have the following AVs based on income:

FPL	CSR AV	VCSR AV
100-150	94	n/a
150-200	87	n/a
200-250	73	77
250-300	n/a	73

¹ An act relating to making appropriations for the support of government, financing education and vital records at <https://legislature.vermont.gov/assets/Documents/2018.1/Docs/Acts/ACT011/ACT011%20As%20Enacted.pdf>

In 2018, more than 6000 Vermonters received the VCSR benefit. To finance VCSR, DVHA makes payments to QHP issuers based on the number of enrollees in the applicable enhanced silver plans. This payment is the equivalent of an increased premium for these plans, specifically 5% of the premium for each household with an income between 200 and 250 FPL and 3% of the premium for each household with an income between 250 and 300 FPL. For example, because a two-person Standard Silver plan from Blue Cross Blue Shield of Vermont (BCBSVT) had a 2018 premium of \$1122.04 per month, DVHA would pay \$56.10 to BCBSVT for each month that the couple was enrolled. After the close of the plan year, these payments are reconciled against customer utilization of the reduced cost-sharing based on data provided by issuers. Unlike Vermont Premium Assistance, which is more than half-funded by federal match, VCSR is paid with 100% state dollars.

This method of calculating and administering cost-sharing assistance is identical to that used by the federal government (Centers for Medicare and Medicaid Services or “CMS”) for the federal CSR benefit until October 2017 when it ceased making CSR payments.

Federal Changes and SFY19 Budget

In October 2017, the federal government stopped making CSR payments to QHP issuers. More than 12,000 Vermonters were enrolled in a federally funded CSR plan for all or part of 2017. Federal payments were on track to be approximately \$12.4 million for the year.

Notwithstanding this de-funding, federal law still requires provision of the CSR benefit.² Therefore, federal de-funding of the CSR program created a budget deficiency for QHP issuers of roughly \$15 million for 2017 and 2018. For 2019, stakeholders developed, and the Green Mountain Care Board approved, a method to pay for the federal CSR benefit through a rate increase or “load” on silver-level QHP premiums.³ Because federal premium assistance (advanced premium tax credits, “APTC”) is tied to the cost of the second lowest cost silver plan, this approach increased APTC for eligible customers in scale with the premium increase. In order to hold the unsubsidized population harmless, Act 88 (2018)⁴ authorized the offering of “reflective” silver plans: nearly identical to corresponding silver QHPs but offered off the exchange and without the CSR-related rate increase.⁵ Some unsubsidized customers who prefer a silver-level plan have enrolled in this option for 2019. DVHA and the insurance issuers continue to conduct outreach to the remaining unsubsidized members to ensure they know that they can transfer plan management – and thus reduce their premium – anytime during the year.

² 45 CFR 155.305(g)

³ At least 45 states have implemented silver loading. See <https://www.healthaffairs.org/doi/10.1377/hblog20180613.293356/full>

⁴ <https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT088/ACT088%20As%20Enacted.pdf>

⁵ 33 VSA 1813

Concurrent with the development of this “silver loading” strategy for 2019, AHS proposed to eliminate funding for the VCSR program as part of the Governor’s state fiscal year 2019 budget. This proposal was developed in response to general budget pressures, the prioritization of programs for which there is federal match, and a commitment to preserve benefits for the most vulnerable. While it was not initially driven by the federal CSR changes, it would have simplified options for the VCSR population in a way that aligned with the silver loading strategy.

VCSR Issues

Any plan selection, for any subsidized or unsubsidized member, involves a cost-benefit analysis that weighs probabilities of various medical and prescription needs, comfort with risk, and preparedness for a worst-case scenario. Ideally the member makes an educated decision based on their particular circumstance and chooses a plan that has both a relatively low expected total cost and a manageable worst-case scenario. In practice, this is often easier said than done.

The availability of cost-sharing assistance changes the equation but still does not produce a one-size-fits-all solution. For example, a rational comparison shopper could still choose a bronze plan over an enhanced silver plan with cost-sharing reductions, if they were very healthy and prepared to accept the risk of potentially high out-of-pocket costs. With the CSR benefit for the under 200% FPL population, however, risk-averse members at least had the peace-of-mind of knowing that their particular enhanced silver plan was a better choice than higher metal levels. This is because their silver plan options (at 87 or 94 AV) offer out-of-pocket costs that are similar to a platinum plan alongside a silver-level premium, thereby producing lower expected total costs. This clear-cut choice is not always true for the 200 to 300% FPL population, where their less generous enhanced silver plans carry the potential for more out-of-pocket costs than gold and platinum plans.

