# Health insurance affordability in the individual market

JCHC Affordability Workgroup

August 18, 2021

# Agenda

- Staff update on other state strategies
- Staff update on strategies to be modeled as part of the study
- Overview of Urban Institute Health Insurance Policy Simulation Model (HIPSM)

# States can address affordability in many different ways

- Statutory and regulatory changes
- Subsidies for premiums and/or cost sharing
- Adoption of the Basic Health Program
- Adoption of a public option

# Many states address affordability through statutory/regulatory changes

| Topics | What is being done | Who's doing it |
|---|---|---|
| Age calculation | Change age-curve ratios from 3:1 | Examples: AL, MA, MS, NJ (8 states) |
| Tobacco calculation | Eliminate smoking surcharge | Examples: DC, NJ, RI (7 states) |
| Stop loss & Reinsurance | Establish state-based programs | Examples: AK, CO, DE (15 states) |
| State coverage mandate | Requirement with penalties | CA, DC, MA, NJ, RI |
| Plan competition | Implement public option | WA (2021); CO (2023); NV (2026) |
| Plan availability | Require standardized plans | Examples: CA, CT, NY, OR, WA, VT |
| Size of household calculation | Apply different calculation for number being covered | NY and VT |

# Some states are offering premium and cost sharing subsidies

| State | Eligibility | State funds | Enrollment | Avg. cost/enrollee |
|---|---|---|---|---|
| California (premium, 2019) | 100% - 600% FPL | $430,000,000 | 625,000 | $688 |
| Massachusetts (premium and cost sharing, 2006) | Up to 300% FPL | $178,883,000 | 298,000 | $600 |
| Minnesota (premium, only in 2017) | 138% - 200% FPL | $137,300,000 | 117,985 | $1,164 |
| New Jersey (premium, 2021) | Up to 400% FPL | $125,000,000 | 197,000 | $634 |
| Vermont (premium and cost sharing, 2015) | Up to 300% FPL | $6,902,994 | 16,237 | $425 |

FPL = federal poverty level
NOTE: Massachusetts subsidies only apply to silver plans. Vermont CSR subsidies for silver plans only.

# Two states adopted the Basic Health Program

- Program under the ACA that covers individuals between 138% ($17,774) and 200% ($25,760) of FPL
  - Federal government funds 95% of what it would have spent on premium assistance tax credits and cost sharing
  - “Trust Fund” is required for benefit related expenses
  - Administrative costs are state responsibility
- NY and MN transitioned state funded programs to a Basic Health Program in 2015, saving state funds

NOTE: Lawfully present immigrants under 138% of poverty but not yet eligible for Medicaid are also eligible for a BHP.

# State profiles of the Basic Health Program

| New York Essential Health Program<br>~800,000 enrollees in 2020 | MinnesotaCare Health Program<br>~90,000 enrollees in 2020 |
|---|---|
| • No premiums beginning in 2021<br>• $0 deductibles and very low co-pays<br>• Enrollment primarily through exchange<br>• Federal funds cover 98% of $4 billion cost<br>• State cost is 1.9% ($80 million) | • Premiums on a sliding scale based on income - anywhere from $16/month to $80/month<br>• Co-pays for office visits and certain services (e.g. inpatient hospital, emergency room visit, etc.)<br>• Enrollment through exchange or by application<br>• Federal funds cover 87% of $453 million cost<br>• Enrollee premiums and cost sharing is 6.8% of cost ($31 million)<br>• State cost is 5.7% ($26 million) paid for with a 1.8% gross revenue provider tax |

# WA, CO, and NV created public options, only one is operational

- WA “Cascade Select” contracted with five insurers
  - At least one carrier with a public option available in 19 of 39 counties
  - Aggregate provider reimbursements limited to 160% of Medicare
  - Premiums were higher than originally estimated on average
    - Range was -2% to +24% for each carrier
  - Average deductibles were $1,000 lower than other plans
  - 1,872 enrollees (<1% of total individual market enrollment)
- Network development was a challenge
  - Hospitals accepting Medicaid/public employer plan must accept Cascade Select in 2022

