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AGENCY OF HUMAN SERVICES

Report on Health Insurance Affordability and Merged Markets

Senate Committee on Finance

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Agenda

- Act 63 of 2019: Review Statutory Charge

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- Vermont Insurance Marketplace Highlights
- Marketplace Configuration Analysis
- Policy Options for Addressing Affordability

Section 2: Strategies for Making Health Insurance More Affordable

- Maximum Amount of Income for Health Insurance Premiums
- Investing Savings from Maximum Allowable Co-payments
- Establishing a Regional, Publicly Financed, Universal Health Care Program

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Act 63 of 2019

Requires the Agency of Human Services (AHS) to:

- Evaluate the impact on health insurance premiums from fully separating the merged individual and small group markets;

- Develop a strategy for making health insurance more affordable for all Vermont residents, including younger Vermonters and Vermonters who are not eligible for financial assistance including consideration of:
  - The maximum amount of income that should be required for health insurance premiums and how to link the cost of health insurance to income so that no one pays more than the maximum identified
  - Requiring individuals between 100-138% of FPL enrolled in the Medicaid program to pay the maximum co-payments under federal law
  - The potential for establishing a regional, publicly financed, universal health care program in cooperation with other states

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Section I:
Wakely Consulting Group
Actuarial Analysis

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Wakely Consulting: Vermont Insurance Marketplace Highlights (1 of 2)

Vermont has one of the lowest uninsured rates (3%) in the country

The most common characteristics of the remaining uninsured are:

- Younger individuals (ages 25 to 44)
- Poorer individuals and families (below 250% of the Federal Poverty Level, or FPL)
- Individuals and families that do not qualify for subsidies (above 400% FPL)

Vermont has a merged Affordable Care Act market

- A single risk pool exists for both the individual and small group markets
- Applicable market reform rules (i.e. guaranteed availability) are merged
- Vermont is the only state to have a fully merged market

Vermont is one of only two states to have no age rating (i.e. community rating)

- No age rating means that an individual's premium is the same regardless of age
- Vermont has an average age in the individual market that is higher than the national average
- Factors that influence the average age in the individual market that are unique to Vermont include:
  - Higher average age of population
  - Community rating results in higher premiums for younger adults
  - Children's Health Insurance Program (CHIP) eligibility rules that cover children at higher income levels relative to the national average

Vermont Insurance Marketplace Highlights (2 of 2)

Roughly half of Vermont's individual market enrollees are aged 50 and above, where the premiums are most competitive compared to other states.

2019 Premiums On-Exchange by Selected Age and State

State, Major City	Lowest Cost Bronze Before Tax Credit			2nd Lowest Cost Silver Before Tax Credit			Lowest Cost Gold Before Tax Credit		
	21 Year Old	40 Year Old	60 Year Old	21 Year Old	40 Year Old	60 Year Old	21 Year Old	40 Year Old	60 Year Old
Maine, Portland	$262	$335	$711	$379	$485	$1,030	$455	$582	$1,236
Massachusetts, Boston	$213	$251	$426	$273	$321	$545	$284	$334	$567
New York, New York	$421	$421	$421	$587	$587	$587	$697	$697	$697
New Hampshire, Manchester	$237	$303	$643	$315	$402	$854	$347	$444	$943
Vermont, Burlington	$426	$426	$426	$622	$622	$622	$584	$584	$584

Data from https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/ and Federal or state age factors applied as appropriate. Provided by Wakely Consulting Actuarial Analysis to Satisfy Act 63.

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Marketplace Configuration Analysis

FULLY MERGED

- Guaranteed issue, rate setting, and risk adjustment occur across both markets (individual and small group)
- Premiums are the same in both markets
- Has advantages in terms of stability--reduces options in regards to policy flexibility:
  - Since the markets are joined, it is harder to create policy solutions targeted to either market.
  - Issuers have a harder time of targeting products to segments of the population.
  - Policies designed to reduce premiums for unsubsidized enrollees in the individual market, i.e. reinsurance, have a harder time targeting only the individual market—It would take greater funding to decrease premiums for the unsubsidized individual market since the impact of reinsurance would need to be spread across both markets.

FULLY UNMERGED

- In a fully unmerged market, guaranteed issue, rate setting, and risk adjustment occur within each market (individual and small group) separately
- Products can be developed specifically for one market

Estimated 2021 Impact of Fully Unmerging the Markets

Market	Average Members	Impact of Separate Risk Adjustment	Premium Adjustment to even out Experience in the Markets	Premium Impact by Market
Individual	33,040	4.3%	2.5%	7.0%
Small Group	40,358	-3.6%	-2.3%	-5.8%

These are not absolute premium changes for 2021, but rather the change in premiums <u>solely attributed to unmerging the markets</u>

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Partially Unmerged Market

- In a partially unmerged market, rate setting and risk adjustment generally occurs across markets but issuers can create plans targeted to each market
- Partially unmerging the market achieves the goal of increasing policy flexibility, including increasing the potential for Federal pass-through dollars
- Under ACA requirements, a partially unmerged market is technically considered unmerged but CMS can allow risk adjustment to occur across individual and small groups (i.e., merged)
- A partially unmerged market is more operationally complex due to the additional federal approvals required to allow risk adjustment across the unmerged individual and small group markets
- There is no premium impact in a partially unmerged market, unless other policies are implemented

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Additional Policy Options Explored

- Reinsurance
- Premium Subsidies
- Reference-Based Pricing Plan
- Implementing Age Rating

