JOINT COMMISSION ON HEALTH CARE

HEALTH INSURANCE AFFORDABILITY IN THE INDIVIDUAL MARKET

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #652

COMMONWEALTH OF VIRGINIA
RICHMOND
2021

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Health Insurance Affordability in the Individual Market

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Health Insurance Affordability in the Individual Market

Key terms and definitions

Actuarial value (AV) – The estimated percentage of health care costs for covered benefits that are paid for by an insurance plan using plan premiums, versus out-of-pocket costs paid for by the plan's enrollees. The higher the actuarial value, the lower the out-of-pocket costs are.

Advance premium tax credit (APTC) – Federal tax credit provided to consumers monthly or taken as a tax deduction when filing taxes to offset premiums. APTCs are calculated based on the estimated household income, the maximum percentage of that income that can be applied to premiums, and the premium of the second lowest cost silver plan in the consumer's area. APTCs can be applied to any insurance plan on an exchange, except catastrophic plans.

Affordable Care Act (ACA) – Federal legislation passed in 2010 that restructured the individual and small group health insurance markets. Also established criteria for Medicaid expansion.

Cost sharing reductions (CSRs) – Silver plans with lower out-of-pocket costs for individuals at or below 250% of FPL. These are factored into the premium calculations for silver plans, and they are only available to eligible individuals who purchase silver plans.

Federal Poverty Level (FPL) – Established each year by the federal government with the poverty levels varying by household size. In 2021, 100% of FPL for an individual was $12,880.

Marketplace exchange – A web-based system where people apply for health insurance coverage. These can be operated by states or the federal government, and the system helps determines eligibility for APTCs, CSRs, and Medicaid.

Medicaid Expansion – Applies to idnividuals ages 19 through 64 with household income up to 138% of the federal poverty level

Metal tiers – Health insurance plans sold on the exchange are categorized into metal tiers based on their actuarial value.

Bronze:	60% AV
Silver:	70% AV
Gold:	80% AV
Platinum:	90% AV

Health Insurance Affordability in the Individual Market

POLICY OPTIONS IN BRIEF

There are 7 policy options in the report for Member consideration. Below are highlighted options.

Option: Direct the state-based exchange to develop a budget for enhanced marketing and navigator services (Option 1, page 20).

Option: Prohibit the use of a tobacco surcharge when setting premiums (Option 2, page 24).

Option: Establish state-specific individual mandate penalty (Option 3, page 25).

Option: Implement a state-funded cost sharing program through either an FSA-style debit card or by enhancing federal cost-sharing reductions (Options 4-5, pages 27, 28).

Option: Establish a public option insurance plan to be sold in all localities, with provider reimbursement rates set below current individual market rates (Options 6-7, pages 31, 32).

FINDINGS IN BRIEF

Younger, healthier individuals left Virginia's market as premiums increased

Adults between 18 and 34 years old accounted for more than half of the reduction in individual market enrollment since 2016 (not including those were newly eligible for Medicaid expansion). Younger individuals tend to have lower health care costs, so this left a less healthy, higher cost group of Virginians, which further increased premiums. Additionally, more than half of uninsured individuals in this age group indicate they are unaware of individual market coverage options and federal financial assistance that is available to reduce their costs.

Improved marketing and navigation could bring more healthy people into the market and assist with plan choice

Virginia has an opportunity to significantly improve its marketing, outreach, and navigator assistance when it transitions to a state-based exchange in 2023. Federal funding reductions in recent years for marketing and navigators limited Virginia's ability to promote coverage options and help individuals select the best plan based on their circumstances.

There are multiple state policy options to improve affordability but impacts are moderate compared to federal subsidies

State policy options to improve affordability can reduce premiums and out of pocket costs to attract more Virginians into the individual market. However, the impact of these options is estimated to be moderate compared to the federal decision on whether to extend the current enhanced premium subsidies that are scheduled to expire after 2022. Implementing a state-funded cost sharing reduction program is estimated to reduce the number of uninsured in Virginia the most, if enhanced federal subsidies expire. Prohibiting the use a tobacco surcharge is estimated to have the second largest reduction in the number of uninsured. Both options would have a smaller impact if enhanced subsidies are extended.

Health Insurance Affordability in the Individual Market

The purpose of this study is to examine Virginia's individual health insurance marketplace with a goal of making the marketplace stable, more affordable for those covered, and more accessible for those who are not covered (see Appendix 6 for the study resolution). Specifically, the study resolution directs JCHC staff to:

- review policy options being implemented in other states directed at stabilizing the individual marketplace;
- identify options that may make health coverage more affordable and available to individuals regardless of income;
- assess the methods of achieving stability and affordability to maximize any federal funds that may be available to offset any increased costs; and
- determine, where possible, the impact of each option on the state, insurers, providers and consumers, including any unintended consequences.

Policy changes in recent years impacted premiums, cost sharing, and enrollment in Virginia's individual market

Changes at the state and federal level impacted premiums and enrollment in Virginia's individual marketplace between 2016 and 2021. The changes included:

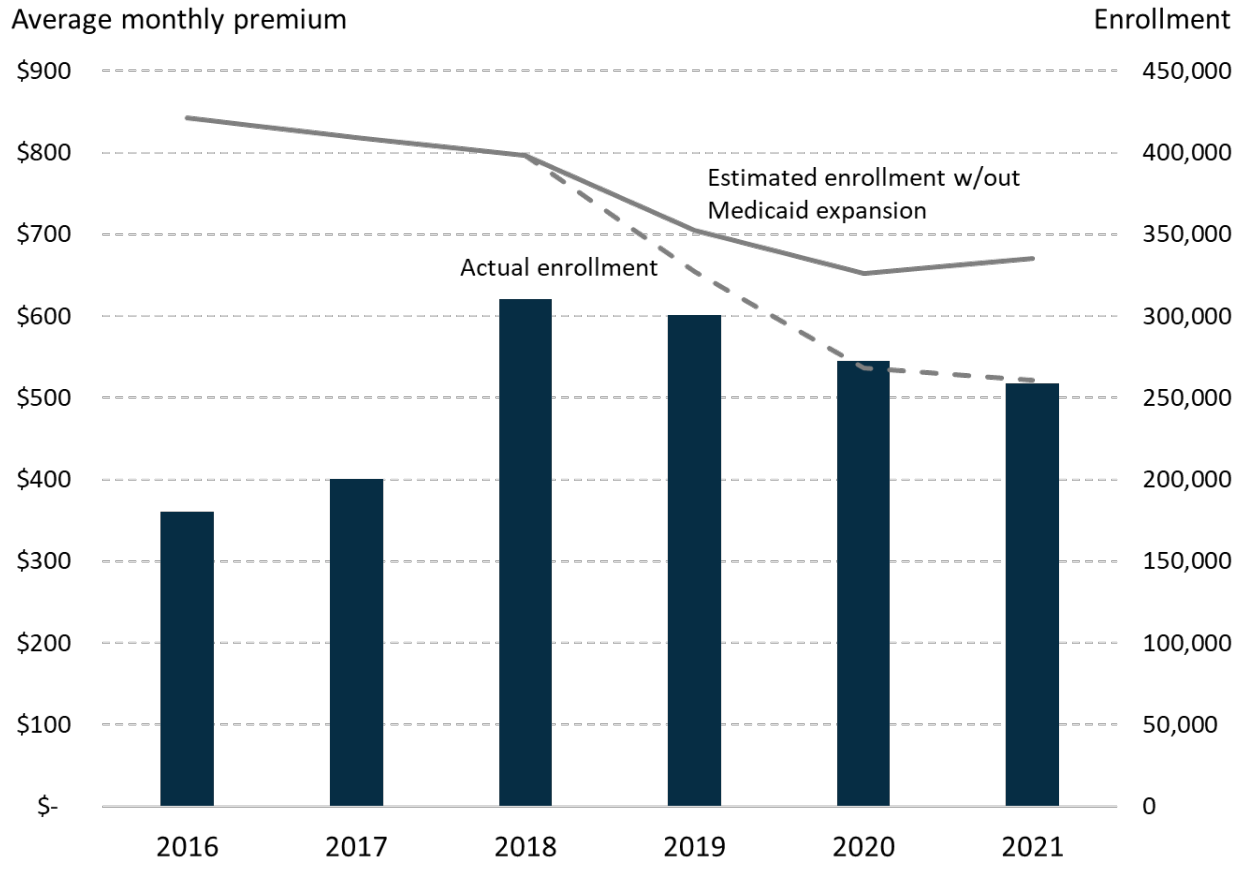
- elimination of federal funding for cost-sharing reductions (CSRs) for people under 250% of the federal poverty level (2017/2018);
- Medicaid expansion in Virginia for people ages 19 through 64 (effective 2019);
- elimination of the federal individual coverage mandate penalty (2017, effective 2019); and
- implementation of enhanced advance premium tax credits (APTCs) under the American Rescue Plan Act (ARPA, 2021).

Virginia's Medicaid expansion allowed adults with incomes at or below 138% of the federal poverty level to enroll in Medicaid, beginning in 2019. JCHC staff estimate that approximately 100,000 people shifted from the individual marketplace to Medicaid between 2019 and 2020 (Appendix 2). This major shift needs to be accounted for to analyze other changes in the market, such as the number of people leaving the market due to increasing premiums.

Premium increases between 2016 and 2018 caused a drop in enrollment in the individual market

Rising premiums in Virginia between 2016 and 2018 caused a reduction in enrollment that continued through 2021 before the passage of the American Rescue Plan Act (ARPA). Premiums increased by 52% for a bronze level plan and 76.5% for a silver level plan, resulting in a 20.5% drop in enrollment by 2021. During the same period, approximately 100,000 additional people shifted into Medicaid from the individual market (FIGURE 1).

FIGURE 1: Enrollment in the individual market declined in Virginia due to Medicaid expansion and increasing premiums



SOURCE: JCHC staff analysis of data extracted from FFM QHP landscape files and Marketplace Open Enrollment Period Public Use Files.

Premiums increased significantly between 2016 and 2018 due to several factors. First, when the federal government stopped funding CSRs in late 2017, insurers were authorized to incorporate these costs into premiums. The Congressional Budget Office estimated an increase of 20% to 25% in premiums from this change. Insurers rolled the majority of the costs for CSRs into silver plans, because APTCs were calculated based on the second lowest cost silver plan. This became known as "silver loading." Additionally, the elimination of the

federal individual mandate penalty was anticipated to cause insurers to add between 10% and 20% more to their premiums for 2018, based on Congressional Budget Office estimates at the time. According to BOI staff, actual increases varied significantly between plans, and averaged between 3% and 5% in Virginia.

Cost-sharing reductions (CSRs) were originally direct payments to insurance carriers to reduce the out-of-pocket costs of eligible individuals. After the federal funding for these payments stopped, insurers were still required to offer CSR plans with lower out-of-pocket costs, but they increased premiums to cover the cost of the CSRs.

"Silver loading" resulted in many people switching from silver plans to bronze or gold plans, as premiums for silver plans increased more significantly than for bronze or gold plans. Because APTCs are calculated based on the second lowest cost silver plan, the premiums individuals had to pay for a bronze plan became much cheaper for individuals after applying the APTCs. Additionally, gold plans, which have lower out-of-pocket costs, were similar in price to silver plans. Silver plan premiums increased by nearly 60% on average between 2016 and 2021 (TABLE 1). This corresponded with a 41% drop in silver plan enrollment (TABLE 2).

TABLE 1: Silver plan premiums increased more than bronze and gold plans since 2016

Metal level	2016	2017	2018	2019	2020	2021	Percent change
Bronze	$325	$354	$494	$526	$468	$446	37.1% ($121)
Silver	$375	$418	$662	$720	$639	$599	59.5% ($223)
Gold	$477	$550	$853	$709	$650	$596	25.0% ($119)

SOURCE: JCHC staff analysis of data from FFM QHP landscape files.

TABLE 2: Estimated enrollment decreased most significantly in silver plans since 2016, with individuals switching to bronze plans

Metal level	2016	2017	2018	2019	2020	2021	Percent change
Bronze	95,194	86,878	104,211	109,950	117,537	136,746	43.7% (41,552)
Silver	289,626	303,803	271,953	216,941	182,718	170,842	−41.0% (−118,784)
Gold	27,732	11,159	15,832	19,450	20,819	22,401	−19.2% (−5,331)
Total	412,552	401,840	391,996	346,341	321,074	329,989	−20.0% (82,562)

SOURCE: JCHC staff analysis of data from FFM QHP landscape files.
NOTE: Estimated enrollment calculated by removing individuals who left the individual market due to Medicaid expansion. Totals for all historical enrollment tables may not match due to differences in how the data are reported by CMS across plan types, income levels, and age.

Some who switched to bronze or gold may be forgoing valuable CSRs, choosing plans based on premiums alone and not considering that their health care needs may require more out-of-pocket expenses than expected. An individual making less than 200% of the federal

Actuarial value is the estimated percentage of health care costs for covered benefits that are paid by the insurer using plan premiums, versus out-of-pocket costs paid by the plan's enrollees. The higher the actuarial value, the lower the out-of-pocket costs are.

poverty level might choose a gold plan with an actuarial value of 80%, unaware that they would benefit more from a silver plan with CSRs with an actuarial value of 87%.

Many who left the market were young adults just above Medicaid income threshold and those ineligible for federal tax credits

Many of those who left the health insurance market between 2016 and 2021 had incomes at 150-200% of the federal poverty level (FPL) ($19,320 to $25,760 per year). At this level, individuals may not have had the disposable income to purchase coverage. For example, an individual at 175% of FPL ($1,878 per month) would have paid about $45 a month for an individual policy premium pre-ARPA. In addition, children in families at this poverty level are eligible for Medicaid or CHIP, which can lead their parents to forego coverage for themselves because they do not have to purchase it for their children. Another group that left the market were those with incomes over 400% of FPL (over $51,520 per year). These individuals were not eligible for APTCs prior to the passage of ARPA, so they were required to pay the full cost of premiums and increases (TABLE 3).

TABLE 3: Greatest decline in estimated enrollment was individuals just above Medicaid income limit (150-200% FPL) and those who were ineligible for federal tax credits

Income level (percent of FPL)	2016	2021	Total change	Percent change
≤ 150%	155,117	135,460	(19,657)	−12.7%
> 150% to ≤ 200%	87,790	60,938	(26,852)	−30.6%
> 200% to ≤ 250%	61,592	51,108	(10,484)	−17.0%
> 250% to ≤ 300%	34,199	31,009	(3,190)	−9.3%
> 300% to ≤ 400%	32,951	33,111	160	0.5%
> 400% (ineligible for APTCs)	49,245	33,220	(16,025)	−32.5%
Total	**420,894**	**344,846**	**(76,048)**	**−18.1%**

SOURCE: JCHC staff analysis of Marketplan Open Enrollment Period Public Use Files.
NOTE: Estimated enrollment calculated by removing individuals who left the individual market due to Medicaid expansion. Totals for all historical enrollment tables may not match due to differences in how the data are reported by CMS across plan types, income levels, and age.

Nearly 80% of those who left the market between 2016 and 2018 were young adults between the ages of 18 and 34 (TABLE 4). These younger individuals tend to be healthier and therefore have lower average health care costs. When younger, healthier people leave the market, what remains is a smaller covered population with higher average health care costs. Premiums increase as a result.

TABLE 4: Estimated enrollment declines were most significant among younger, healthier individuals

Age group	2016	2021	Total change	Percent change
< 18	47,443	40,001	(7,442)	−15.7%
18-25	48,980	26,917	(22,063)	−45.0%
26-34	75,885	50,827	(25,058)	−33.0%
35-44	68,044	52,820	(15,224)	−22.4%
45-54	83,023	65,044	(17,979)	−21.7%
55-64	94,379	95,959	1,580	1.7%
65+	2,307	8,450	6,143	266.3%
Grand total	**420,061**	**340,019**	**(80,042)**	**−19.1%**

SOURCE: JCHC staff analysis of Marketplan Open Enrollment Period Public Use Files.
NOTE: Estimated enrollment calculated by removing individuals who left the individual market due to Medicaid expansion. Totals for all historical enrollment tables may not match due to differences in how the data are reported by CMS across plan types, income levels, and age.

Virginia experienced adverse selection and a lack of competition in the individual market

Insurance markets that have competition among insurers and a large risk pool are most likely to keep premiums low. Insurers are forced to compete for enrollees based on the price of their insurance plans (and other factors such as provider network and customer service). A large risk pool, with enough healthy people to offset the high cost of health care for those with chronic conditions, enables insurers to more accurately predict their costs. When these factors are not in place, premiums can increase significantly, and Virginia has experienced this in recent years.

Adverse selection occurs when individuals with greater health care needs purchase or remain in a health insurance plan while healthy people delay or decide not to purchase health insurance until they need it or get sick.

Between 2018 and 2021 some of the most expensive health insurance plans sold in the U.S. within the individual market were in Virginia. Analyses of actuarial reports and publicly available data from the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) suggest that the high premiums for these plans were the result of three circumstances that occurred in Virginia between 2018 and 2021: adverse selection, political uncertainty, and lack of competition.

Adverse selection increases the cost of health insurance for those remaining in the individual market

Adverse selection, which occurs when individuals with low health care costs leave the marketplace, leads to a lopsided distribution of health insurance coverage and can cause a

substantial imbalance in plan premiums that may further discourage healthy people from buying health insurance. Virginia's individual market experienced this over the last five years, with 80% of the reduction in enrollment coming from young adults, who tend to be healthier and have lower health care costs.