To see a benefit of cost-sharing reductions, members must reach their deductible or out-of-pocket cap. Only 11% of all individual QHP enrollees reach out-of-pocket caps, and the proportion is lower for those in silver plans. Data from one of the QHP issuers shows that fewer than 2% of VCSR recipients hit their medical out-of-pocket cap. Those with higher medical needs may have lower costs in a gold plan than in an enhanced silver CSR plan. Thus, the traditional encouragement to enroll in silver plans because of the potential for reduced cost-sharing obscures choices for members between 200 to 300% FPL.

2019: Silver loading

Plan selection confusion for the 200 to 300% FPL population is exacerbated by silver loading. As described, silver loading increases silver QHP premiums in order to pay for the federally-mandated CSR benefit. The resulting increase in APTC changes the plan selection landscape by making bronze, gold, and platinum plans much cheaper for subsidized members. As a result, non-silver plans could be a more prudent choice, and result in lower total costs, than VCSR plans for a large segment of eligible members.

Despite this outcome, VCSR was funded and remains in place for 2019 alongside silver loading. DVHA has focused on outreach and education to encourage members to evaluate their plan options and select the best one for their circumstances given the increased premium assistance. The campaign utilized email, phone calls, and postal mail and resulted in 40,000 sessions on the 2019 Plan Comparison Tool by the end of 2018, more than a 60% increase over the previous year. Despite this success in driving customers to comparison shop, over half of VCSR members ultimately stayed in a silver-level plan for 2019. This speaks to a strong bias for the status quo. DVHA, in consultation with the Office of the Health Care Advocate, recommend continued targeted outreach to this population for 2020 enrollment.

2020: Uncertainty

Silver loading is the optimal solution to the problem of federal CSR de-funding and generally beneficial to the marketplace. If silver loading were certain to continue into 2020, AHS would again recommend eliminating the VCSR benefit. To do so would ease budget pressures and, most importantly, simplify choices for Vermonters in the 200 to 300% FPL range.

However, there is a great deal of uncertainty surrounding silver loading. It is expected that the federal government will take action to limit or prohibit the practice in 2020. Although no such guidance has yet been issued, the State must be prepared for that eventuality. Stakeholders are discussing contingency options and monitoring federal guidance closely.

Because of this uncertainty, AHS recommends preserving stability wherever possible and **maintaining VCSR in its current form for 2020.**

VCSR Alternatives

Although AHS recommends maintaining the VCSR benefit in 2020, it has consulted with stakeholders, including the Green Mountain Care Board, Office of the Health Care Advocate, and QHP issuers, and considered alternatives for future plan years as directed.

For 2020 and future plan years, the Health Care Advocate has made a proposal to the Green Mountain Care Board to maximize the actuarial value in on-exchange silver plans. This would result in the maximizing the APTC available in Vermont and could serve to reduce out-of-pocket costs for VCSR members and other subsidized enrollees.

In considering other alternatives for future plan years, AHS recommends considering QHP enrollment more broadly and not focusing exclusively on the 200 to 300% FPL population. Further subsidies for this population would only steepen one of Vermont's benefit "cliffs" (the limit of eligibility for both VCSR and Vermont Premium

Assistance⁶). There are other pressure points in the marketplace that could more significantly alleviate costs for Vermonters. In particular, it may make sense to focus on age or the premium assistance benefit cliff in structuring a new state program. AHS also looked at programs with the potential for a market-wide impact.

Reinsurance

AHS and DVHA convened a study group during summer 2018 to consider reinsurance as an option for the Vermont marketplace. Reinsurance is a mechanism to reduce health insurance premium increases by reimbursing health insurance issuers for certain high-cost claims. Some states have used the ACA's section 1332 waiver program to receive federal funding to establish a state-based reinsurance program. The study group found that a reinsurance program would require a significant state investment, but it may be a useful option, especially on a temporary basis as individual and small group marketplace premiums become less stable due to federal changes.