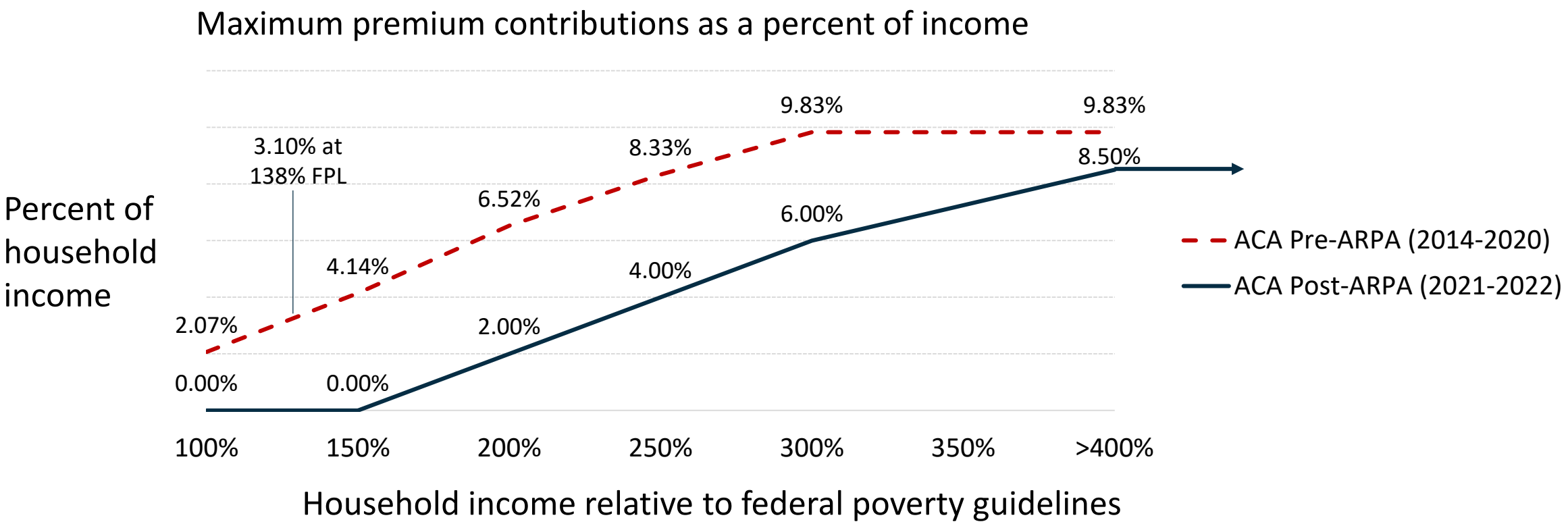
NOTE: CO public option goes into effect in 2023. NV public option goes into effect in 2026.

# Different strategies address different aspects of affordability

- Make coverage more affordable – premium assistance
- Make access to services more affordable – cost sharing
- Reduce the number of uninsured
  - 11.2% of Virginians ages 19 to 64 years of age had no health insurance (559,000 non-elderly adult Virginians)
  - Most uninsured Virginians were part of working families (82%); more than half (54%) with at least one full time worker

SOURCE: Virginia Health Care Foundation, *Profile of Virginia's Uninsured*, 2019.