CASE STUDY: Adverse selection in one northern Virginia health plan resulted in the highest premiums in the country

An example of adverse selection is occurring in Northern Virginia. While there are many insurers and plans to choose from, there is only one insurer, GHMS, offering a "legacy" PPO plan. Sometimes consumers choose or maintain PPO plans – usually the most expensive type of plan – in order to have access to a choice of providers, to avoid switching plans, or because they are not aware of less costly coverage options. According to actuarial reports, "healthy members" left the GHMS plan in 2018 when premiums increased by 70%, leaving the plan with a higher proportion of members with greater health care needs and attracting new members who also had greater health care needs. Premiums in the legacy PPO plan are now three times as high as other plans in the market due to adverse selection (TABLE 5).

HMO – requires PCP and referral before specialist service

POS - requires PCP and referral before specialist service

EPO – No PCP and typically no referrals required

PPO – no PCP or referral required

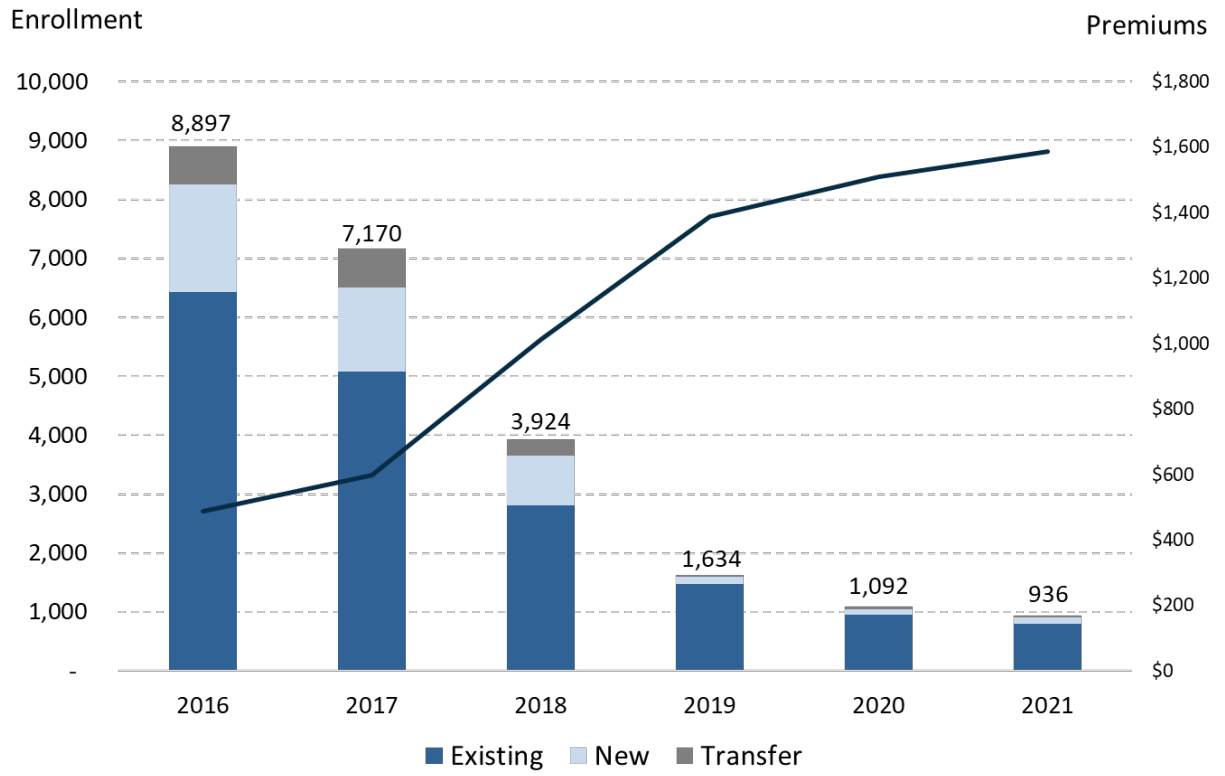
TABLE 5: Premiums in the GHMS plan, the only legacy PPO plan in Northern Virginia, are three times the premiums of other plans

Insurer	Plan type	# of plans	Average Premium
Anthem Healthkeepers	HMO	9	$487.79
CareFirst BlueChoice, Inc.	HMO	3	$549.00
Kaiser Foundation Health Plan - Mid-Atlantic States, Inc.	HMO	11	$564.10
Optimum Choice, Inc.	HMO	7	$535.70
Cigna Health and Life Insurance Company	EPO	9	$505.80
GHMS	PPO	2	$1,587.50

SOURCE: FFM QHP landscape files: Health and dental datasets for researchers and issuers, 2021.

As premiums in the GHMS plan rose between 2016 and 2019, plan enrollment declined by 89.5% (FIGURE 2). Actuarial reports from the company indicate that 87% to 90% of the enrollees in GHMS plans between 2019 and 2021 were existing members.

FIGURE 2: GHMS experienced significant decline in enrollment, leading to significant premium increases

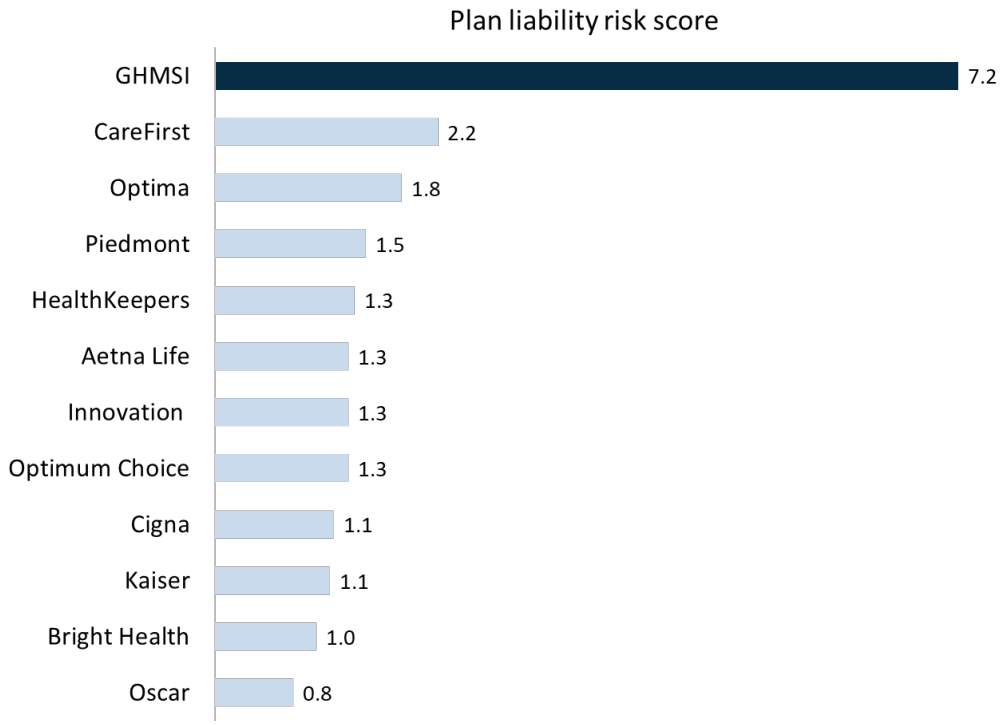


SOURCE: JCHC analysis of Group Hospitalization and Medical Services, Inc. (GHMSI) rate filings and actuarial memorandums, 2016 through 2021.

One measure of how high the health care needs of the GHMS enrollees are compared to enrollees in other plans due to adverse selection is the company's "plan liability risk score." The plan liability risk score is a way to compare the relative health of a plan's enrollees and is part of the premium development process required by the Affordable Care Act (ACA). The mechanism was originally intended to prevent companies from "cherry picking" healthy enrollees and to offset medical spending considered beyond the control of the companies for enrollees with greater health care needs. The ACA's risk adjustment program was designed to be budget neutral, so that insurers with healthier enrollees pay into a fund that compensates insurers with less healthy enrollees.

GHMS's PPO plan liability risk score is 7.2, over three times the next highest risk score in the state. The per enrollee risk adjustment payment to GHMS is $21,856, which is 7.3 times greater than the next highest per enrollee risk adjustment payment in the state. And even with the risk adjustment payments, premiums for the GHMS PPO plan remain the highest in the country (FIGURE 3).

FIGURE 3: GHMS had a risk score three times greater than the next highest in the state, due to adverse selection



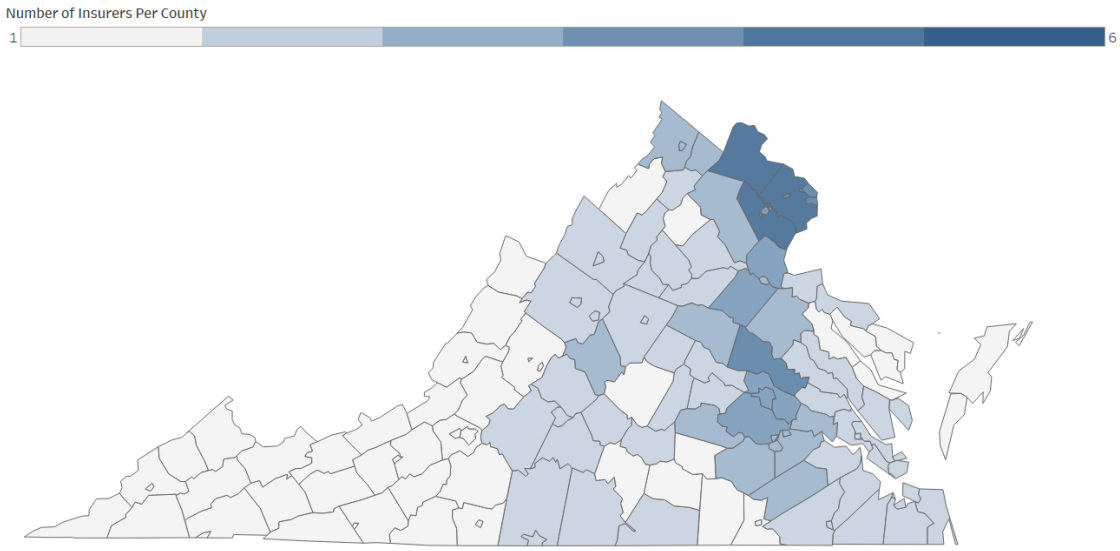
SOURCE: Individual market risk adjustment calculation from Virginia rate filing data, Virginia State Corporation Commission, Bureau of Insurance.

This case study illustrates the problem of adverse selection, which Virginia's individual market has experienced statewide. A shrinking enrollment, coupled with high allowable medical claims, leads to higher and higher premiums. Existing enrollees in the plan are paying the highest premiums in the country, while healthy consumers avoid the plan, and other insurers in the state are offsetting the costs of GHMS plan operations through the risk adjustment payments. It should also be noted that if Virginia adopts a reinsurance program, GHMS would most likely be the biggest beneficiaries of the program due to their high cost claims.

Lack of competition among insurers often leads to higher prices

There were nine insurers offering plans in Virginia in 2021; nevertheless, in 53 Virginia counties, there was no competition – individuals had access to only one insurer (FIGURE 4). Research literature consistently finds that a lack of competition leads to higher premiums, because insurers are not forced to compete for customers based on price.

FIGURE 4: 53 counties in Virginia had only one insurer offering plans in 2021



Source: JCHC analysis of FFM QHP landscape files: Health and dental datasets for researchers and issuers, 2021.

CASE STUDY: Political uncertainty, insurance companies withdrawing from the exchange, led to the highest premiums in the country in Charlottesville, VA (2018)

The Charlottesville area in 2018 offers an extreme example of how a lack of competition and political instability can lead to significant spikes in premiums. Due to political uncertainties in 2017, health insurance actuaries struggled to establish premiums within the rate filing timeline. Pending a vote in Congress and a Supreme Court decision, insurers were not sure they could count on continued federal support and funding for key ACA provisions.

In 2017, insurers were withdrawing from the market in Virginia. Anthem withdrew from the individual market in August and then re-entered in September. When the company re-entered the market it was the only health insurer in 63 counties and cities. Other major insurers in Virginia, Aetna and United Health Care, withdrew completely.

Optima was the only insurer offering plans in Charlottesville City, Albemarle, Fluvanna, and Greene counties. Its premiums for the 2018 plan year were the highest in the country, with an average adult premium in those four localities of $1,151.54 per month and the highest individual plan premium that year of $1,765.47 per month. This represented an average increase of 81.8% over the prior year. According to Optima, 70% of its individual marketplace enrollees qualified for premium subsidies and CSRs that offset the increases. But the 30% who did not qualify for assistance either had to pay the full increase in premiums or leave the individual market.

Optima's premium increases were approved by the state Bureau of Insurance in 2018. Regardless, the company exceeded the federal minimum medical-loss-ratio (MLR) of 80%, a consumer protection provision included in the ACA. The most significant issue according to Optima officials was that the plan received substantially more from the risk adjustment program than it anticipated (the program where insurers contribute or receive funds based on the health of their enrollees). This was partially responsible for Optima's MLR for 2018 being just under 50%. Optima refunded their members $98.9 million for 2018, the highest amount refunded by a health insurer in the country. Optima's MLR trend continued into 2019 even though, prior to 2018, Optima's MLR was over 90%.

The MLR calculation is done by each insurance company and compares overall spending on medical claims and quality improvements to premiums collected. The ACA requires health insurers in the individual market to spend at least 80% of their income from premiums on medical claims and quality improvement initiatives.

Part of Optima's high premiums in this case were due to the incorporation of CSRs into the premiums, the political uncertainties of the time, and underestimating the risk adjustment payments. Finally, the lack of insurer competition in the area also contributed to the high premiums. According to statements from the company in 2017, Optima originally planned a 20% premium increase but added another 21% because of uncertainty surrounding CSR payments, and another 38% due to assuming unknown risk in a new market. While the premiums were offset for most consumers through APTCs, the high premiums also priced out consumers who were unable to take advantage of the APTCs due to their income.

This is an example of how uncertainty and lack of competition in the market can lead to extremely high premiums, but this has not happened in Virginia in most cases. Anthem was the only insurer in the 63 counties and cities during the same year (2018), but the average adult premiums in those localities was $593.26 per month. This is about half of the average adult premium of the Optima plans in the Charlottesville area and $28 lower than the overall average adult premium across the state in 2018 ($621 per month).

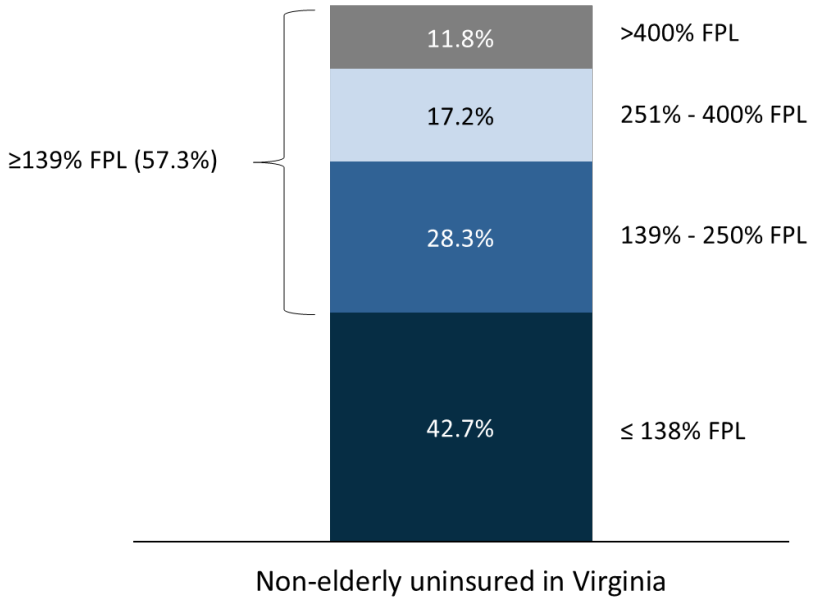
Virginia's main health insurance goals are fewer uninsured people and lower out-of-pocket costs

Studies show that having coverage and a regular source of health care leads to better health outcomes and better quality of life, and improves financial security for most people. Between 2013 and 2021, Virginia's uninsured rate dropped from 14.2% to 8.5%. The drop in the number of uninsured contributed to a drop in uncompensated care at Virginia hospitals of approximately $330 million. The reduction in uncompensated care costs reduced the cost shifting of unpaid bills to those who pay, and improves the financial stability of hospitals and the health care system.

Many adults in Virginia could receive federal subsidies to reduce their premiums, but many are unaware of eligibility, assistance, and benefits

Virginia's non-elderly uninsured rate was 8.5% in 2021 (668,000 individuals). More than half of the non-elderly uninsured had family incomes above 138% of FPL, which is Virginia's income limit for Medicaid eligibility (FIGURE 5). Most uninsured Virginians are part of working families (82.3%), with more than half (60%) having at least one full-time worker.