A detailed analysis of reinsurance options including example budgets can be found on DVHA's [exchange informational site](#).⁷

Targeted Reforms

In exploring more targeted reforms or new state programs, AHS recommends analysis and focus on certain populations within the individual and small group market. This can be informed by both the most recent Vermont Household Health Insurance Survey and trends in net premiums (i.e. what Vermonters have paid over the last six years).

Two ideas include:

- **The benefit cliff population:** those at or beyond 400% FPL. 400% FPL is the highest limit of eligibility for any health care subsidy. Because of the way the programs are structured, people who receive subsidies are shielded from premium increases. The appendix of this report illustrates how subsidized members actually pay slightly less for health insurance in 2018 compared to 2014. On the other hand, Vermonters with incomes over 400% FPL are not protected from premium increases and may pay more than twice as much as a household earning a few dollars less. Customers who are at the cusp and choose not to enroll in QHPs through the exchange also forfeit their ability to claim the premium tax credit when they file their taxes.⁸
- **The young adult population:** ages 26-35. Because of Vermont's pure community rating structure, young adults pay the premium equivalent of what a 52-year-old

⁶ 33 VSA 1812(a)

⁷ <https://info.healthconnect.vermont.gov/sites/hcexchange/files/VT%20Reinsurance%20Report%209%2028%202018%20with%20Appendices.pdf>

⁸ See 26 CFR 1.36B-2(a)(1)

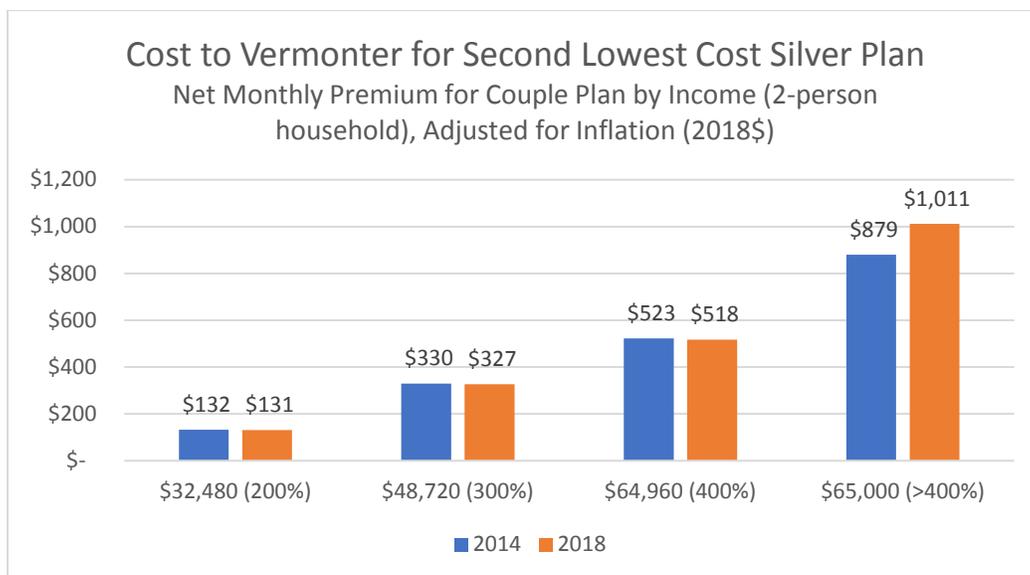
would pay if the State allowed age bands. Nearly all other states allow age bands. Not surprisingly, the ratio of uninsured young adults to uninsured older adults is higher in Vermont than in other states.