# Changes in ARPA temporarily address premium assistance

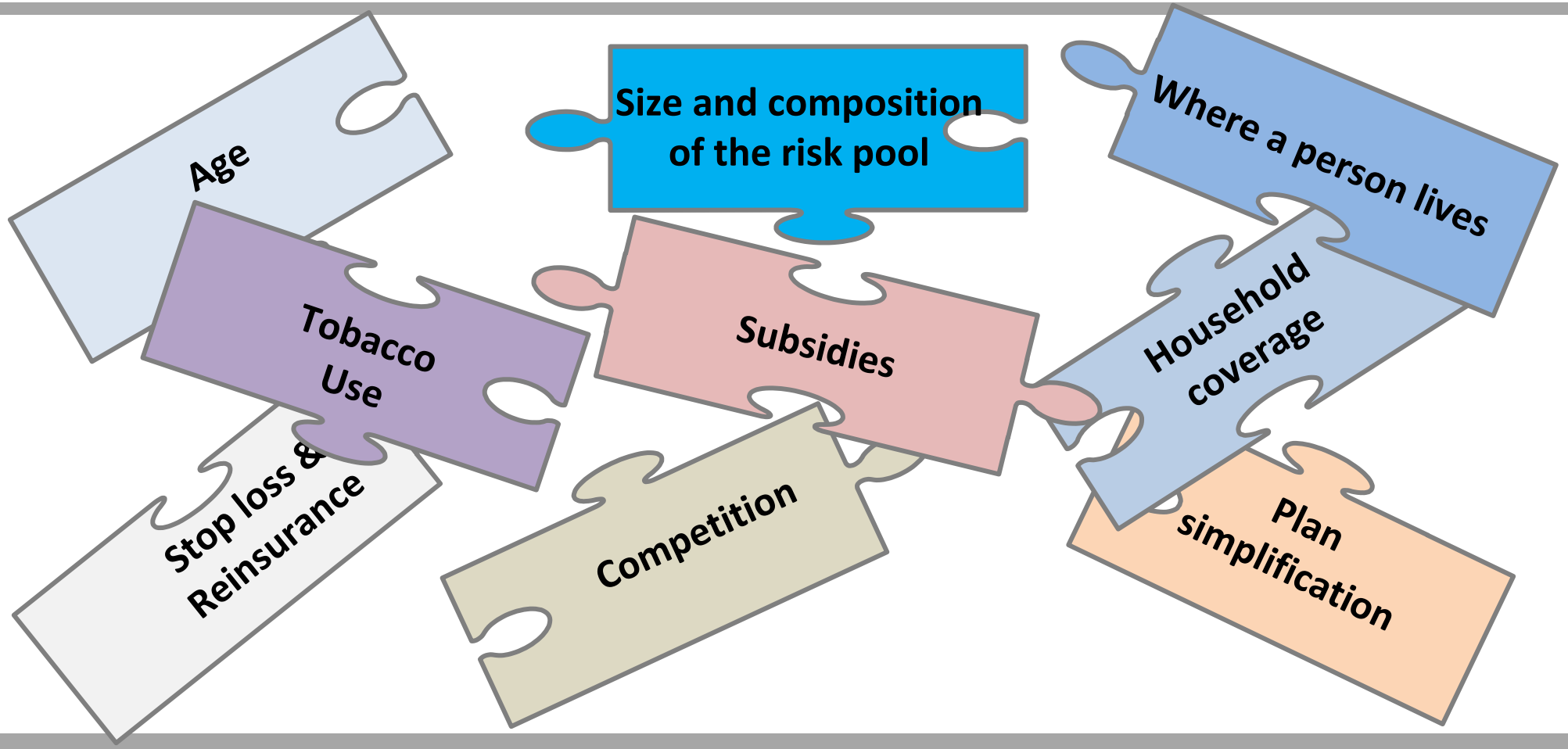



NOTE: 138% is the Medicaid expansion threshold.

# Defining “who” to help determines the most appropriate strategy

- Statutory and regulatory changes can reduce premiums for smokers, older enrollees, and families
- Premium subsidies and/or cost sharing reductions can be targeted to any income level
- A public option can create competition and provide the framework for a standard plan

# Assessing different options requires analyzing many interconnected pieces



# Preliminary staff analysis identified several affordability challenges in VA

- Out of pocket costs were not addressed in ARPA
  - Deductibles range from $1,500 to $8,550 depending on the plan selected
  - 87% require the deductible be paid for a specialist office visit before coinsurance begins (2,183 plans offered in VA)
- Competition and plan choice vary widely across the state
  - 53 counties had only one carrier, with 8 plans in each county
  - 80 counties had as many as 5 carriers offering up to 47 plans

SOURCE: 2021 CMS Marketplace Open Enrollment Period Public Use Files.

# Preliminary staff analysis identified several affordability challenges in VA

- Age and family size have a significant impact on premiums
  - Average monthly premium for a 21 year old is $347
  - $941/month for a 60 year old
  - $1,317/month for a 30 year old couple with 2 children
- Smoking surcharge added after tax credits are calculated, increasing premiums for some low-income individuals
  - For some plans, surcharge could result in a $565/month premium, even if tax credits result in a "$0 premium"

SOURCE: 2021 CMS Marketplace Open Enrollment Period Public Use Files.
NOTE: Example of smoking surcharge is based on the average premium for a 60 year old couple with a 30% smoking surcharge.

# Contract with Urban Institute to analyze the impact of five strategies

| Strategy | Affordability goal |
|---|---|
| State funded cost sharing program | Improve access to health care services for enrollees by making cost sharing more affordable |
| Public option | Improve competition in the marketplace with standardized and affordable health plans |
| Health insurance coverage mandate | Increase enrollment in the marketplace, reduce the number of uninsured, and improve access to health care |
| Adjust age rating curve | Make coverage more affordable for people in the higher age ranges |
| Eliminate smoking surcharge | Make coverage more affordable and improve access to health care |