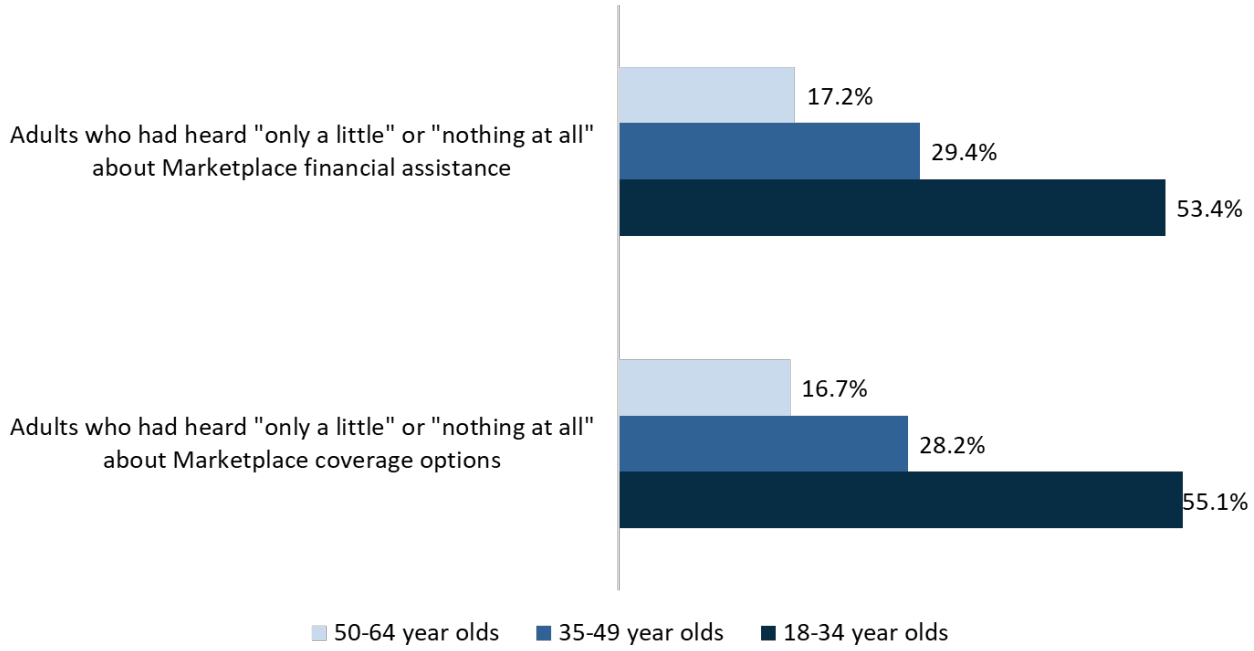
FIGURE 5: More than half of non-elderly uninsured Virginians had family income over 138% of federal poverty level



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

National studies and surveys continue to find that many people do not know they are eligible for tax credits and possibly cost-sharing reductions offered by the Affordable Care Act (ACA). Most importantly, those with little awareness of the individual market and available financial assistance tend to be younger and healthier. A 2021 survey of independent contractors and "gig" workers found that 31% lacked health insurance and 64% said they were concerned about affordability. However, 78% were unaware that they might be eligible for assistance through the ACA. In a study in April 2021, more than half of those who had heard "only a little" or "nothing at all" about the health insurance marketplace and available subsidies were under the age of 35 (FIGURE 6). In a 2018 survey by the Commonwealth Fund, 50% of uninsured adults may have been eligible for assistance through the ACA, and 67% of them did not apply because either they did not think they could afford it, did not think they were eligible, were not aware of the ACA marketplace, or did not think they needed it.

FIGURE 6: More than half of uninsured individuals who are not aware of insurance and financial assistance availability through the individual market are younger



SOURCE: Health Reform Monitoring Survey, Urban Institute Health Policy Center, 2021.
NOTE: Survey respondents who were either not asked or did not report their awareness of the Marketplace are excluded from the results.

Federal government subsidizes premiums for most Virginians on the individual market

In 2021, 83.6% of the 261,943 Virginians who purchased coverage on the marketplace received premium subsidies before the passage of the American Rescue Plan (ARPA). ARPA made significant changes to the individual market for 2021 and 2022, reducing premiums as a percentage of income and making advance premium tax credits (APTC) available to more income levels. The federal government also suspended the disenrollment of individuals who qualify for Medicaid.

Advance premium tax credits (APTC) included in the original ACA made individual coverage more affordable based on household income

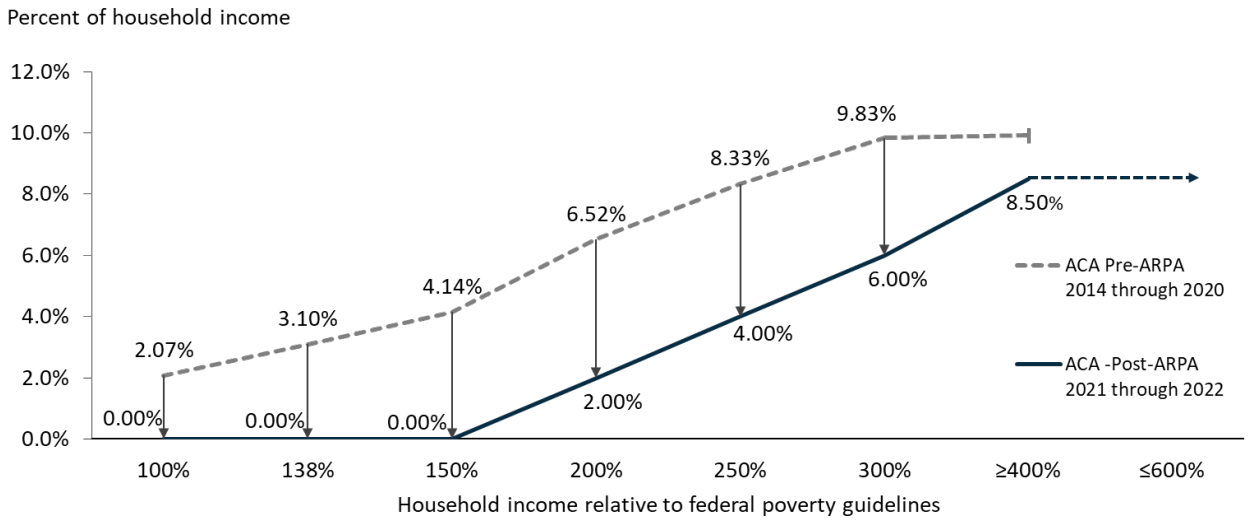
Up until 2021 APTCs were available to individuals whose household income was between 100% and 400% of FPL (see Appendix 3 for a history of the ACA). The amount of the credit is the difference between the cost of the second lowest silver plan premium in the region and an established percentage of income that is contributed to their premium. For example, an individual with income of $25,000 per year (approximately 200% of FPL) will have their premium costs capped at $1,130 per year (6.52% of income). If the second lowest cost silver plan in their region costs $6,000 per year, then the individual is eligible to receive

APTCs worth $4,570 ($6,000−$1,130=$4,570). These APTCs can be applied to any qualified health plan even if it is not a silver plan.

ARPA temporarily but significantly reduced premiums across all income groups

ARPA has significantly reduced the percentage of income that individuals pay toward their premiums. This results in significantly higher APTCs and lower premiums for nearly everyone in the individual market. These changes significantly increased the affordability of premiums and increased enrollment. According to CMS, 48,272 Virginians signed up for coverage after ARPA passed, with 37% paying $10 or less for their premium. People whose household income is below 150% of FPL receive APTCs that cover the entire cost of their premiums, and people above 400% of FPL can now access APTCs. The percentage of household income required for those between 150% and 400% of FPL dropped by an average of 2% (FIGURE 7).

FIGURE 7: ARPA significantly reduced premiums for most Virginians on the individual market



SOURCE: JCHC staff analysis of the ACA and ARPA.

The implementation of ARPA resulted in significant reductions in the cost of premiums for many people on the individual market. The improved affordability impacted individuals across the income spectrum but was most significant for those between 150% and 300% of the federal poverty level (TABLE 6).

TABLE 6: Example of annual premiums and tax credits for individuals post-ARPA

	Annual premium calculations using 2021 federal APTC and poverty guidelines		
Percent of FPL	150%	250%	500%
Income	$19,320	$32,200	$64,400
Premium (2021)	$5,651	$5,651	$5,651
Maximum percentage of income paid toward premium	0. 00%	4.00%	8.50%
Individual responsibility for premium	$0	$1,288	$5,474
Premium tax credit for 2021	$5,651	$4,363	$177
Premium tax credit without ARPA	$4,851	$2,968	$0
Annual savings due to ARPA	−$800	−$1,394	−$177

SOURCE: JCHC staff analysis of the ACA and ARPA.
NOTE: Examples are based on an individual health insurance plan purchased by a 40-year-old in Loudoun County, VA. Household income and premiums are based on 2021 plan year guidelines and marketplace data.

To complete this study, JCHC staff contracted with the Urban Institute to provide impact analysis on multiple policy options. The Urban Institute uses the Health Insurance Policy Simulation Model (HIPSM) to estimate the impact of policy changes on health insurance coverage and costs.

According to the HIPSM, if ARPA APTCs are made permanent, by 2023 an estimated 108,000 more people will be enrolled in the individual market and would result in providing tax credits to an additional 7,000 people who are currently enrolled without the credits. There would be 81,000 fewer uninsured Virginians and individual market premiums would decline by an estimated 8.5%. These estimates are in comparison to a baseline estimate when the enhanced APTCs end after 2022, which is the current law.

Out-of-pocket costs remain a burden for many Virginians on the individual market

ARPA significantly increased many Virginians' ability to buy insurance by making premiums more affordable, but out-of-pocket costs remain a concern. According to Commonwealth Fund analysis of federal surveys, 12% of Virginians went without care at some point during 2019 due to the high cost, and 8.3% of Virginians had high out-of-pocket costs in proportion to their income.

CSRs help consumers with household incomes less than 250% of the federal poverty level to offset out-of-pocket health care expenses

In 2021, 36% of the more than 260,000 Virginians who purchased coverage on the individual market received CSRs. Federal CSRs are available to people with a household income under 250% of FPL but only if the individual buys a silver plan. Individuals who

choose a bronze plan or a gold plan do not receive CSR benefits. Of the approximately 104,000 people who purchased a silver plan, 91% received CSRs.

Actuarial value is the estimated percentage of health care costs for covered benefits that are paid for by the insurance plan using plan premiums, versus out-of-pocket costs paid for by the plan's enrollees. The higher the actuarial value, the lower the out-of-pocket costs are.

The reductions are based on the "actuarial value" of a plan, rather than a fixed dollar amount. A standard silver plan has an actuarial value of 70%. Insurers have flexibility to adjust actuarial values by changing any combination of premiums, copays, deductibles, maximum out-of-pocket expenses, and co-insurance. Once the plans meet the actuarial value established in the ACA, the CSRs are recovered directly by insurers through a combination of premiums and federal advance premium tax credits (TABLE 7).

TABLE 7: Federal CSRs reduce out-of-pocket expenses for low-income individuals who purchase silver plans

Income as a percent of federal poverty level	Actuarial value for standard silver plan	Actuarial value for CSR silver plan
100% - 150%	70%	94%
150% - 200%	70%	87%
200% - 250%	70%	73%

SOURCE: American Recovery and Reinvestment Act.

Individuals earning over 250% of FPL have the most significant out-of-pocket cost burden. Plan cost-sharing requirements do not change with household income for those above 250% of FPL. Therefore, people just above the CSR eligibility limit have the highest out-of-pocket costs as a percentage of income. Out-of-pocket expenses remain high for individuals with more income, but it represents a smaller share of their income (TABLE 8).

TABLE 8: Out-of-pocket cost burden falls disproportionately on middle-income individuals

	Cost-sharing calculations using 2021 federal poverty levels			
Percent of FPL	150%	250%	300%	500%
Income	$19,320	$32,200	$38,640	$64,400
Maximum out-of-pocket	$1,400	$6,800	$8,550	$8,550
Maximum out-of-pocket as % of income	7.3%	21.1%	22.1%	13.3%
Medical deductible	$50	$2,400	$6,250	$6,250
Maximum deductible as % of income	0.3%	7.5%	16.2%	9.7%

SOURCE: JCHC staff analysis of the ACA and ARPA.
NOTE: Examples are based on an individual health insurance plan purchased by a 40-year-old in Loudoun County, VA. Household income and premiums are based on 2021 plan year guidelines and marketplace data.

CSRs are complicated to understand and can be confusing to consumers, leading to suboptimal plan choices

CSRs included in health plans are often confusing to consumers. A questionnaire sent to Virginia navigators found that 6 out of 10 regional respondents reported that callers are often confused and do not understand the differences between the plans offered on the marketplace.

The complexity of CSR plan choice leads some consumers to choose plans with higher costs, even if they are eligible for CSRs. For example, people with limited resources and household incomes below 150% of FPL can get a silver Plan with a $5,650 annual premium for zero dollars and reduced cost sharing under ARPA. But they might think they are getting more value buying a "gold" plan for zero dollars, or even a slightly higher premium because gold plans are perceived to be better than silver plans in all cases. However, a CSR silver plan will have lower out-of-pocket costs than a gold plan. The differences among the plan levels may appear small to a consumer but out-of-pocket expenses may be higher than expected if the person gets sick or did not accurately estimate their annual expected medical expenses.

Individuals who shop for health coverage on the exchange by primarily comparing premiums may choose a plan that does not fit with their medical conditions (TABLE 9).

TABLE 9: Complexity of plan choices may lead some individuals to forgo federal cost-sharing reductions, increasing their out-of-pocket health care spending

Example: Individual earning $25,000 per year (approximately 200% of FPL)

Metal level	Premium after APTCs	Deductible	Max OOP	PCP office visit	Specialist office visit	Generic Rx copay
Bronze	$0.00	$8,200	$8,550	40% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible
Silver with CSRs	$500	$550	$2,850	$10	20% coinsurance after deductible	$15
Gold	$550	$2,000	$8,550	$25	20% coinsurance after deductible	$10

SOURCE: Plan details from 2021, using premium for a 40-year-old in Loudoun County. Anthem HealthKeepers Bronze X 8200, Anthem HealthKeepers Silver X 6250, and Anthem Gold X 2000.

State policy options would likely have a moderate impact on affordability

Virginia has several policy options that are estimated to reduce the number of uninsured and improve affordability in the individual market. However, the current federal debate about whether to extend or make permanent the enhanced APTCs will have an outsize impact on premium affordability. State policy options will still have a positive impact, but the impacts will be more moderate than this federal policy decision.

Each state policy option is designed to make coverage more affordable and attractive to healthier people in the individual market. This addresses the primary issue of younger, healthier individuals leaving the market over the last five years, or being unaware of available financial assistance.

JCHC staff asked Urban Institute to model eight distinct scenarios and multiple combinations of those scenarios. The most impactful scenarios are included in the report as policy options (TABLE 10) and the complete results of all of the analyses can be found in (Appendix 1).

TABLE 10: Goal of strategies modeled by the Urban Institute for this study

Strategies	Affordability goal
Elimination of smoking surcharge (Option 2)	Improve affordability and access to health care
Health insurance coverage mandate (Option 3)	Increase enrollment in the marketplace, reduce the number of uninsured, and improve access to health care
State funded cost-sharing program (Options 4 and 5)	Make cost sharing more affordable
Public option (Options 6 and 7)	Improve competition in the marketplace – standardized and affordable health plans

NOTE: Not all strategies modeled by the Urban Institute are discussed in the body of the report or included as policy options.

Impact of ARPA on the uninsured: 48,272 Virginians enrolled in marketplace coverage after ARPA passed. HIPSM estimates enrollment will increase to 108,000 by 2023. If ARPA is not extended the HIPSM model estimates that the overwhelming majority of the newly enrolled will not enroll again and there will be a negative impact on the uninsured rate regardless of any future state changes. The negative impact is reflected in all of the estimates in this report.

The estimated impact of each policy option depends on whether the current, enhanced APTCs under ARPA expire after 2022, or these enhanced subsidies are extended or made permanent. The enhanced subsidies are already bringing more individuals into the market, and the HIPSM estimates that by 2023, 108,000 more people will be in the market (104,000 of whom would otherwise be uninsured) unless the enhanced subsidies expire (TABLE 11). Due to the uncertainty of this significant federal policy decision, each of the options includes an estimated impact under both scenarios (current law with expiring enhanced APTCs, or extended enhanced APTCs). The estimated impacts shown for each option are the isolated impact of the state policy.

TABLE 11: Extension of the current, enhanced APTCs would result in about 108,000 more Virginians enrolling in individual market health insurance plans (2023)

	Reduction in premiums	Total uninsured	Individual market enrollment
Baseline under current law	--	748,000	333,000
ARPA APTCs extended	−8.5%	644,000	441,000

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

Improved marketing and access to navigators would bring more individuals into the market

More than half of younger, uninsured individuals are not aware of marketplace insurance options and the availability of subsidies. Even for those who do seek coverage through the exchange, choosing a health plan is complicated and challenging. Comparing the premiums, office visit co-pays, deductibles, out-of-pocket expenses, and whether their physicians and medicines are included in a plan's benefit description can be overwhelming. Effective marketing is necessary to increase awareness, and navigator assistance is necessary to help individuals choose the best plan for their situation.

Virginia is currently transitioning to a state-based market exchange program and is using the federal platform until the transition is complete and fully operational by 2023 (in time for plan year 2024). During the transition, the state is responsible for the costs of marketing and navigators.

Effective marketing and navigation in the state-based exchange will require sufficient funding. Virginia's ability to provide marketing and navigation in recent years has been significantly limited by federal funding reductions. Federal grant funds for ACA navigators in Virginia decreased by 76% between 2016 and 2019 (pre-pandemic). Nationally, federal spending on marketing for healthcare.gov decreased by 85% during the same period. As a result of the reductions, the Virginia navigator program saw a 63% drop in the number of consumers it could help with health insurance enrollment.

As a state-based exchange, Virginia has control over how it markets health coverage and how it helps individuals navigate the exchange. Marketing may include web-based advertisements, television and radio commercials, and print media and mailers. Marketing may also include information directing consumers to their local or regional navigators for assistance in choosing a plan.