Conclusion

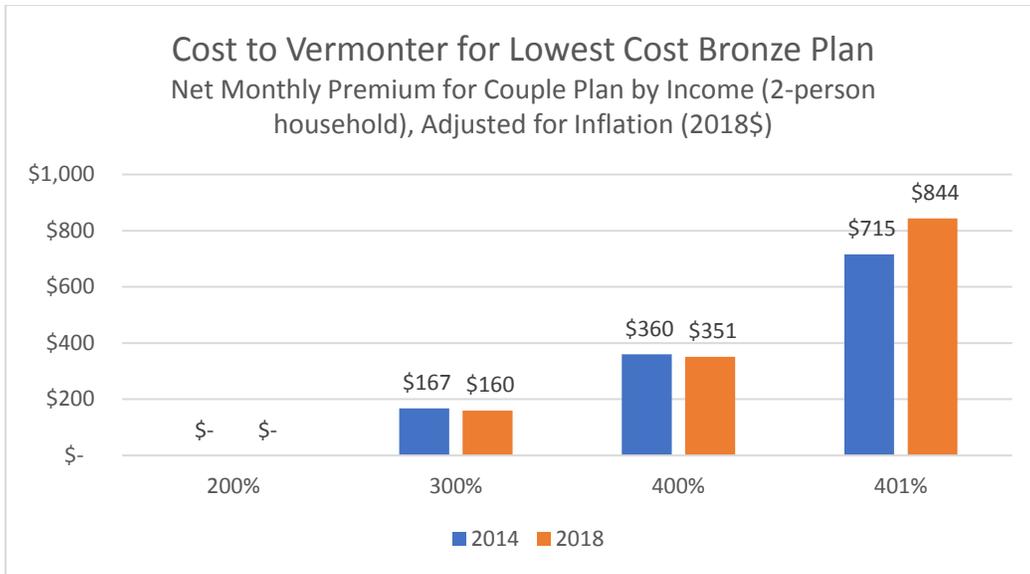
AHS has analyzed Vermont cost-sharing assistance in light of federal changes and strongly recommends that VCSR remain in place through 2020. If silver loading were certain to continue, AHS would recommend eliminating the VCSR benefit. In exploring future alternatives to VCSR, consideration should be given to the market as a whole as well as specific populations within the individual and small group market. AHS notes that changes cannot be made to subsidy programs in the middle of a plan year and any future proposals must be implemented on a plan year (calendar year) basis.

Appendix

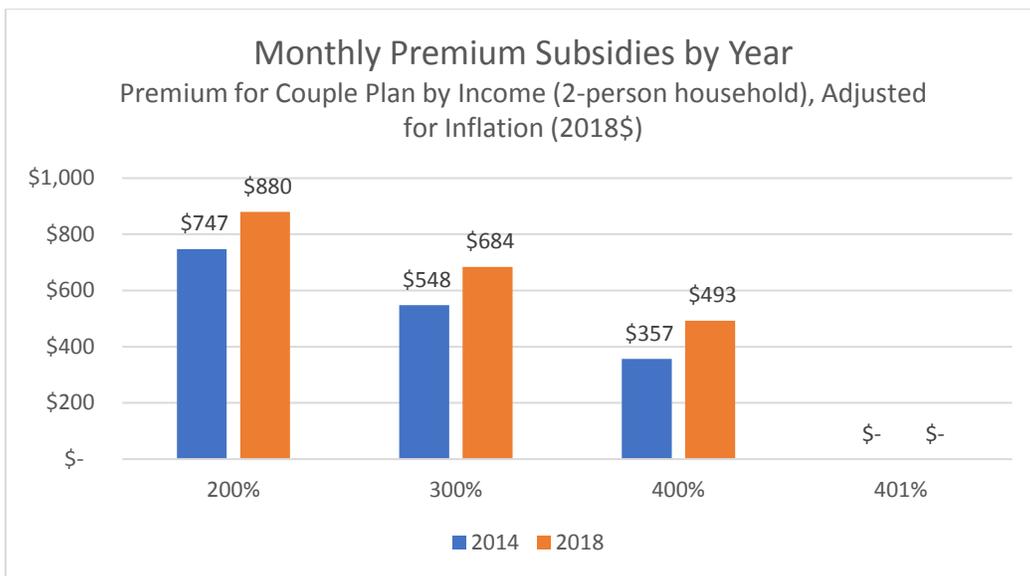
The subsidy programs under the Affordable Care Act have succeeded in shielding low- and middle-income Vermonters from health insurance premium increases. Vermonters up to 400% of the federal poverty level (in 2019, roughly \$66,000 for a couple and \$100,000 for a family of four) could actually enroll in a health plan for slightly less in 2018 than they could in 2014. Vermonters with incomes over these thresholds are not protected from premium increases. This phenomenon means that the benefit cliff continues to grow, leaving a Vermont couple just over the subsidy threshold to pay more than twice as much as a couple earning a few dollars less.⁹



⁹ This disparity is exaggerated in 2019 due to silver loading which enables subsidized Vermonters to pay less than ever before.



Subsidized Vermonters have been protected because subsidies increase alongside premium increases.



Source: Plan and subsidy costs from Vermont Health Connect. 6.46% cumulative inflation adjustment from <https://www.usinflationcalculator.com/>