# Staff are working to define the parameters of each strategy

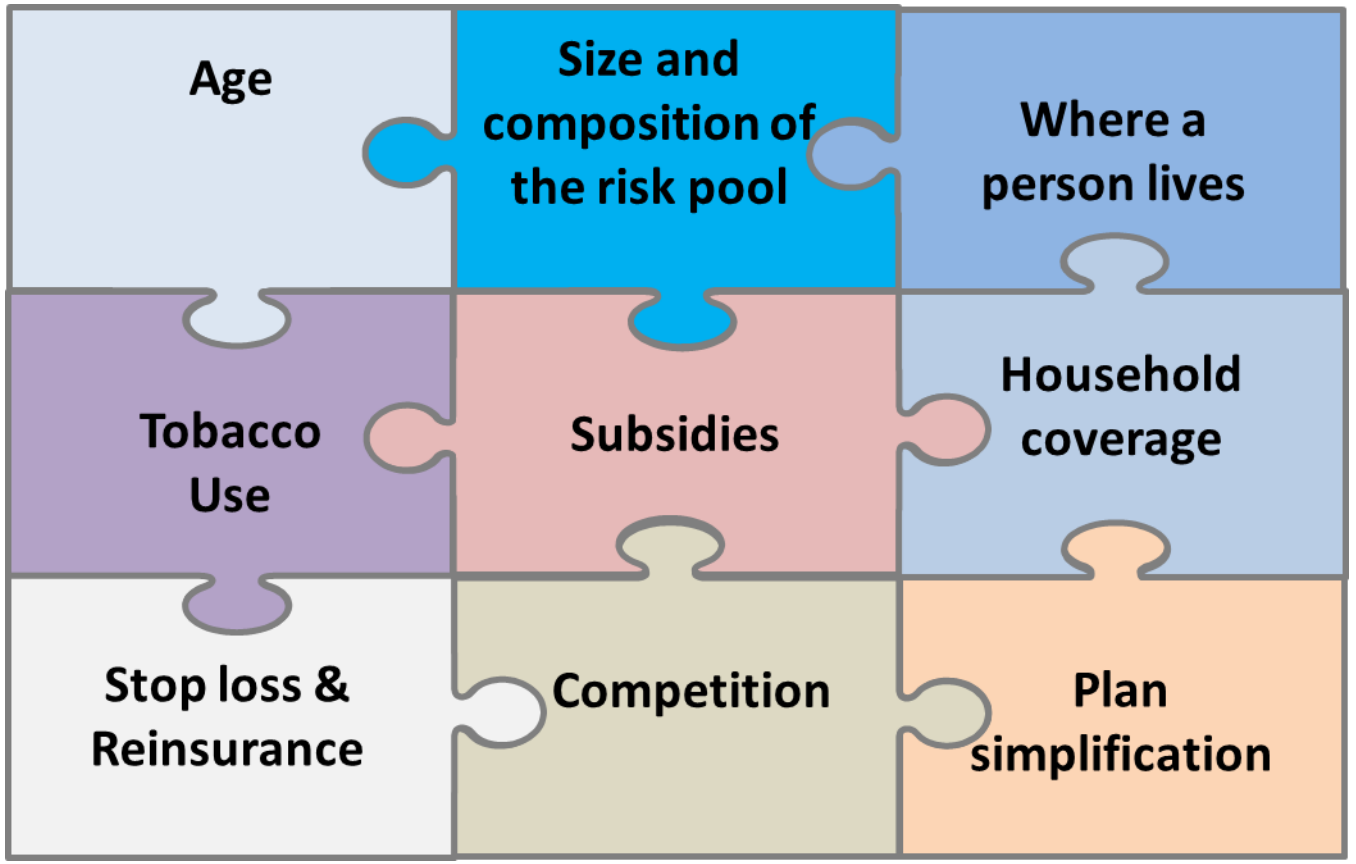
| Strategy | Key questions and considerations |
|---|---|
| State funded cost sharing program | • Special account or debit card?<br>• Can these dollars be pre-federal tax?<br>• Variable amounts based on income or family size and age?<br>• FSA regulations concerning over-the-counter medicine?<br>• What happens to unspent funds? |
| Public option | • Benefits include VA mandated benefits and EHB<br>• Provider reimbursement rates competitively negotiated, or based on percentage of Medicaid rates |
| Health insurance coverage mandate | • What should the penalty be?<br>• Who should be exempt from the mandate? |
| Adjust age rating curve | • Narrowing maximum ratio from 3:I to 2:I (Massachusetts example) |
| Eliminate smoking surcharge | |

# HIPSM will assess the impacts and tradeoffs of each strategy

- The model will assess the impacts on:
  - Individual market premiums and cost sharing
  - Individual market enrollment and the number of uninsured
  - Total spending on health care
  - State spending on health care
- Model will assess how the impacts differ by population

# States are addressing multiple pieces of the puzzle at the same time

- States studying health insurance affordability are enhancing or replacing some programs that were originally part of the ACA
- Example: the NJ coverage mandate includes a subsidy program



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