In addition to marketing and navigation, Virginia can extend its enrollment periods to maximize enrollment. For example, the federal exchange open enrollment period for 2021 lasted from November 1 through December 15, 2020 (this is being extended to January 15th in future years). In contrast, open enrollment for state-based exchanges varied, with most extending their open enrollment into January 2021. State-based exchanges were also able to establish their own special enrollment periods during the pandemic that were earlier and longer than the federal special enrollment period. California, Colorado, and the District of Columbia have permanently extended open enrollment. Twelve other states have fully state-run exchanges, and nearly all of them extended open enrollment for 2021 coverage — including Pennsylvania and New Jersey, both of which had just transitioned to having their own exchange platforms in 2020, and thus had their first opportunity to offer a longer enrollment window.

Funding to administer the Virginia exchange is currently limited by code to a premium assessment of 3.0% levied on insurers operating on the exchange. For 2022 and 2023, most

of the assessment is allocated to the federal government. Health insurance premium data for exchange plans indicates that collections from the total assessment may be as high as $65 million by the end of 2021, with $54 million allocated to the federal government and $11 million to the state for transition related expenses. In the first eight months of 2021 the state exchange collected $5.7 million from the 0.5% assessment. The state is currently spending approximately $2 million on navigator functions and plans to spend $1.3 million on marketing in 2022. Starting in 2024, all of the revenue will be allocated to the state for operational costs.

Business surveys of different industries indicate that the marketing budget of health care companies averages 11% of company spending. An 11% marketing and navigator budget for Virginia's health insurance exchange may be as much as $7 million to be on par with the health industry average. This amount is consistent with the average spending for advertising and navigators as reported by nine of the 15 states operating state-based exchanges as of 2021.

To ensure sufficient marketing and navigator support, the General Assembly could require the exchange administrators to provide a detailed statewide marketing plan along with appropriate fund allocations for consumer outreach and navigator programs. Virginia's health insurance exchange issued an RFP for assistance with marketing and outreach for the exchange. This could serve as a basis for a statewide marketing plan. Additional appropriations would need to be made for FY23 so that sufficient marketing could begin in advance of the 2024 plan year open enrollment period, which is scheduled to begin on November 1, 2023. This appropriation could be from general funds, to supplement (not supplant) the existing funding being used for marketing from the assessment. This could be a one-time appropriation, if assessment revenue is used in future years.

➔ **Option 1:** JCHC could introduce a budget amendment to appropriate $3.7 million in general funds (for a total of $7 million when combined with assessment funds) to the exchange for an annual marketing program that would begin before open enrollment starts in November of 2023 for the 2024 plan year, and amend § 38.2-6505 of the Code of Virginia to direct the exchange administrator to prepare an annual marketing plan that includes outreach and navigator programs.

Bringing more healthy people into the market would likely reduce premiums

Removing the tobacco use surcharge or establishing an individual mandate would result in more Virginians entering the market. The individuals entering the market are likely to be healthier, and therefore incur lower health care costs than the current enrollees. Increasing the number of healthy individuals in the market spreads costs over a larger pool, reducing premiums.

Eliminating the tobacco surcharge would reduce premiums by bringing tobacco users into the individual market

The ACA allows health insurers to charge tobacco users up to 50% more (or premiums that are 1.5 times higher) than non-smokers through a tobacco surcharge, but also permits states to either establish a lower surcharge or eliminate it altogether. The surcharge is calculated after APTC and CSRs are calculated, meaning that people who use tobacco products pay for the additional costs themselves rather than have them subsidized. Six states plus Washington, D.C., prohibit the use of a tobacco surcharge (TABLE 12) (see Appendix 4 for a discussion of other states' strategies to address affordability). Virginia allows the use of the full tobacco surcharge, but health insurers operating on the exchange have either eliminated the tobacco surcharge or are using a lower percentage than allowed under the ACA (TABLE 13).

TABLE 12: Nine states plus Washington, D.C. either prohibit or restrict the use of a tobacco surcharge in their individual markets

States that prohibit a tobacco surcharge	California, Massachusetts, New Jersey, New York, Rhode Island, Vermont, and Washington, D.C.
States that restrict the amount of the tobacco surcharge	Colorado – up to 15% of the premium Arkansas – up to 20% of the premium Kentucky – up to 40% of the premium

SOURCE: Health Markets Insurance Agency.

TABLE 13: Most insurers in Virginia impose reduced tobacco surcharges

Insurer	2021 tobacco surcharge
Piedmont	0-50%
Anthem	0-30%
Kaiser Permanente	20%
Optima Health	20%
UnitedHealthcare	0-20%
Oscar	0-12.5%
CareFirst	0%
Cigna	0%

SOURCE: Enroll Virginia data on tobacco surcharge use in Virginia.
NOTE: For insurers with a range, the actual amount of the surcharge varies with the age of the enrollee.

The purpose of the tobacco surcharge is to encourage people to take advantage of tobacco cessation programs offered by insurers. However, numerous studies have found that the tobacco surcharge does not promote tobacco cessation and is more likely to act as a barrier to coverage, especially for individuals with low income. While tobacco use of any kind

among the adult population is less than 20%, it may be as high as 40% for low-income adults. This results in low-income individuals who would otherwise receive significantly subsidized premiums forgoing coverage because of the increased cost. The tobacco surcharge can be a significant portion of income for low-income individuals (TABLE 14).

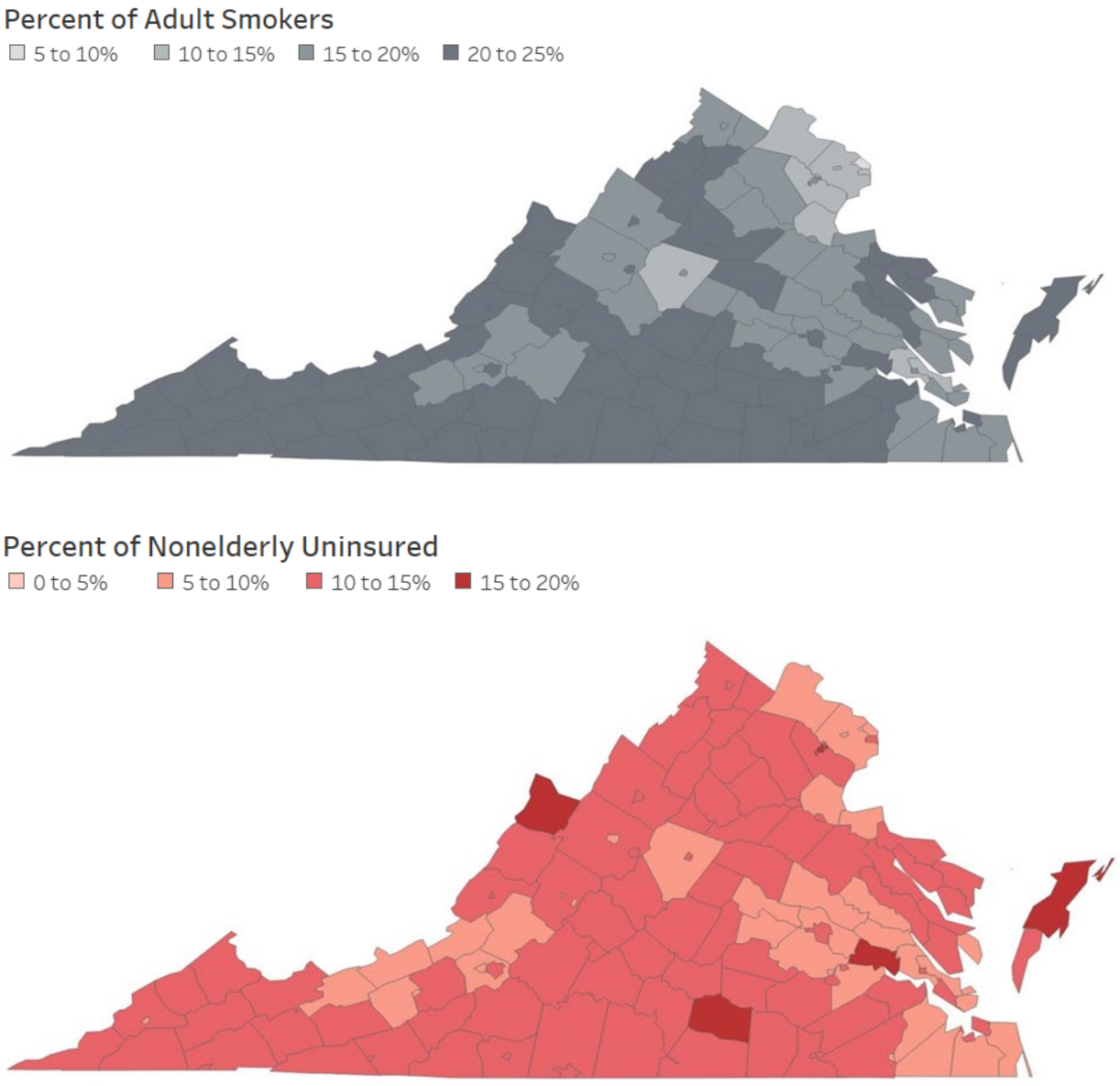
TABLE 14: Tobacco surcharges can result in low-income individuals paying a significant percentage of income for premiums, even if they are eligible for APTCs

	Premium calculations using 2021 federal APTC and poverty guidelines		
Percent of FPL	150%	250%	500%
Income	$19,320	$32,200	$64,400
Premium (2021)	$5,651	$5,651	$5,651
Maximum amount of income paid toward premium	0.00%	4.00%	8.50%
Individual responsibility for premium before tobacco surcharge	$0	$1,288	$5,474
20% tobacco surcharge	$1,130	$1,130	$1,130
Total premium including tobacco surcharge	$1,130	$2,418	$6,604
Percent of income for premiums	5.8%	7.5%	10.3%

SOURCE: JCHC staff analysis of the ACA and ARPA.
NOTE: Examples are based on an individual health insurance plan purchased by a 40-year-old in Loudoun County, VA. Household income and premiums are based on 2021 plan year guidelines and marketplace data.

Localities in Virginia with some of the highest uninsured rates in the state also have some of the highest tobacco-use rates. The only two insurers offering plans in these localities – Anthem and Piedmont – apply a tobacco surcharge on a sliding scale based on age (FIGURE 8).

FIGURE 8: Localities with some of the highest rates of tobacco use also have the highest rates of uninsured



SOURCE: University of Wisconsin – Robert Wood Johnson Foundation, County Health Rankings, 2021.

Eliminating the tobacco surcharge is estimated to reduce premiums and the number of uninsured. The HIPSM estimates that premiums may fall by 3%, and the number of individual market enrollees is estimated to increase by as much as 13,000 compared to the baseline under current law. The number of uninsured is estimated to fall by up to 14,000 (TABLE 15). This option is projected to have a larger impact on premiums, but a smaller impact on the number of uninsured, if ARPA APTCs are extended.

TABLE 15: Estimated impact of eliminating the smoking surcharge in Virginia (2023)

	Reduction in premiums	Reduction in uninsured
Impact if ARPA APTCs not extended	3.0%	14,000
Impact if ARPA APTCs extended	4.5%	3,000

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

➔ **Option 2:** JCHC could introduce legislation to prohibit the use of a tobacco surcharge by amending § 38.2-3447 of the Code of Virginia to change the tobacco use rate to 1:1.

Instituting an individual mandate penalty would have a marginal impact on premiums and enrollment

The ACA individual mandate required most people across the country to have health insurance or pay a tax penalty. Beginning in 2019, the penalty for not meeting the requirements of the individual mandate was reduced to zero and no longer assessed.

JCHC staff worked with the Urban Institute to model the impact of implementing an individual mandate in Virginia based on the penalties and exemptions originally included in the ACA. The maximum tax penalty would be the lesser of (a) 2.5% of annual household income and (b) the annual premium cost for a bronze plan sold through the individual market that year. As with the original ACA mandate, people who are not required to file taxes — a large share of the uninsured — would be exempt.

According to the HIPSM, implementing an individual mandate with a state tax penalty would reduce premiums slightly and the number of uninsured. Premiums would likely fall by 0.5%. The number of individual market enrollees would increase by as much as 2,000, compared to a baseline under current law, and the number of uninsured could be reduced by up to 6,000. Further, the state could collect up to $9 million in tax penalties assessed against those who do not comply with the mandate (TABLE 16). The impact of an individual mandate in Virginia would be slightly smaller if ARPA APTCs are extended.

TABLE 16: Estimated impact of implementing an individual mandate in Virginia (2023)

	Reduction in premiums	Reduction in uninsured	Tax Penalty Collections
Impact if APRA APTCs not extended	0.5%	6,000	$9 million
Impact if ARPA APTCs extended	0.2%	4,000	$7 million

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

Another significant change that could occur from the imposition of an individual coverage mandate in Virginia may be an increase in enrollment in Medicaid and the Children's Health

Insurance Program (CHIP) due to increased awareness. As more people look for coverage options to comply with the individual mandate, some will be eligible for, and enroll in these public programs. The HIPSM estimates that CHIP program enrollment may increase by up to 5,000 and an additional 1,000 adults may enroll in Medicaid. The increased cost to the state of between $7 million and $8 million due to the increase in enrollment could be covered by the estimated increase in collections from the tax penalty associated with the individual mandate.

➔ **Option 3:** JCHC could introduce legislation to amend § 58.1 of the Code of Virginia to require the Virginia Tax Commission to include a self-attestation check box on all individual state income tax returns, indicating whether or not the individual and family has health coverage, matching the check box with the W-2 form or the federally required "IRS-1095" form, and by adding a tax penalty to the Code of Virginia if health coverage cannot be verified or does not exist.

Providing state funding to reduce cost sharing would reduce out-of-pocket costs and the number of uninsured

JCHC asked the Urban Institute to model two different approaches to a state-funded CSR program. The first approach would enhance the federally required CSRs through silver plans by increasing the subsidy for people earning 250% or less of the federal poverty level and providing a subsidy for people earning up to 400% of the federal poverty level. The second approach would establish "flexible spending accounts," with a debit card for everyone who purchases a plan through the individual market. Out-of-pocket costs remain a burden for many lower- and middle-income individuals, and the enhanced federal premium subsidies do not directly address this problem.

Enhancing CSRs through the current federal method is estimated to reduce out-of-pocket expenses by $1,000 per person on average

Under current federal law CSRs are built into the actuarial value of silver plans based on poverty brackets. The CSRs reduce out-of-pocket expenses, including office visits, deductibles, co-pays, and maximum out-of-pocket expenses. A person must buy a silver plan to receive the enhanced CSR benefit. Insurers modify the out-of-pocket cost structure of their plans to meet the required actuarial value for CSR plans (TABLE 17).

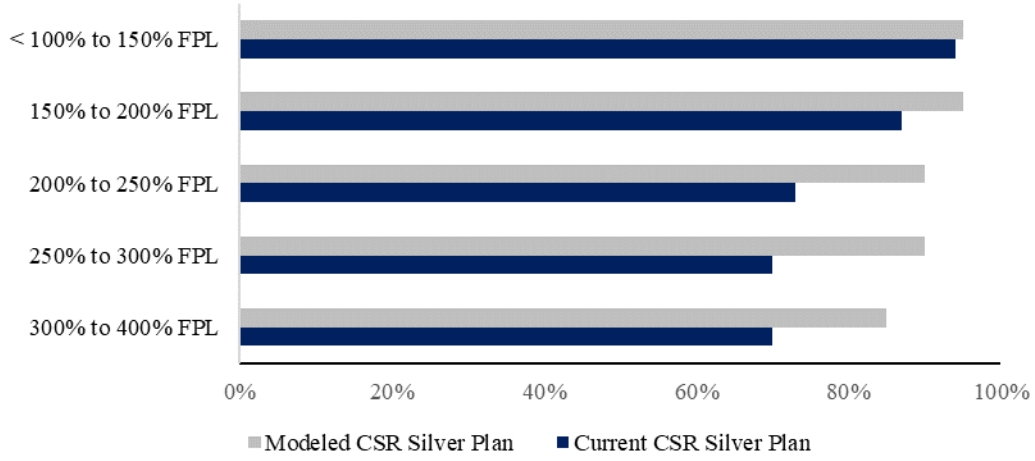
TABLE 17: Example of how CSRs impact out-of-pocket expenses

	Standard silver plan	CSR silver plan 201-250% FPL	CSR silver plan 151-200% FPL	CSR silver plan up to 150%
Medical deductible	$5,300	$2,250	$400	$70
Physician office visit	$20	$15	$10	$5
Specialist office visit	must meet deductible before 25% coinsurance	must meet deductible before 25% coinsurance	must meet deductible before 25% coinsurance	must meet deductible before 5% coinsurance
Generic drug copay	$20	$15	$15	$5
Maximum out-of-pocket cost	$8,550	$6,800	$2,850	$1,500

SOURCE: JCHC staff analysis of FFM QHP landscape files: Health and dental datasets for researchers and issuers, 2021.

The JCHC staff worked with the Urban Institute to model the impact of enhancing the current CSRs in Virginia. The proposal would increase the actuarial value for silver plans to 95% for individuals between <100% and 200% of FPL, 90% for those between 200% and 300% of FPL, and 85% for those between 300% and 400% of FPL (FIGURE 9).

FIGURE 9: Modeled state-funded cost-sharing reductions would increase the actuarial value of CSR silver plans by up to 20% depending on household income



SOURCE: Urban Institute, An Analysis of Policy Options for Virginia, 2021.