State-Based Reinsurance Program

A claims-based reinsurance program is a program in which the state reimburses a portion of high cost-claims in the market, thereby reducing premiums

- The reinsurance program that was modeled includes a successful 1332 waiver which would allow CMS to provide Federal pass-through funds to assist with the cost of the state reinsurance program
- Between $10.2 and $19.5 million in state funds are required to arrive at a 10% premium impact
- More funds are required in an unmerged scenario than in a partially unmerged market

Additional Premium Subsidies

Premium subsidies in addition to the Federal Advance Premium Tax Credits provide premium assistance to a subset of enrollees

- The impact of a premium subsidy program would be similar in a fully merged or partially unmerged market structure
- To achieve a 10% premium reduction for only those between 400% and 500% FPL approximately $2.2 million in funding would be necessary. To impact all persons over 400% FPL, approximately $9.3 million in funding would be necessary
- Premium subsidy programs address premium affordability, but do not lower the overall claims costs at the single risk pool level
- Considerable operational complexity would be involved for the State to administer such a program

Reference-Based Pricing Plan

A reference-based pricing plan is a plan whose provider reimbursements are set by the state, with the policy goal of having lower reimbursement rates than the current market, which in turn would lower premiums for the specific plan

- Would require a partially unmerged or unmerged market structure in order to target the specific plan to the individual market and reduce impact on providers

- A 10% relative reduction in premiums would require a 20% decrease in facility reimbursements

Caution:

- Vermont facilities are operating below or near margin at current provider rates, facility rate reductions could further diminish financial strength

- The state would incur operational costs to operate, contract, or provide oversight on the reference-based pricing plans

Implementing Age Rating

- Most states follow the Federal standard age factors, which sets a 3:1 age ratio limit for premiums. Age rating could be set at something less (e.g. 2:1)

- Wakely developed age rating rules that would result in a 10% relative premium reduction for the youngest adult age group (21-24 year olds)—resulting in age rating rules with a 1.2-1.0 ratio
  - Age factors could be phased in over time to limit the impact from occurring all at once

Relative Impact on Premiums for a 1.2:1.0 Age Factors

Age Group	Estimated 2021 Market Distribution (Adults Only)	Relative Premium Impact
21-24	6.3%	-10.0%
25-29	8.4%	-8.0%
30-34	8.4%	-6.0%
35-39	8.3%	-4.0%
40-44	8.5%	-1.9%
45-49	10.4%	0.2%
50-54	12.5%	2.4%
55-59	15.5%	4.7%
60-64	18.6%	6.9%
65+	3.1%	9.3%

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Section II:

Strategies for Making Health Insurance More Affordable

Standards for affordable % of income for health insurance premiums vary by purpose

- Multiple standards are used to define health insurance affordability
- Definitions vary by purpose (e.g. establishing subsidies or imposing penalties)
- Relative consensus exists across state and federal requirements
  - For individuals earning up to 400% FPL, no more than 9.86% of income is reasonable to spend on health insurance premiums
  - A penalty for lack of health insurance would be unreasonable if health insurance costs exceeded 8.24% of income
  - Very few states have examined an affordability standard for persons over 400% FPL
    - In MA, no more than 8% of income (for tax penalty purposes)
    - In CA, up to 18% of income for persons at 600% FPL (for tax subsidy purposes)

Investing Savings from Maximum Allowable Co-Payments

- Increasing certain co-payment amounts may be allowable under federal regulations, but there are significant operational barriers to doing so that would likely eclipse any savings. Barriers include:
  - issuing new administrative rules,
  - seeking federal approval to amend the Medicaid State Plan,
  - and updating provider materials

- Cost-sharing is currently imposed across non-exempt membership and not by income level

Regional, Publicly Financed, Universal Health Care Program

Opportunities

- Efficiencies of scale
- Increased competition, if commercial payers have a role
- Large risk pool
- Increased bargaining power

Challenges

- Reduces individual state flexibility
- Integrating risk pools creates winners and losers
- Added administrative complexity
- Changes to state laws and state marketplaces would be required—myriad marketplace configurations exist
- Subject to different state regulations and appropriations
- No state Medicaid program is the same
- Could introduce larger national carriers and impact local carriers

Standards for affordable % of income for health insurance premiums vary by purpose (2 of 2)

Purpose	Federal/State	Standard
Tax subsidies	Federal	For individuals earning between 100-400% FPL, required contribution is on a sliding scale between 2.06% and 9.78%
Tax subsidies	CA	• For individuals earning between 100-400% FPL, required contribution is on a sliding scale between 0% and 9.68%. • For earners between 400-450% FPL, contribution is on a sliding scale between 9.68 and 14% • For earners between 450-500% FPL, contribution is on a sliding scale between 14 and 16% • For earners between 500-600% FPL, contribution is on a sliding scale between 16 and 18%
Employer penalty	Federal	Employee's contribution for self-only coverage does not exceed 9.78% of projected household income
Exemption from individual mandate tax penalty	Federal	Exemption provided to individuals who must pay more than 8.24% of their household income towards health insurance (as of 2020)
Exemption from individual mandate tax penalty	DC, MA, NJ, CA, RI	Exemption requirements vary by state. Individuals who must pay more than the following percentage of their household income towards health insurance are exempt: sliding scale between 0 and 8% (MA), 8.05% (NJ), 8.24% (CA), 9.86% (RI)
Cost-sharing	Federal	Maximum annual limitation on cost sharing for self-only coverage and other than self-only coverage is $8,150 and $16,300. Amounts are reduced for individuals/families at or below 250% FPL