Enhancing CSRs through state policy under the HIPSM model would cost the state up to $44 million. Implementing the policy is estimated to reduce premiums by 2.5% and reduce the number of uninsured by 37,000 Virginians compared to the baseline under current law. Out-of-pocket costs for individuals eligible for the enhanced CSRs would decrease by an average of $1,000 per person (TABLE 18). The savings would be most significant for those

close to 400% of FPL. If ARPA APTCs are extended, the reduction in the uninsured would be minimal because the enhanced subsidies would already be bringing most of those individuals into the market.

TABLE 18: Estimated impact of a state-funded enhancement to federal cost-sharing reductions (2023)

	Change in premiums	Reduction in uninsured	Reduction in OOP costs	Implementation costs
Impact if APRA APTCs not extended	−2.5%	37,000	$1,000	$44 million
Impact if ARPA APTCs extended	+0.6%	4,000	$1,000	$49 million

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.
NOTE: Increasing the number of people in the individual market involves shifting of individuals from employer-sponsored coverage and other nongroup coverage, and a reduction in the uninsured to the individual market.

➔ **Option 4:** JCHC could introduce legislation to enhance federal CSRs by amending Title 38.2 of the Code of Virginia to direct the Bureau of Insurance to pay insurers offering plans on the state exchange based on the same methods used by the United State Secretary of Health and Human Services pursuant to 42 U.S. Code § 18071, and by appropriating the funds necessary for the cost of the payments.

Providing a "flexible spending account" debit card to all enrollees would help people of all incomes and encourage more people to enroll

JCHC staff worked with the Urban Institute to model the impact of implementing a flexible spending account debit card for individuals who qualify for APTCs. Unlike the current CSRs, the cards may be made available to all eligible enrollees regardless of the plan selected. The scenario modeled would provide a debit card worth $500 per adult and $300 per child to individuals with income up to 400% of FPL. Those with higher incomes would receive $250 per adult and $150 per child. The General Assembly could also allow the debit card to be used for approved over-the-counter health care costs, similar to the program operated by the Virginia Department of Human Resource Management for state employees.

According to HIPSM, the cost to implement a "flexible spending account" with a debit card to all qualifying enrollees would be about $114 million, plus up to $1 million in administrative costs. Implementing a debit card program would reduce premiums by 5% and the number of uninsured by 18,000, compared to the baseline under current law. Out-of-pocket spending would be lower by either $250 or $500 per person, depending on the individual's income (TABLE 19). The impact on premiums and the uninsured would be significantly lower if ARPA APTCs are extended.

TABLE 19: Estimated impact of a state-based "flexible spending account" debit card to reduce out-of-pocket costs (2023)

	Change in Premiums	Reduction in uninsured	Reduction in OOP costs	Implementation costs
Impact if APRA APTCs not extended	−5.0%	19,000	$250-500	$114 million
Impact if ARPA APTCs extended	−0.9%	7,000	$250-500	$161 million

SOURCE: Results of the Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

In order for this proposal to work, the amount provided to recipients must be excluded from state income taxes and meet IRS requirements to be considered "general welfare." The IRS has three principle requirements for payments to be considered "general welfare": (1) the payments are from a government fund, (2) the purpose meets the general welfare and economic needs of a household, and (3) the purpose is to assist people who have an economic need, and the assistance is not compensation for services.

➔ **Option 5:** JCHC could introduce legislation to establish a state-based cost-sharing reduction program by amending Title 38.2 of the Code of Virginia to require the exchange to distribute and administer flexible spending account debit cards to all qualified enrollees of the individual marketplace and appropriating necessary funding for the program.

There are several important differences between the two types of state-funded CSR proposals. A flexible spending account using a debit card makes money available immediately to those enrolled and it may be viewed by consumers as more valuable than a state-enhanced CSR program, particularly to people who do not have high expected health costs. The perceived value of the debit card may attract more people into the individual market based on behavioral economics that could not be simulated by the HIPSM. On the other hand, ACA-like CSRs provide protection against the risk of high health care costs that a fixed-amount debit card cannot provide. Including a state CSR program in the current system may be more attractive to enrollees with relatively high expected costs (TABLE 20).

TABLE 20: Different approaches to state-based cost-sharing reductions have advantages and disadvantages

	Enhancing ACA CSRs	OOP Debit Card
Marketplace plan choices	Available only to those choosing silver plans. This cannot be changed; otherwise, everyone could pick the lowest premium for the least comprehensive plan but get the same coverage.	Could be made available to all, regardless of plan choice. This increases state costs but is more attractive to those currently uninsured.
Individual market premiums	Because these CSRs make the plans cover more of the cost of services, they benefit those with higher medical costs the most. This results in some adverse selection and higher premiums.	The dollar value is the same, regardless of health risk, and the money is available immediately to help pay down OOP spending. Does not drive adverse selection. In fact, individual market premiums decrease.
Over-the-counter costs	Could not be included.	Could be included.

SOURCE: Urban Institute, An Analysis of Policy Options for Virginia, 2021.

Impact of a public option would vary significantly depending on provider reimbursement rates

One way for the General Assembly to address competition and help consumers with their plan choices is to establish a public option in Virginia that is available to all Virginians. A public option plan may include state and federal benefit mandates, provider reimbursement rates that are either limited to a percentage above Medicaid rates or competitive within each region. The state Bureau of Insurance and exchange administration could work together to competitively select at least one insurer in the state to provide the public option statewide. This is similar to how Washington state has implemented its public option, which is the only active public option in the country. It is important to note that for any public option to be effective, the plan would need to be offered in every locality across Virginia.

Public option scenarios in Virginia modeled with varying reimbursement rates

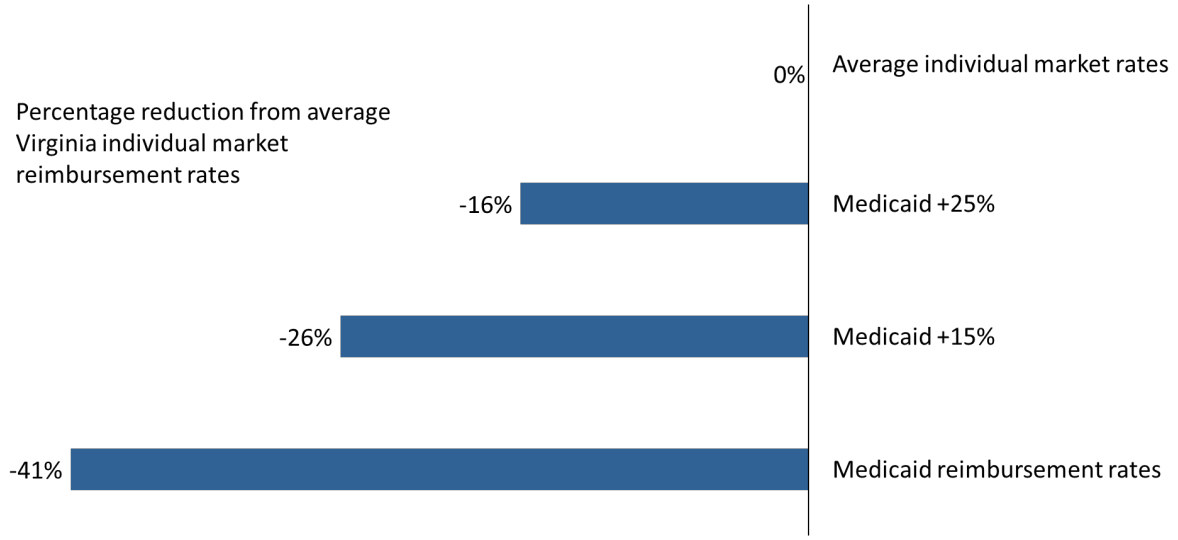
JCHC staff worked with the Urban Institute to model three public option scenarios for Virginia. The first two scenarios assume the addition of a new plan in the individual market with provider reimbursement rates administratively set at specific percentages above each region's average Medicaid rates. The third scenario assumes a public option plan in each of the 12 rating regions to encourage competition among all plans but that does not administratively set rates. (For detailed assumptions in each of the three scenarios, see Appendix 1.)

The Urban Institute used Virginia Health Information (VHI) claims data to calculate the ratio between the average individual market, Medicare, and Medicaid reimbursements for

both hospital and non-hospital services. The decision to use a percentage increase from Medicaid rates as the benchmark is to present information to the General Assembly that Members are familiar with and can easily access information about. The modeled rates are increased at a percentage above Medicaid based on the VHI data.

VHI data indicated that, on average, Medicaid reimbursements for hospital and physician services are 41% lower than what individual market plans reimburse for services. This varies significantly by region and specific services. Based on this data, the scenarios estimate that setting rates at Medicaid plus 15% will reduce provider reimbursement rates by an average of 26%, while setting rates at Medicaid plus 25% will reduce provider reimbursement rates by an average of 16% (FIGURE 10). The model assumes that additional prescription drug discounts will not be available to any public option plan because a state level public option plan would likely not be able to negotiate better prescription drug discounts than commercial plans. Provider reimbursements included in the models are to illustrate the range of scenarios and are not the only scenarios that could be pursued. The General Assembly may be able to establish reimbursement rates through discussions with insurers and providers for any of the public options that are considered.

FIGURE 10: Public options were modeled using a spectrum of reimbursement rates between Virginia's Medicaid rates and Virginia's average individual market rates



SOURCE: JCHC staff and Urban Institute analysis of aggregated claims data provided by VHI.

Administratively setting reimbursement rates below the current average individual market rates would cause significant provider reimbursement reductions, especially for hospitals. This may impact the willingness of providers to participate in the public option plan. Washington state's public option program initially had difficulty establishing provider networks due to low reimbursement rates. The Washington General Assembly addressed

the issue by requiring all providers that accept Medicaid or any other type of publicly supported coverage to also accept the state public option plans.

Low reimbursement rates could enable low premiums but likely would not significantly reduce the number of uninsured

A public option that sets provider reimbursement rates below what is currently being paid in the market is estimated to reduce premiums. The lower the state sets provider reimbursement rates, the greater the reduction in premiums. However, this benefit would mostly impact higher-income individuals who are already buying insurance through the individual market but are not eligible for APTCs. Most individuals eligible for APTCs would not see a change in their premiums as premiums drop. As a result, the HIPSM estimates that enrollment in the public option would primarily be individuals switching from current individual market plans, rather than uninsured individuals signing up for new insurance under the public option.

According to the Urban Institute, a state public option could save the federal government between $328 million and $570 million in APTCs, depending on the option chosen. If an individual mandate and a public option were included as part of a Section 1332 State Innovation Waiver, some of the federal government's savings could be passed on to the state.

Scenario 1: Public option with reimbursement rates set at Medicaid plus 15%

If Virginia establishes a public option and sets reimbursement rates for the plan at Medicaid plus 15% (a 26% reduction in average reimbursement rates paid by plans in the individual market), the HIPSM estimates that individual market premiums would fall by as much as 21.1% compared to a baseline under current law. The number of individual market enrollees would increase by about 14,000, but the number of uninsured would drop by about 10,000 (TABLE 21). The impact on premiums would be slightly larger, but the impact on the number of uninsured would be smaller if ARPA APTCs are extended.

TABLE 21: Estimated impact of implementing a public option with reimbursement rates set at Medical plus 15% (2023)

	Reduction in premiums	Reduction in uninsured
Impact if APRA APTCs not extended	21.1%	10,000
Impact if ARPA APTCs extended	22.2%	3,000

SOURCE: Results of the Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

➔ **Option 6:** JCHC Members could include language in the Appropriation Act directing the Bureau of Insurance to develop a Request for Proposals to administer a public option health insurance plan that would be sold on the Virginia exchange in all Virginia localities, with

average provider reimbursement rates set at 26% below current average individual market reimbursement rates using data from Virginia Health Information.

Scenario 2: Public option with reimbursement rates set at Medicaid plus 25%

If Virginia establishes a public option and sets reimbursement rates for the plan at Medicaid plus 25% (a 16% reduction in average reimbursement rates paid by plans in the individual market), the HIPSM estimates that individual market premiums would fall by as much as 9.7% compared to a baseline under current law. The number of individual market enrollees would increase by about 10,000, but the number of uninsured would likely drop by 8,000 (TABLE 22). The estimated impact on premiums would be larger, but the impact on the number of uninsured would be smaller if ARPA APTCs are extended.

TABLE 22: Estimated impact of implementing a public option with reimbursement rates set at Medicaid plus 25% (2023)

	Reduction in premiums	Reduction in uninsured
Impact if APRA APTCs not extended	9.7%	8,000
Impact if ARPA APTCs extended	13.0%	5,000

SOURCE: Results of the Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

➔ **Option 7:** JCHC Members could include language in the Appropriation Act directing the Bureau of Insurance to develop a Request for Proposals to administer a public option health insurance plan that would be sold on the Virginia exchange in all Virginia localities, with average provider reimbursement rates set at 16% below current average individual market reimbursement rates using data from Virginia Health Information.

Increasing competition through a public option with competitive reimbursement rates is unlikely to significantly reduce premiums or the number of uninsured

Research literature consistently indicates that competition in the individual market reduces premiums. However, the current data in Virginia is inconclusive on whether competition has that effect. For example, the case study involving Northern Virginia showed an abundance of insurers and plans available, yet the area has a plan with the highest premiums in the country. In addition, while there were issues in 2018 in Charlottesville involving one insurer, other areas of the state where there was only one insurer did not have the same experience.

In 2021 there were 53 localities in Virginia with only one insurer (see page 9 for map). However, premiums in those rating areas are similar to those with more competition and the uninsured rate is higher in some areas where there is competition. It is not clear that adding another insurer would result in lower premiums or lower uninsured rates (TABLE 23).

TABLE 23: Premiums are not currently higher in Virginia rating areas with no competition

	Bureau of Insurance rating area					
	1	**4**	**5**	**7**	**8**	**11**
Anthem premiums	$458	$437	$404	$391	$426	$423
Average premiums of other insurers		$483		$462		$470
Total insurers	1	2	1	5	1	2
Average uninsured rate	9.6%	13.5%	10.9%	11.1%	9.7%	12.4%

SOURCE: JCHC staff analysis of FFM QHP landscape files for researchers and issuers, and data on the uninsured from the Wisconsin Population Health and Robert Wood Johnson Foundation County Health Rankings, 2018.

Appendix 1: Urban Institute report on scenarios

The following information is the complete, unedited report to the JCHC staff from the Urban Institute.

Introduction

For this report we used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to construct a detailed picture of health coverage and costs in Virginia. We begin by simulating current law in 2023, both with and without the American Rescue Plan Act's (ARPA's) enhanced premium tax credits (PTCs) being extended. It is currently uncertain whether Congress will make these permanent.

These current-law simulations are then used as the baseline to compare a variety of policy alternatives in which the Joint Commission on Health Care is interested:

1. Reducing cost sharing for people with private nongroup coverage
2. Implementing a public option in Virginia
3. Introducing a state version of an individual coverage mandate
4. Eliminating the Affordable Care Act's (ACA's) premium surcharge for tobacco users

We include the results of multiple options for each of these policies and conclude with two possible combinations of policy proposals.

HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. Changes to individual or employer decisions in one insurance market interact with decisions in other markets. The model is iterative, in that policy changes are simulated, information from that simulation is fed back into the model, and the model continues to iterate until there is little to no change in coverage and costs between iterations, that is, until the model reaches equilibrium. HIPSM is designed for quick-turnaround analysis of policy proposals. It can be rapidly adapted to analyze a wide variety of new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Complete methodology for the model is available online.[i]

Results from HIPSM simulations have been favorably compared with actual policy outcomes and HIPSM has been compared with other respected microsimulation models, as assessed by outside experts.[ii] Findings from the model were cited in the majority opinion in the Supreme Court case *King v. Burwell* and in many amicus briefs submitted to the court in that case. Findings from HIPSM have been broadly cited

i Matthew Buettgens and Jessica Banthin, "The Health Insurance Policy Simulation Model for 2020" (Washington, DC: Urban Institute, 2020).

ii Sherry A. Glied, Anupama Arora, Claudia Solís-Román, "The CBO's Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?" (New York: Commonwealth Fund, 2015).

in top-tier media, including the *New York Times*, the *Washington Post*, *Wall Street Journal*, *Vox*, CNN, and the *Los Angeles Times*. Results from HIPSM have been displayed on the floor of the US Senate during debate and are widely distributed among Congressional legislative staff.

The model has also been used in many individual states to provide a detailed picture of policy alternatives like those in this report. These states include Alaska, Massachusetts, Missouri, New Mexico, New York, Ohio, Oregon, and Washington.

The Virginia Baseline Calibration

The purpose of establishing a Virginia baseline was to tune to the model to produce a comprehensive picture of projected 2023 health care coverage and costs in Virginia under current law. This has two main purposes. First, this task incorporates a wide variety of real-world data into the model, as explained below. It enables the model to account for factors specific to Virginia when simulating the impact of policy changes in subsequent tasks. Second, the results under current law provide a dependable point of comparison for the alternative simulations we produce.

Calibrating Major Types of Health Coverage

Medicaid enrollment targets for 2023 are primarily based on pre-pandemic (earlier than March 2020) data from the Virginia Department of Medical Assistance Services Medicaid data book. Pandemic-era enrollment numbers are not appropriate for this purpose because they are strongly influenced by factors such as the COVID-19 relief Medicaid continuous coverage provision and pandemic-related job losses that will not be applicable in 2023.

Enrollment estimates in our model represent average monthly enrollment. This differs from the count of unique recipients that also appears in the data book. The latter is always higher because it includes anyone who was ever enrolled, even if they left the program later that year. We use average monthly enrollment because it can be used with per member per month (or year) spending estimates to replicate total spending.

A final distinction is that we count full-benefit Medicaid programs for the nonelderly. We simulate health insurance, so we only count types of Medicaid that provide comprehensive benefits. This excludes programs such as family planning waivers.

Enrollment targets for Medicaid expansion enrollees required further adjustment, because two lines of evidence suggested the relatively recent expansion in Virginia had not reached its long-term enrollment level by February 2020. First, the Medicaid expansion population was still growing much faster than normal up to that point (by 5.3 percent in December 2019, 6.5 percent in January 2020, and 2.9 percent in February 2020), suggesting newly eligible people were still in the process of learning of their eligibility and signing up. Second, when we projected Medicaid expansion enrollment in Virginia using the average take-up rate across earlier expansion states, the result was notably higher than expansion enrollment as of

February 2020.[iii] It is reasonable to assume Medicaid expansion take-up in Virginia would eventually reach similar levels to other expansion states; we see no reason to believe that it will permanently be lower. Data on Virginia Medicaid expansion enrollment in 2020 and the first months of 2021 also suggest about the same level of enrollment in the long term. The growth in the Medicaid expansion population during 2021 has been steady at roughly 1.7 percent, or 9,000 people, per month. This is consistent with growth due to the Medicaid continuous coverage requirement that we have observed in all states (paper forthcoming). Monthly growth of the Medicaid expansion population in 2020 was consistently higher, so the continuous coverage requirement does not appear to account for all the growth. We took the difference between 2020 growth under the pandemic and the average 2021 growth of 9,000 people per month as a measure of additional Medicaid expansion enrollment. The result was a total of roughly 420,000 to 430,000 Medicaid expansion enrollees, which is close to our earlier estimates assuming take-up similar to the average across earlier expansion states.

As of October 2021, DMAS reported 589,000 Medicaid expansion enrollees.[iv] This is higher than the number that will likely be enrolled in 2023 because of the continuous coverage requirement during the COVID-19 public health emergency (PHE). States cannot disenroll beneficiaries during that period even if their income rises above the eligibility threshold. The PHE is currently expected to expire at the end of 2021, and it will take about 12 months for normal eligibility processing to fully resume. [v]

The Children's Health Insurance Program (CHIP) line we report is enrollment in separate CHIP. We also have CHIP-funded Medicaid in our model and can report that separately if needed.

Medicaid per member per month costs (PMPMs) were taken from state fiscal year 2019 in the data book. Specifically, we divided total spending by average monthly enrollment and aged the result to 2021 using historical Medicaid cost growth trends. The resulting PMPMs were $29,600 for the disabled, $7,150 for nondisabled adults, and $3,500 for Medicaid children. Costs for Medicaid expansion adults and other nondisabled adults were virtually the same.

Marketplace enrollment targets were based on 2019 effectuated enrollment. Again, we do not use pandemic-era enrollment data because it includes the effect of extraordinary economic and policy factors that will not last into 2023. However, we had to make an important modification for enrollment among people with incomes below 150 percent of the federal poverty level (FPL). The effectuated enrollment data were from early 2019, so they excluded the full effect of the shift of low-income (up to 138 percent of FPL) Marketplace enrollees to Medicaid expansion. We measured the full effect by comparing plan choices among those with incomes below 150 percent of FPL after the 2020 open enrollment period (OEP) with those after the 2018 OEP. Plan choices during the 2019 OEP were transitional between these two.

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iii Michael Simpson, "The Implications of Medicaid Expansion in the Remaining States: 2020 Update" (Washington, DC: Urban Institute, 2020).

iv https://www.dmas.virginia.gov/data/medicaid-expansion-access/ Accessed October 8, 2021.

v Matthew Buettgens and Andrew Green. "What will happen to unprecedented high Medicaid enrollment after the public health emergency?" (Washington, DC: The Urban Institute, 2021).

Nongroup premiums in the model are based on 2021 premiums in each Virginia rating region, aged to 2023 using long-term cost growth trends in private insurance.

The 2019 American Community Survey (ACS) estimates that about 9 percent of nonelderly Virginians were uninsured that year. After our model was calibrated to Medicaid and nongroup market targets, the projected 2023 uninsurance rate was 8.9 percent. This is a little lower than the ACS estimate, primarily because Medicaid expansion enrollment is somewhat higher.

The second-lowest-premium silver plans in all but two of Virginia's premium rating regions are variants of Anthem's HealthKeepers plans. These plans have tobacco use rating that varies by age, with a maximum of 30 percent. The other two rating regions (7 and 11) have a benchmark plan with no tobacco use rating (Cigna).

Health Coverage in 2023

The first column of table 1 (all tables are in the associated Excel workbook) gives a detailed distribution of estimated health coverage in Virginia in 2023 under current law. To match administrative data on Medicaid enrollment, people who have both Medicaid and some other type of coverage—generally employer coverage—are counted as Medicaid enrollees.

Projected Characteristics of the Uninsured in Virginia in 2023

In addition to looking at overall changes in uninsurance when establishing the 2023 Virginia baseline, we also examine how the projected number of uninsured Virginians differs across demographic and economic groups. Even with high Medicaid expansion enrollment, one third of uninsured Virginians would have family incomes below 138 percent of the federal poverty line (Table 13). About 48 percent of the uninsured would have incomes between 138 percent and 400 percent FPL, the income range for Marketplace tax credit eligibility under the ACA. The remaining 19 percent have higher incomes. Many of these people would qualify for tax credits under ARPA, as discussed below.

White, non-Hispanic Whites account for 45 percent of the total number of uninsured people (301,000). Non-Hispanic Whites also have the lowest uninsured rate of any racial or ethnic group, 6.4 percent. Alternatively, those identifying as Hispanic make up 27.2 percent of the uninsured population (182,000) and have the highest uninsurance rate among the subgroups at 25.8 percent. Non-Hispanic Blacks make up 16.8 percent of the uninsured and have an uninsured rate of 8 percent. Asians and Pacific Islanders make up 8.0 percent of the uninsured and have the second-highest uninsured rate, 10.9 percent.

About three quarters of the uninsured are in families with a full-time worker. For many people, employment does not bring access to affordable health coverage, highlighting the importance of Medicaid and the Marketplaces.

We project that 71.1 percent of the uninsured population are U.S. citizens (475,000), 25.4 percent are undocumented non-citizens (170,000), and 3.5 percent are documented non-citizens (23,000.) Among undocumented non-citizens, over 50 percent are uninsured. Additionally, those who do not speak English

very well make up 39.3 percent of total non-citizen uninsured people (134,000) and have a much higher uninsured rate than those with greater English proficiency (36 percent versus 9 percent). English proficiency can be a major barrier to enrollment.

Age, sex, and education levels also exhibit variance in the number of uninsured. Adults in the 19 to 34 and 35 to 54 age groups make up the majority of uninsured individuals and also have the highest uninsurance rates among age groups. Children under 18 and adults between 55 and 64 represent significantly smaller portions of the number of uninsured (64,000 and 60,000) while also having a much lower uninsurance rate due primarily to the Children's Health Insurance Program. A majority of the uninsured are male, and they have a higher uninsured rate than females. It is a general pattern that take-up rates for insurance are higher for women than for men. Roughly half of uninsured people had a high school education or less. Those with less than a high school education had a much higher uninsurance rate than all other groups (36 percent).

The Impact of Making ARPA Premium Tax Credits Permanent

The president's budget for 2021 includes a provision that would make the enhanced PTCs in the ARPA permanent. Currently, they will expire after 2022. The enhancement makes PTCs more generous for those currently eligible, and it extends eligibility to people with incomes above 400 percent of FPL. We find that if these PTCs made permanent in 2023, they would affect Virginia health coverage and costs as follows:

- About 108,000 more people would be enrolled in the nongroup market, an increase of almost one-third (table 1). Overall, 60,000 more people with incomes below 400 percent of FPL would be enrolled in Marketplace coverage with tax credits, and 55,000 people with incomes above this level would begin receiving them. Some of the latter were previously enrolled in nongroup coverage without PTCs, so that is why the total change in the market is 108,000 rather than 115,000.
- There would be 81,000 fewer uninsured Virginians.
- Nongroup premiums would decline by 8.5 percent (table 4).
- Federal spending on PTCs would increase by $509 million.
- We estimate that the change in demand for uncompensated care funded by the federal government would decline by $172 million. However, decreases in demand do not necessarily translate into actual savings. We estimate that the federal government would realize at least $86 million in savings, primarily through Medicare disproportionate share hospitals.
- The demand for uncompensated care funded by the state would decline by $107 million. It is difficult to estimate how much of this would be realized as savings to the state. If half the change in demand is realized as savings, that would be $54 million.

Enhanced Cost-Sharing Reductions in Virginia

We present estimates of the impact of several options to reduce the amount that Virginia Marketplace consumers spend on health care. We simulated two very different approaches to reducing cost sharing. The first builds on the ACA's cost-sharing reductions (CSRs) and makes them more generous and the second provides enrollees with a debit card.

Enhancing the ACA's Cost-Sharing Reductions

Under the first approach, directly enhancing the ACA's CSRs, we set the following enhanced CSR levels (exhibit 1).

EXHIBIT 1

Standard and Enhanced Cost Sharing Reductions

	Standard ACA CSR AV (%)	Enhanced CSR AV (%)
Income as relative to the FPL		
< 138	94	95
138–150	94	95
150–200	87	95
200–250	73	90
250–300	70	90
300–400	70	85

Note: The changes for those with incomes up to 150 percent of FPL are negligible.

An important thing to note about CSRs is that they are only available to people who choose the benchmark plan. Those who, for example, choose bronze coverage to lower their premiums forgo any CSRs for which they are eligible. In recent years, the number of people choosing to do this has increased.

We find that the following would occur if Virginia enhanced the ACA's CSRs in 2023:

- There would be 21,000 more nongroup enrollees than with ARPA PTCs alone (table 3).
- The number of people uninsured would decline by 5,000 compared with ARPA PTCs alone.
- Nongroup premiums would be 7.9 percent lower than under pre-ARPA PTCs (table 4). However, this means they would be 0.6 percent higher than with ARPA PTCs alone. Enhanced CSRs are most attractive to those who expect to incur significant health care costs, leading to some adverse selection.
- The federal government would spend $152 million more in PTCs than with ARPA PTCs alone.
- Enhanced CSRs would cost the state $49 million. If fewer people choose bronze plans, this cost would be larger.
- Among those taking CSRs, the reductions in out-of-pocket (OOP) health care spending would average about $1,000 per person. The amount per person would be about the same at all income levels above 150 percent of FPL.
- Uncompensated care savings would be slightly larger than with ARPA PTCs alone.

Providing Marketplace Enrollees with a Debit Card for Out-of-Pocket Medical Spending

The second proposal to reduce cost sharing is very different from the ACA's CSRs. Those enrolled in Marketplace coverage with PTCs would receive a debit card to be used for paying OOP health care costs. The amount would vary by family size and income:

- Those with incomes up to 400 percent of FPL would receive $500 per adult and $300 per child.
- Those with higher incomes would receive $250 per adult and $150 per child.

Unlike the ACA's CSRs, these cards could be made available to all enrollees, regardless of the actuarial value of the plan they select. Alternatively, the state could choose to only make them available to people who choose silver plans. We show results with both options in the detailed tables, though our discussion focuses on the former.

We assume this money will not be subject to state or federal taxes and that funds not spent in one year can be rolled over to the next.

The state could also choose to allow the debit card to be used for approved over-the-counter (OTC) health costs. Medicaid programs in Virginia and many other states have OTC benefits. The new debit card proposal could draw on the experience of those programs to verify that it is used only for legitimate OTC health care.

We find that the following would occur if the debit cards are made available to all Marketplace enrollees receiving PTCs:

- Nongroup enrollment would increase by 8,000 people compared with ARPA PTCs alone (table 3).
- The number of people uninsured would decline by 7,000 from the ARPA PTC scenario alone.
- The benefit per person specified for this option, $500, is about half the average per person benefit of the CSR option. However, the state would end up spending more ($160 million) because everyone is eligible regardless of plan choice (table 4).
- This CSR option would see a larger decrease in the uninsured, so potential uncompensated care savings are somewhat larger.
- Nongroup premiums would decline by 1 percent relative to under ARPA PTCs alone. When combined with ARPA PTCs, premiums would decline by 9.5 percent.

If the debit cards are restricted to those choosing silver plans, state costs would be about the same as under the first CSR option, but the coverage impact would be much smaller.

Lower Cost Sharing without ARPA PTCs

The results discussed above assume ARPA PTCs are made permanent. We also examine what would happen if standard ACA PTCs resume in 2023 and the state reduces cost sharing. For the debit card option, we find the following would occur:

- Nongroup enrollment would increase by 18,000 people (table 3). This is somewhat larger than the impact of the debit card option on top of ARPA PTCs, because the enhanced PTCs would by themselves lead to the enrollment of many people who would be attracted by enhanced CSRs.
- The number of people uninsured would fall by 18,000. We see again that most of the new enrollment due to the debit card option would be among those otherwise uninsured.
- The debit card option would cost the state $114 million in 2023 (table 4).
- Demand for state-funded uncompensated care would decline by about $9 million. Due to the complexity of funding uncompensated care through state and local governments, it is difficult to say how much would be realized as savings to the state. However, it is reasonable to expect that about half of the change in demand would be savings.
- Nongroup premiums would decline by 5 percent. We see again that the debit card option can improve the nongroup market risk pool.

Any proposal that reduces cost sharing would apply to all existing enrollees, who will greatly outnumber new enrollees because of enhanced CSRs. Thus, the strongest argument for a state CSR would be to show in detail how it would reduce families' health care spending. Just looking at state cost per newly insured person misses the main impact of the policy.

There are several important differences between the two types of CSRs that we considered (exhibit 2).

EXHIBIT 2

Comparison of Two Approaches to Cost-Sharing Reductions

	Enhancing ACA CSRs	OOP Debit Card
Marketplace plan choices	Available only to those choosing silver plans. This cannot be changed; otherwise, everyone could pick the lowest premium for the least comprehensive plan but get the same coverage.	Could be made available to all, regardless of plan choice. This increases state costs but is more attractive to those currently uninsured.
Nongroup premiums	Because these CSRs are more comprehensive insurance, they benefit those with higher medical costs the most. This results in some adverse selection and higher premiums.	The dollar value is the same, regardless of health risk, and the money is available immediately to help pay down OOP spending. Does not drive adverse selection. In fact, nongroup premiums decrease.
Over-the-counter costs	Could not be included.	Could be included.

A debit card would make the money available immediately, and so it would be more valuable than the equivalent dollar amount for ACA-like CSRs, particularly to people who do not have high expected health costs. On the other hand, ACA-like CSRs are actual insurance, so they provide protection against the risk of high health care costs that the fixed-amount debit card would not. This would make CSRs more attractive to those with relatively high expected costs. This is why our simulation model projects opposite results in terms of nongroup premiums for the two types of CSRs. Though our model accounts for this difference, one can argue that the behavioral economics literature could justify higher take-up for the debit card option than we have simulated here. We did not include such a boost in these results.

Public Options in Virginia

We present estimates for three public option scenarios in Virginia. The first two approaches assume the addition of a new plan in the Marketplace that would set nongroup rates to be a percentage above each region's average Medicaid rates. The third scenario assumes one additional plan would enter each of the 12 rating regions, sparking increased competition among all plans and resulting in lower costs. For example, this policy might require a Medicaid managed-care plan to enter the Marketplace in each region that does not currently have one. (Region 7 is the only region that currently does.) We show results both

(1) under the assumption that the ARPA's PTCs are made permanent and (2) under the assumption that standard ACA PTCs return beginning in 2023.

Virginia Payment Rate Adjustments

The table below details the rating region adjustments used for the public option simulations based on Medicaid rates (exhibit 3). We used Virginia Health Information (VHI) claims data to compute the ratio between nongroup market and Medicaid reimbursement for hospital and nonhospital services. The data show hospitals would see their reimbursement cut by much more than other providers under a public option.

Prescription drug discounts (column 4) are set to zero because we assume the pharmacy benefit managers (PBMs) with which Virginia could realistically contract are unlikely to have more negotiating power than the PBMs commercial plans currently use. Indeed, they would likely be one of the same PBMs. As a result, they would not have the same leverage as those who negotiate rebates for the national Medicare program. The levels of payment rates that we were asked to assume do not imply that we think they could necessarily be implemented without potentially serious problems. We cannot predict the responses of health care providers—particularly hospitals, who would see the largest cuts—and insurance carriers to such cuts.

EXHIBIT 2

Payment Rate Adjustments, by Rating Region

Virginia rating region	VHI nongroup hospital	VHI P series (nonhospital)	Rx discount	Resulting Medicaid adjustment	Medicaid +15%	Medicaid +25%
1	-70%	-42%	0%	-45%	-30%	-20%
2	-65%	-54%	0%	-47%	-32%	-22%
3	-67%	-49%	0%	-46%	-31%	-21%
4	-57%	-48%	0%	-41%	-26%	-16%
5	-50%	-36%	0%	-34%	-19%	-9%
6	-65%	-42%	0%	-43%	-28%	-18%
7	-39%	-47%	0%	-33%	-18%	-8%
8	-70%	-42%	0%	-45%	-30%	-20%
9	-63%	-57%	0%	-47%	-32%	-22%
10	-46%	-44%	0%	-35%	-20%	-10%
11	-59%	-40%	0%	-39%	-24%	-14%
12	-61%	-45%	0%	-42%	-27%	-17%
Unweighted average	**-59%**	**-46%**	**0%**	**-41%**	**-26%**	**-16%**

Setting Nongroup Payment Rates to Medicaid Plus 15 Percent

The first two simulations set provider payment rates at a certain percentage above Medicaid rates. The first and largest cut to payment rates sets nongroup rates to be 15 percent higher than regional Medicaid rates. Under this condition, we predict the following outcomes:

- Nongroup premiums would fall by an additional 22.2 percent compared with ARPA premiums (table 6). This is not the same as the 26 percent in exhibit 3 because that estimate is an unweighted average across rating regions, whereas the 22.2 percent computation considers the distribution of enrollees across regions.
- The number of nongroup enrollees would increase by 6,000 compared with ARPA PTCs alone (table 5). The public option would not affect the premiums paid by those eligible for PTCs, which make up the large majority of the nongroup market.
- Lower premiums mean some people who previously received PTCs no longer do so because the premiums are already lower than the applicable percentage of income. This is particularly true of those with incomes above 400 percent of FPL.
- This also means the federal government would spend $570 million less on Marketplace PTCs than under the ARPA PTC scenario alone.
- The number of people uninsured would fall by 2,000 compared with ARPA PTCs alone.

Setting Nongroup Payment Rates to Medicaid Plus 25 Percent

The second option similarly uses a Medicaid reference point but instead sets nongroup rates at 25 percent above average Medicaid rates. Because this option is less generous than the first, federal spending on Marketplace PTCs would be higher and household costs would decrease by less than the previous scenario. We also observe the following:

- Nongroup premiums would be 13 percent lower than ARPA premiums (table 6).
- The number of people uninsured would decline by 4,000. This is comparable with the previous option (table 5).
- Nongroup enrollment would increase by 6,000 compared with ARPA PTCs alone. Some people who were previously receiving PTCs would become ineligible and join full-pay or other private nongroup plans, but this number would be lower than under the previous public option.
- The federal government would spend $328 million less on Marketplace PTCs compared with the ARPA PTC scenario.

Enhancing Regional Competition by Increasing Plan Choices

We also consider a scenario where each region has one additional insurance plan. This would reduce household costs and increase coverage by fostering more competition among insurers. Whereas the previous two scenarios assumed Medicaid targeted payment rates directly, this option is based on prior research by our colleagues on the impact on premiums of increasing the number of insurers participating in the Marketplaces.[vi] If each region had one additional Marketplace plan, the following would occur:

vi John Holahan, Erik Wengle, and Linda J. Blumberg, "What Characterizes the Marketplaces with One or Two Insurers? An Update" (Washington, DC: Urban Institute, 2019).

- Nongroup premiums would decline by 5.8 percent compared with premiums under ARPA PTCs (table 6).
- Compared with the ARPA PTC option alone, 4,000 more people would enroll in nongroup coverage (table 5).
- Compared with the ARPA PTC option alone, $144 million less would be spent on Marketplace PTCs.
- The number of people uninsured would fall by 4,000 compared with the ARPA PTC option. This is similar to both of the previous options.

Public Options without ARPA Premium Tax Credits

We also estimate how these results would differ without ARPA PTCs assuming payment rates of Medicaid plus 15 percent and increased Marketplace competition. Both scenarios result in much more moderate changes to nongroup coverage. When first looking at the Medicaid plus 15 percent option, we find the following:

- The number of nongroup market enrollees would increase by 14,000, most of whom would not be eligible for PTCs (table 5).
- Uninsurance would decline by 8,000 people. This is around 10 percent of the decrease that would be observed if this option were combined with ARPA PTCs.
- Federal spending on Marketplace PTCs would decrease by $369 million (table 6).
- Nongroup premiums would decrease by 21.1 percent compared with pre-ARPA premiums.

We also look at the effect of adding one additional plan to each region without including ARPA PTCs. The results are as follows:

- Nongroup enrollment would increase by 5,000 people. This is around 5 percent of the combined ARPA PTC effect.
- The number of people uninsured would decrease by 4,000.
- Federal spending on Marketplace PTCs would decrease by $36 million, or 2.7 percent
- Nongroup premiums would fall by 1.5 percent relative to pre-ARPA premiums.

Coverage impacts of the public option are smaller than those of other options, such as enhancing tax credits, because the public option affects the premium paid by those who are ineligible for PTCs, a minority of the nongroup market. This is particularly true if ARPA PTCs are renewed.

The main goal of a public option is to bring down health care costs, whether by imposing payment rates or by adding low-cost competitors to the existing market. The federal government would spend substantially less on PTCs. Indeed, most nongroup enrollees receive PTCs, so the federal government would be the main beneficiary of a public option. If Virginia were to add a public option to one of the other alternatives we simulate, it would not directly reduce the cost to the state for any of the options we simulate. However, if an individual mandate is included as part of a Section 1332 State Innovation Waiver, at least some of the federal government's savings could be passed on to the state.

Individual Mandate in Virginia

In this section, we estimate the effect of implementing an individual mandate in Virginia. Each scenario applies penalties and exemptions based on the mandate rules originally set forth in the ACA. The

maximum tax penalty paid is the lesser of 2.5 percent of yearly household income and the yearly premium cost for a bronze plan sold through the Marketplace that year. As with the ACA's mandate, people not required to file taxes—a large share of the uninsured—are exempt. The first approach projects the impact of an individual mandate under the assumption that the ARPA's PTCs are made permanent. The second approach estimates the individual mandate's effect under the assumption that standard ACA PTCs return beginning in 2023.

Our estimates of the revenue collected in individual mandate penalties represents the maximum that could be collected by the state. There will likely be special exemptions for things like financial hardship and religious conscience, just as there were with the ACA's mandate. We cannot model exactly what mandates would be allowed and how many Virginians would gain exemption as a result. Also, we do not model tax enforcement, so we assume 100 percent collection of penalties from those not exempt.

Individual Mandate with ARPA Premium Tax Credits

We first present the impact of an individual mandate assuming ARPA PTCs are made permanent. Similar to the previous section, we look specifically at the marginal effect of the individual mandate when subtracting the changes that resulted directly from implementing ARPA PTCs. Under this approach, we predict the following outcomes:

- Nongroup enrollment would increase by 1,000 people relative to ARPA PTC enrollment (table 7).
- Federal spending on Marketplace PTCs would increase by $4 million compared with ARPA PTC spending (table 8).
- The number of people enrolled in Medicaid/CHIP would rise by 4,000. Because of this, federal Medicaid costs would increase by $16 million and state Medicaid costs by $7 million.
- Compared with the ARPA PTC scenario alone, 4,000 fewer people would be uninsured.
- Nongroup premiums would decrease by 0.2 percent relative to the ARPA PTC scenario. The combined effect of an individual mandate and ARPA PTCs would be an 8.7 percent reduction in nongroup premiums.
- The state would raise up to $7 million in mandate penalties. This is a maximum amount, as explained above.

Individual Mandate with Pre-ARPA Premium Tax Credits

The second approach applies the same individual mandate conditions but instead assumes pre-ARPA PTCs resume in 2023. We see a slightly larger marginal increase in coverage resulting from the individual mandate under pre-ARPA conditions compared with what is seen from the individual mandate with ARPA PTCs. This is because the enhanced ARPA PTCs by themselves increase participation substantially. Thus, the pool of uninsured people is smaller to begin with under the ARPA individual mandate. Additionally, we predict the following changes to Virginia health costs and coverage:

- The number of nongroup enrollees would increase by 2,000, the majority of whom would be PTC recipients (table 7).
- Federal spending on Marketplace PTCs would increase by $2 million (table 8).
- Medicaid/CHIP enrollment would increase by 5,000. This would be accompanied by an additional $17 million in federal Medicaid spending and $8 million in state Medicaid spending.
- There would be 6,000 fewer people uninsured in Virginia.
- Nongroup premiums would fall by 0.5 percent relative to pre-ARPA premiums.

- The state would raise up to $9 million in mandate penalties. This is a maximum amount, as explained above.

The goal of an individual mandate is to encourage more people to enroll in coverage, which decreases the number of people uninsured and reduces premiums by stimulating a healthier risk pool. Beginning in 2019, the tax penalty for failing to comply with the federal-level individual mandate was eliminated. However, people who previously enrolled in coverage because of the mandate likely remained enrolled even after the penalty was eliminated. As a result, we do not estimate a sharp increase in coverage in these scenarios.

By enacting an individual mandate in Virginia, uninsurance and nongroup premiums would both fall slightly. The federal government would spend somewhat more on Marketplace PTCs, and the additional costs to the state would be moderate.

Eliminating the Tobacco Use Surcharge in Virginia

We present estimates on the impact of eliminating the tobacco use surcharge in Virginia. Current federal law allows insurers to increase premiums by as much as 50 percent for tobacco users; however, insurers typically do not invoke the maximum tobacco surcharge. In Virginia, 10 of 12 rating regions have second-lowest silver plans with tobacco use surcharges. Anthem is the second-lowest silver plan in these 10 rating regions. Anthem's surcharge varies by age (exhibit 4):

EXHIBIT 3

Anthem Tobacco Use Surcharge

Percent of premium by age

Age	Tobacco Factors
0–17	0
18–24	5
25–29	10
30–39	15
40–49	20
50–59	25
60+	30

As a result of these surcharges, tobacco users can face significantly higher costs for obtaining coverage than those who do not use tobacco. If the second-lowest silver premium in a region has a tobacco use surcharge, premium tax credits do not cover the surcharge. We simulate two scenarios to measure how Virginia health care costs and coverage would change by eliminating this surcharge. The first scenario assumes the ARPA's PTCs are made permanent, and the second scenario assumes standard ACA PTCs resume in 2023.

Eliminating the Tobacco Use Surcharge with ARPA Premium Tax Credits

We first look at the effect of eliminating the tobacco surcharge with ARPA PTCs made permanent. In presenting these results, we look specifically at the marginal effect of eliminating the tobacco surcharge when subtracting the changes that would result directly from implementing ARPA PTCs. We predict the following outcomes:

- About 9,000 more people would enroll in the nongroup market; most of the new enrollment would take place in off-Marketplace plans. The number of receiving premium tax credits would fall slightly (table 9).
- Because the surcharge deters smokers from enrolling, many of whom are relatively healthy, removing the surcharge increases nongroup enrollment and consequently causes premiums to decline slightly.
- The number of people uninsured would decline by 3,000.
- Federal government spending on premium tax credits would decrease by $99 million (table 10).
- Medicaid spending would increase by $5 million at the state level and $9 million at the federal level. With ARPA PTCs alone, Medicaid spending at both levels would decrease.

Eliminating the Tobacco Use Surcharge with Pre-ARPA Premium Tax Credits

We also present the impact of eliminating the tobacco use surcharge assuming pre-ARPA PTCs resume in 2023. Under these conditions, we find the following results:

- There would be 13,000 more nongroup enrollees, around 4,000 of whom would be PTC recipients (table 9).
- Nongroup premiums would decrease slightly because of increased enrollment.
- The number of people uninsured would fall by 10,000.
- Federal government spending on PTCs would decrease by $26 million (table 10).
- State Medicaid spending would rise by $9 million, and federal Medicaid spending would rise by $16 million.

People have debated whether including a tobacco use surcharge goes against the ACA's goal of protecting people from high health care costs. Because premium subsides cannot be used toward covering tobacco surcharges, eliminating the surcharge causes an increase in the number of enrollees in the nongroup Marketplace. However, the impact on health coverage and federal government spending on PTCs varies depending on whether ARPA PTCs are made permanent.

Reducing the Allowed Premium Rating by Age

Under the ACA, premiums may vary by age up to a ratio of 3:1, meaning that premiums for the oldest adults can be up to three times higher than those faced by an 18-year-old. A few states have reduced this ratio, and New York does not allow any variation by age. We investigated the impact of compressing this ratio to 2:1, based on the current age rating in Massachusetts. Doing so will make young adults pay higher premiums, while reducing premiums for older adults.

We find that there would be a net reduction in nongroup enrollment of about 9,000 (Table 13). Higher premiums discourage some younger adults from enrolling. Older adults currently have higher enrollment

rates than young adults, so lowering their premiums does not bring in enough new enrollment to fully offset the loss of young adults. Young adults are more likely to be uninsured without Marketplace coverage than older adults, so this decline in nongroup enrollment results in 7,000 more uninsured people. There is also an increase of 2,000 in ACA-noncompliant plans, such as short-term, limited duration coverage, and a tiny increase in employer coverage.

We also find that compressing the age rating would lead to a small increase in nongroup premiums.

Combination Policy Proposals for Virginia

In addition to estimating the effects of various policies on their own, we also simulate two scenarios in which the policies described above are combined. Both scenarios assume ARPA PTCs are made permanent. These estimates will allow the state to determine whether it is optimal to implement multiple policies to achieve their coverage goals.

Policy Combination #1: Cost-Sharing Debit Card, Individual Mandate, and No Tobacco Use Surcharge

We first look at the effect of combining the debit card option and individual mandate and eliminating the tobacco use surcharge. Similar to the previous policies, we look specifically at the marginal effect of these combined policies relative to the ARPA PTC scenario. We find the following:

- Compared with ARPA PTCs, 13,000 fewer Virginians would be uninsured (table 11).
- About 7,000 more people would enroll in the nongroup market, around 5,000 of whom would be eligible for PTCs.
- Nongroup premiums would decrease by 1.2 percent compared with the ARPA PTC scenario alone; the combined premium effect when including ARPA PTCs would be a 9.7 percent reduction (table 12).
- Because nongroup premiums would fall, the federal government would spend $2 million less on Marketplace PTCs compared with the ARPA PTC scenario.
- The state would spend an additional $159 million on Marketplace CSRs to fund the debit card option.
- The state would raise up to $7 million in mandate penalties. This is a maximum amount, as explained above.
- State Medicaid costs would rise by $8 million, and federal Medicaid costs would rise by $20 million to account for 5,000 more people enrolling in Medicaid/CHIP.

Policy Combination #2: Combining All Policy Options

Additionally, we look at the cost and coverage effects when adding a public option on top of the combination described above. Thus, the second combination simulation includes the following: the debit card option, individual mandate, elimination of the tobacco use surcharge, and a public option that sets nongroup rates to be 25 percent higher than regional Medicaid rates. Under these conditions, we predict the following results:

- The number of people uninsured would fall by 41,000 (table 11).

- Nongroup premiums would decrease by 18.2 percent compared with ARPA PTCs alone. This would be a combined 26.7 percent decrease when including the ARPA PTC effect (table 12).
- An additional 33,000 enrollees would be in the nongroup market. The lower nongroup premiums would result in some people who previously received PTCs transitioning to the full-pay market. Most of them would have incomes above 400 percent of FPL.
- This would also mean federal government spending on PTCs would fall by $460 million compared with ARPA PTCs. The federal government may agree to pass at least part of these savings on to the state if the public option were part of a Section 1332 waiver.
- The state would raise up to $6 million in mandate penalties. This is a maximum amount, as explained above.
- State Medicaid costs would rise by $13 million and federal Medicaid costs by $48 million. The number of people enrolled in Medicaid/CHIP would rise by 9,000.

Each of these policies serves to decrease the number of people uninsured while making coverage more affordable to those already enrolled. Thus, combining multiple policies has the ability to augment these coverage outcomes. Both of these scenarios result in cuts to nongroup premiums and significant declines in the number of people uninsured. Both would require increases to state government spending, which would be partially offset by individual mandate penalties and a possible federal pass-back to the state if a public option were included in a Section 1332 waiver.

Conclusions

We find that whether Congress decides to make the ARPA's enhanced PTCs permanent will have a large impact on Virginia, reducing the number of people uninsured by 81,000. The policy options that we considered would have an impact even if ARPA PTCs were allowed to expire, but the policy options would be much more effective combined with permanently enhanced PTCs.

Though both options for reducing cost sharing would reduce OOP spending and increase coverage, there are some important differences between the OOP debit card proposal and enhancing the ACA's CSRs. With the debit card option, the money would be immediately available without a deductible, so it would be more attractive to relatively healthy people. Thus, it would reduce nongroup premiums, whereas enhanced CSRs would increase them. On the other hand, enhanced CSRs would be more attractive to people at higher risk of incurring medical expenses and would give them more protection from high health care costs than the debit cards. Also, the debit cards could be made available to all enrollees regardless of what plan they choose, whereas CSRs are restricted to people who choose a silver plan. Finally, the debit card could be used to pay for approved OTC medical costs, whereas CSRs could not.

We find that a public option would have only a modest impact on coverage because the large majority of nongroup enrollees are eligible for PTCs and have their premiums capped at a percentage of their family's income, particularly under the ARPA. The main impact of a public option is that the federal government would save hundreds of millions on PTCs. If a public option were part of a Section 1332 waiver, the federal government may agree to pass part of these savings back to the state.

An individual mandate would increase enrollment modestly. However, many people who previously enrolled in coverage because of the mandate likely remained enrolled even after the penalty was eliminated, so coverage changes would not be dramatic. Revenue from the mandate would offset some

state spending, though it is difficult to predict the amount that would be collected because we do not know what mandate exemptions would be allowed or how many people would apply for them. Also, we do not know what share of potential penalties would be collected by the state.

Eliminating the tobacco use surcharge would increase enrollment in private nongroup coverage while reducing nongroup premiums slightly. Plans in Virginia are required to cover smoking cessation programs, giving otherwise uninsured smokers affordable access to these benefits.

We find that these policy options can be combined in many different ways and that the benefits of the options included would for the most part be cumulative. This would also allow potential state spending offsets through individual mandate penalties or Section 1332 waivers to reduce the costs to the state of other policy changes. Virginia has many viable options for increasing health coverage, and many would lower nongroup premiums as well.

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Appendix 2: Estimate of individual market enrollment changes after accounting for Medicaid expansion

Virginia's Medicaid expansion coverage began in 2019. The expansion meant that adults with incomes at or below 138% of federal poverty level can enroll in Medicaid. No official data was tracked to determine how many Virginians left the individual market and enrolled in Medicaid, but JCHC staff estimate that approximately 100,000 people shifted from the individual market to Medicaid between 2019 and 2020.

To reach this estimate, JCHC staff analyzed data from the CMS Center for Consumer Information and Insurance Oversight (CCIIO) public use files, which provide individual market enrollment data by poverty, age, and metal tier level for every plan offered on the federally facilitated market exchange. JCHC staff selected five states to use as a model for what Virginia's market enrollment might have looked like had Medicaid expansion not occurred. The states chosen were Arkansas, Kansas, Tennessee, North Carolina and Ohio, which all had similar trends to Virginia in their individual market prior to 2018. JCHC staff analyzed the enrollment changes in these other five states for individuals below 150% of the federal poverty level (Medicaid expansion eligibility is up to 138% of FPL). These changes were used as a baseline for what would have happened in Virginia if Medicaid expansion hadn't occurred, and then compared to Virginia's actual enrollment (TABLES A1 – A3).

TABLE A1: Actual Virginia individual market enrollment for individuals ≤ 150% of FPL

Year	Actual marketplace enrollment	Change	Percent change
2016	155,117		
2017	143,760	(11,357)	-7.3%
2018	131,245	(12,515)	-8.7%
2019	91,810	(39,435)	-30.0%
2020	55,267	(36,543)	-39.8%

SOURCE: JCHC staff analysis of data from FFM QHP landscape files.

TABLE A2: Estimated Virginia individual market enrollment changes without Medicaid expansion for individuals ≤ 150% of FPL

Year	Percent change	Adjusted change based on trend	Adjusted enrollment
2016			155,117
2017	-7.3%	(11,357)	143,760
2018	-8.7%	(12,515)	131,245
2019	-5.0% (estimated)	(6,560)	124,685
2020	-1.9% (estimated)	(2,315)	122,369

SOURCE: JCHC staff analysis of data from FFM QHP landscape files.
NOTE: Estimated percent change for 2019 and 2020 are based on the average change in the five states chosen for the analysis.

TABLE A3: Estimated movement from Virginia's individual market into Medicaid expansion for individuals ≤ 150% of FPL

Year	Actual marketplace enrollment	Estimated adjusted enrollment	Estimated movement into Medicaid expansion
2016	155,117	155,117	-
2017	143,760	143,760	-
2018	131,245	131,245	-
2019	91,810	124,685	32,875
2020	55,267	122,369	67,102
Total			**99,977**

SOURCE: JCHC staff analysis of data from FFM QHP landscape files.
NOTE: Estimated percent change for 2019 and 2020 are based on the average change in the five states chosen for the analysis.

Appendix 3: History of the ACA and the individual market

The Affordable Care Act (ACA) passed in 2010 and became effective in 2014 with the purpose of providing ways for individuals to obtain affordable health coverage through the individual and small group markets, and Medicaid. Making health insurance coverage accessible and affordable is the primary purpose of the Affordable Care Act (ACA, 2010).

Until 2010 the individual market for health coverage was considered expensive and difficult to navigate for the majority of consumers. Individuals with pre-existing conditions were either priced out of the market or unable to obtain coverage. Pre-existing conditions were defined by insurance companies and included conditions such as pregnancy, asthma, cancer, heart disease, and diabetes. Others who got sick while covered often faced rising medical bills and the possibility of being terminated from their insurer because of high cost illnesses. The ACA addressed all of these issues by requiring insurers to cover everyone regardless of pre-existing conditions. To assist and protect insurance companies from losses due to unexpected high cost claims during the transition period (2014 – 2016) the ACA included three different programs: a permanent self-funded risk adjustment program, a temporary risk corridor program, and a temporary reinsurance program.

> **Risk adjustment** - adjusts for differences in the health of plans' enrollees by redistributing funds from companies with healthier-than-average members to plans with sicker-than-average members (permanent)
>
> **Reinsurance** – protects insurers from losses due to unexpected high cost claims (ended in 2016)
>
> **Risk corridors** – allows insurers to make or lose between 3% and 8% more than predicted before paying or receiving between 50% and 80% of the amount above or below those percentages (ended in 2016)

One of the original policies in the ACA was the "individual mandate." The mandate required everyone to have health coverage or pay a tax penalty. The purpose of the "individual mandate" was to guarantee that the risk pool of insured include a mix of healthy and unhealthy people. The mix is important because it determines how much money insurers will spend on medical claims, which in turn determines premiums and other cost sharing features of an insurance plan. The ACA also established premium and cost sharing assistance subsidies based on income for people who otherwise could not afford to purchase health insurance.

The ACA created a "one-stop-shop" internet based shopping experience for individuals called the "marketplace exchange." The exchange can be operated by either the federal or state governments. Health plans sold on the exchanges have to meet specific requirements in the ACA. These plans are called "qualified" health insurance plans.

As a one-stop-shop for coverage a person can apply through a single application, find out if they qualify for government assistance to offset the costs of coverage, or if they or their

children are eligible for Medicaid. Currently, Virginians apply for health coverage through healthcare.gov, the federally facilitated marketplace (FFM). Depending on their income, an individual or household may be eligible for public health coverage through the Medicaid or CHIP programs, or federal subsidies to purchase health insurance through the individual market (TABLE A4).

TABLE A4: Income eligibility for public health coverage and federal subsidies

Program or subsidy	Percent of FPL	Annual income (2021)
ACA advance premium tax credits	≥ 100%	≥ $12,880
Medicaid (adults 19-64)	≤ 138%	≤ $17,774
Medicaid/CHIP (children 0-18)	148% - 205%	$19,062 - $26,404
ACA cost-sharing reductions (silver plan only)	≤ 250%	≤ $32,200

SOURCE: JCHC staff analysis of the ACA and Medicaid program documents.

Plans are valued based on a tiered system known as "metal levels." Plans are assigned to a metal level based on their actuarial value, which is the estimated percentage of health care costs for covered benefits that are paid for by the insurance plan using plan premiums, versus out-of-pocket costs paid for by the plan's enrollees. The higher the AV, the lower the out-of-pocket costs are (TABLE A5).

TABLE A5: Actuarial value of ACA metal level plans

Metal level	Actuarial value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

SOURCE: Patient Protection and Affordable Care Act.

Approximately 3.8% of Virginians obtain health insurance through the individual market. The majority of people in Virginia with health insurance coverage are covered through employer-sponsored health plans (53%). Others receive coverage through Medicaid, Medicare, Tricare or other publicly funded programs (34.5%). Finally, Virginia continues to have a significant percentage of its population that are uninsured and have no coverage at all (8.7%).

Appendix 4: Other state actions to address affordability in the individual market

Virginia was not the only state experiencing instability and affordability issues in the individual market as federal changes occured. The states listed in the below tables also experienced enrollment declines and rising premiums between 2016 and 2018 and explored a number of different strategies to address these issues. Some states address affordability through the statutory and regulatory processes (TABLE A6) while others established state-based programs to subsidize premiums or cost sharing (TABLE A7).

TABLE A6: Other state strategies to improve affordability through regulatory or rate setting changes

Type of change	What is being done	Who is doing it
Age Calculations	Change age-curve ratios from 3:1	Examples: AL, MA, MS, NJ (8 states)
Tobacco Calculations	Eliminate surcharge	Examples: DC, NJ, RI (7 states)
Stop loss & Reinsurance	Establish programs	Examples: AK, CO, DE (15 states)
State coverage mandate	Requirement with penalties	California, DC, MA, NJ, RI
Competition	Implement public option	WA (2021); CO (2023) NV (2026)
Standardized Plans	Limit plan design; make consumer choice manageable	Examples: CA, CT, NY, OR, WA, VT
Size of household calculation	Apply different calculation for number being covered	NY and VT (only two)

SOURCE: JCHC staff analysis of other state programs.

TABLE A7: Other state strategies to improve affordability through state-based subsidies

State	Eligibility	State Funds	Enrolled	Avg. Cost per Enrollee
California (Premium, 2019)	100% - 600% FPL	$430,000,000	625,000	$688
Massachusetts (Premium and cost sharing, 2006)	Up to 300% FPL only for Silver plan	$178,883,000	298,000	$600
Minnesota (Premium, only available 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; Premium subsidy for any plan; CSRs only for silver	$6,902,994	16,237	$425

SOURCE: JCHC staff analysis of other state programs.

New York and Minnesota adopted the Basic Health Program (BHP) in 2015 by transitioning state funded programs into the BHP (TABLE A8). The BHP covers individuals between 138% and 200% of federal poverty level. The federal government funds 95% of what it would have spent on advance premium assistance tax credits and cost sharing and the money has to be deposited into a "Trust Fund" specifically for medical expenses. The cost to administer the program is the responsibility of the state.

TABLE A8: State profiles of the Basic Health Program

New York Essential Health Program ~800,000 enrollees in 2020	MinnesotaCare Health Program ~90,000 enrollees in 2020
• No premiums beginning in 2021 • $0 deductibles and very low co-pays • Enrollment primarily through exchange • Federal funds cover 98% of $4.0 billion cost • State cost is 1.9%, or $80 million of state funds	• Premiums on a sliding scale based on income - anywhere from $16/month to $80/month • Co-pays for office visits and certain services (e.g. inpatient hospital, emergency room visit, etc.) • Enrollment through exchange or by application • Federal funds cover 87% of $453 million cost • Enrollee premiums and cost sharing is 6.8% of cost ($31 million) • State cost is 5.7% ($26 million) paid for with a 1.8% gross revenue provider tax

SOURCE: JCHC staff analysis of other state programs.

Washington, Colorado, and Nevada created public option health insurance programs but only Washington's is operational. The Washington public option became available in 2020. The state contracted with 5 insurers for "Public Option Plans". At least one of the insurers made the plans available within 19 of 39 counties but none of the public option plans were available in all 19 counties. A key feature of the Washington plan is to reduce costs by limiting provider reimbursements in the aggregate to 160% of Medicare reimbursement rates. In addition, the plans are a subset of WA's standardized plans and are designed with low deductibles ($1,000 lower on average than other plans).

When the Washington public option began, premiums averaged 4% higher than other plans sold on the exchange, with a range of between -2% to +24% (the original estimate was -5% to -10% overall). By the end of 2020 the Washington public option plans enrolled only 1,872 out of 222,731 (< 1% of total enrollment in Washington's individual market).

In 2021 Washington's General Assembly began making changes to the public option for 2022 and beyond. The primary changes for 2022 were:

- If a public option plan is made available in a county, any hospitals in that county receiving payment from Medicaid, a public, or school employee health insurance program must contract with the public option plan to provide in-network services
- Requires insurers to offer all standardized plans and limits number of non-standardized plans

— Beginning in 2023, appropriates $50 million for a premium assistance program to help people with income up to 250% of FPL who are enrolled in a silver or gold standard plan

Appendix 5: Analysis of SB1341

Senate Bill 1341 (Barker, 2021) was referred to the JCHC for analysis as part of its study of affordability in the individual insurance market. This appendix includes background on Association Health Plans, a summary of the challenges with implementing SB 1341 as written due to federal requirements, and JCHC staff's analysis of the challenges realtors face in affording health insurance.

Summary of Senate Bill 1341

Senate Bill 1341 authorizes Virginia realtor associations to create something similar to an Association Health Plan, but that is considered as "large group" health insurance, subject to federal regulations defined by the Public Health Services Act (which references ERISA for definitions and regulatory purposes) and the ACA. The bill requires eligible associations to have at least 100 members, be in existence for at least 5 years, and be organized for a purpose other than to provide health insurance.

As currently written, all members of the realtor associations are eligible for coverage by the plan. Members can be employers, employees with a minimum number of working hours (20/week or 80/month), or they can be self-employed. The realtor associations must also have bylaws and hold regular meetings where all members can vote and be represented on governing boards.

The legislation applies to the statewide Realtor Association and may also apply to at least 19 of the 28 local or regional realtor associations in Virginia that have more than 100 members.

What is an Association Health Plan?

Association Health Plans (AHPs) are multiple employer group medical insurance plans that are subject to the federal Employee Retirement Income Security Act (ERISA) and its regulations. The Affordable Care Act (ACA) requires AHPs that enroll individuals or small groups be subject to the ACA's individual and small-group market regulatory oversight laws and regulations, including plans sold outside of the marketplace.

ERISA has a very limited exception for AHPs covering small employers that allows them to be considered single large-group plans. The association itself must:

1. be bound together by a common interest beyond health coverage;
2. operate as a single employer (e.g. every member participates in control of the plan);
3. employers must have a shared common trade, business, or profession; and
4. consist of employers with at least two common law employees (not including self, spouse or business partner (42 U.S. Code § 300gg–91(d)(6)).

AHPs that qualify can be regulated by the less stringent large group plan state and federal laws and regulations. Large group plans have more flexibility to structure benefits and set premiums than individual and small group plans. In addition, the medical loss ratio requirements for large group plans require more of their revenue to go toward medical claims (85%) and less toward administration than is required for individual and small group plans (80%).

The ERISA exception does not apply to associations of individual "sole proprietors", e.g. the self-employed and independent contractors. Nor does it apply to businesses consisting solely of an individual and his or her spouse, and/or a business partner. As a result, associations of individuals can never be considered a single employer and their AHP can never be regulated as a large group plan.

Recent federal activities involving ERISA and AHPs – Impact on Senate Bill 1341

In 2017 the federal administration issued an executive order requiring the US Department of Labor (DOL) to expand access to AHPs by small employers as an alternative to the plans offered on the individual or small group markets regulated by the ACA. As a result, in 2018 DOL changed the federal definition of "employer" under the ERISA regulations to include "partner" and "self-employed." The change would have expanded association member access to AHPs organized as large group plans.

These regulations were challenged in court by 11 states (including Virginia) and the District of Columbia. The court ruled in favor of the challengers and the regulations never went into effect. The executive order and regulations were ultimately rescinded by the current federal administration.

As a result of the federal court decision, SB 1341 attempts to establish this health coverage but define it as "not insurance." This policy cannot go into effect as written however because it is established as fully insured health coverage, which would have to be considered insurance. Stakeholders have indicated that authorizing a similar plan could be possible if it is a self-insured plan, but it is still unclear whether this would be allowed under current state licensing and federal ERISA laws and regulations.

Health insurance affordability challenges for realtors in Virginia

While the American Rescue Plan (ARPA, 2021) made health insurance premiums more affordable to more people by increasing federal tax credits, it appears that affordability is still an issue to be addressed for realtors and other self-employed individuals. As the data below indicate, premium tax credits and cost sharing assistance available through the ACA's individual market may not be available to the average realtor in Virginia. In addition, preliminary research indicates that the availability of small group plans sold on the exchange is limited by location and by plan type. Finally, self-employed individuals purchasing plans on the small group market are not eligible for any ACA financial assistance.

The following data provides some demographic information for realtors that illustrate the health coverage affordability concerns that SB 1341 was trying to address:

- There are 55,834 licensed realtors in Virginia
    - 13,340 (24%) are considered "wage earning employees"
    - 42,500 (76%) may be considered "sole proprietors" (self-employed and/or independent contractors)
    - 35,000 (62.7%) are members of the Virginia Realtors Association
- 65% of all realtors are female, with a median age of 54
- Between 7,818 (14%) and 11,168 (20%) realtors may be uninsured in Virginia
- 55% of realtors reported paying the full cost of their health insurance premium in 2020
- 52% of realtors reported buying a family policy
- 70% of realtors reported household income from all sources to be over $75,000 in 2020 (582% of FPL for an individual; 342% of FPL for a family of three)
    - The median wage of a realtor in Virginia was $65,023 (2020)
    - the average wage of a realtor in Virginia was $80,537 (2020)

Appendix 6: Study resolution

Health insurance affordability in the individual market

Authorized by the Joint Commission on Healthcare on December 15, 2020

WHEREAS, there are approximately 270,000 Virginians who purchase health insurance on the individual market through the ACA marketplace; and

WHEREAS, affordability concerns exist for low income individuals who qualify for federal premium subsidies but are unable to afford to seek medical care because of high out of pocket costs, and for higher income individuals who struggle to afford premiums because they are not eligible for federal subsidies; and

WHEREAS, the ACA marketplace is intended to be a one-stop shop for individuals and small businesses to purchase affordable health insurance coverage; and

WHEREAS, uncertainties and instability in the market have led to a lack of affordable health insurance coverage offered by insurers on the marketplace; and

WHEREAS, the number of Virginians who are uninsured because of affordability remains a concern; and

WHEREAS, multiple state initiatives in Virginia, including adoption of Medicaid expansion, authorization to create a state-based marketplace exchange and authorization to study a state reinsurance program to cover high-cost claims for insurers are now underway; and

WHEREAS, policy proposals to address affordability in the individual market were referred to the Joint Commission on Health Care during 2020, including the use of Association Health Plans, the Basic Health Program, and a public option, now, therefore be it

RESOLVED, by the Joint Commission on Health Care that staff be directed to study additional strategies Virginia can adopt that will help the state create a more stable individual health insurance marketplace that can offer more affordable coverage, regardless of income.

In conducting its study, staff shall (i) review policy options being implemented in other states directed at stabilizing the individual marketplace; (ii) identify options that may make health coverage more affordable and available to individuals regardless of income; (iii) assess the methods of achieving stability and affordability to maximize any federal funds that may be available to offset any increased costs; and (iv) determine, where possible, the impact of each option on the state, insurers, providers and consumers, including any unintended consequences.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia State Corporation Commission and the Virginia Department of Medical Assistance Services shall provide assistance, information, and data to the JCHC for this study upon request.

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