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The Evolution of the Individual Market (Part II)

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Part I of this article series was included in the March 2017 issue of *Health Watch*.[1] It was written a few months after Donald Trump's election to the presidency and 2018 Affordable Care Act (ACA) regulations were finalized. With legislative repeal efforts ongoing and general regulatory uncertainty, the appropriate time to publish Part II has been in flux. In terms of stability in the ACA individual markets, the waters are now as calm as they have ever been. Legislative repeal efforts have failed, and a new divided Congress brings assurance of at least two years of no material changes. President Trump issued a series of regulations in 2017 and 2018 that has brought dynamic changes to the market. As these changes are being implemented, the market has become more profitable and issuers are returning in 2019. Now is the right time to chronicle the past two years and anticipate what to expect in the next two.

Part I carried us from pre-ACA markets through the final 2018 regulations implemented by the Obama administration in 2016. The article indicated that Part II "will discuss the transition from the current market rules to a more decentralized system that seeks to offer coverage incentives with more flexible choices, a likely scenario under a Trump administration."[2] Recent guidance provides states that additional flexibility of waiving ACA rules within their borders.[3] This article begins where we left off in 2017, and it is segmented into four sections, each representing a year with two notable items and a flair of alliteration to keep things interesting.

2017: RATE INCREASES AND REPEAL FAILURES

The year 2017 marked the four-year-old ACA's first time in the swimming pool without a life jacket. An initial three-year discovery period allowed issuers to participate in the market with federal risk corridors and reinsurance acting as stabilizing mechanisms. This allowed health plans to test the waters with some temporary risk protections and provided some incentive to be more aggressive without market-specific historical data in a price-sensitive market.

In determining 2017 ACA premiums, insurers had two years of ACA experience to analyze. It was suggested by health actuaries and other commentators that 2017 might be the telling year to evaluate the market conditions based on carrier participation, as health plans evaluate two years of transitional experience before committing to participate in a riskier market without the temporary risk mitigators.[4] The industry responded with high rate increases that some observers considered a "one-time pricing correction";[5] others were more pessimistic and said the overall ACA model design was unsustainable. The number of both issuers and enrollees dropped for the first time in 2017.

The ACA's struggles greased the wheels of "repeal and replace" efforts from a Republican Congress and a new Republican president. The House of Representatives passed the American Health Care Act (AHCA) in May 2017.[6] The individual market design incorporated in the legislation was largely based on 2016 policy proposals featuring "age-based tax credits."[7] Such a feature is somewhat tax equitable to the deductibility of premiums in group markets, but more highly leveraged for individuals in low tax brackets. At the time, I noted that such a proposal would likely "attract the most people across the age and income spectrum,"[8] be administratively simpler and not involve the Internal Revenue Service.

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Then it was the Senate's turn. The methodology in the Senate's first attempt, the Better Care Reconciliation Act (BCRA), aligned more closely with the ACA's income-based subsidies than the AHCA's age-based tax credits. It was quickly derided by critics as "Obamacare-lite."[9] The BCRA and other Senate repeal attempts that followed came critically close to passage, but all were unanimously rejected by Democrats and none could align the slim-majority Republicans. The stalled legislation increased both the speed and the importance of regulatory action by the executive branch, which changed the market dynamics beginning in 2018.

2018: THE CSR PARADOX AND THE CBO

As Congress explored various repeal bills in 2017, President Trump provided some interesting commentary throughout the process. In a Rose Garden ceremony celebrating the AHCA passage, he spoke of coming reductions in premiums and deductibles.[10] A month later, he decried the legislation as "mean"

and said that perhaps the Senate could be "more generous, more kind."[11] Throughout the failed Senate efforts, he frequently dangled cost-sharing reduction (CSR) payments as a negotiating tool.[12] In October 2017, after receiving a legal recommendation from the Department of Justice, President Trump discontinued the CSR payments. Critics were quick to paint this maneuver as "sabotage," but the mechanical results largely boosted premium subsidies and benefited subsidized enrollees.

While others, including yours truly,[13] had previously written about this paradoxical impact, it was the report from the Congressional Budget Office (CBO) that brought this truth to the attention of the members of Congress who don't frequent actuarial consulting websites. It remains unclear how well this resonated. House Democratic Whip Stenny Hoyer, who had directed the CBO to report on the impact of the matter, characterized the CBO's findings as "sabotage that will cause premiums to rise 25 percent."[14]

The CBO's report on consumer impact actually stated that

> because tax credits would increase and gross premiums for plans other than silver plans in the marketplaces would not change substantially, many people with income between 200 percent and 400 percent of the FPL [federal poverty level] would, compared with outcomes under the baseline, be able to pay lower net premiums for insurance that pays for the same share (or an even greater share) of covered benefits. As a result, more people would purchase plans in the marketplaces than would have otherwise and fewer people would purchase employment-based health insurance—reducing the number of uninsured people, on net, in most years.[15]

As an "overall effect," CBO stated, "Most people would pay net premiums for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise."[16]

Of course, the good news for the market was increased government subsidies, which meant bad news for taxpayers. The favorable new environment attracted enrollment in 2018 that was larger than expected by some observers, particularly those who give more credence to nonfinancial measures such as government-sponsored outreach efforts. It should be noted that the "good news" did not come without the cooperation of states. Most states allowed issuers to properly reflect the additional CSR-induced costs only in silver plans in 2018; others are making this change in 2019.

2019: MORE ISSUERS AND MORE OPTIONS

The benefit of the redesigned market in 2018 has not gone unnoticed. Issuer profitability is at record levels.[17] The beneficial changes have reignited insurer interest in ACA markets, with 17 percent more state-level insurers entering markets in 2019 after a 28 percent reduction in 2017 and a 21 percent reduction in 2018.[18] Partially reflecting the high profitability, the average premium level in 2019 is lower than the prior year for the first time.[19]

Like most mechanisms associated with the ACA, bad news begets good news and vice versa. The good news and bad news in 2018 are being reversed somewhat in 2019. The higher taxpayer burden in 2018 is dampened in 2019 by the lower resulting premiums and subsidy obligations. Conversely, the consumer benefits of 2018 may be more complicated and more challenging to obtain in 2019. At the time of this writing, active open enrollment statistics are lower than the same time period last year. It is too early to tell if this signifies enrollees' need

for time to figure out their options or a reduced enrollment for 2019.

The 2019 consumer enrollment decisions are complicated for two reasons. First, more issuers are present in many markets. Second, more off-market options are available and these plans are relatively more attractive with the 2019 repeal of the individual mandate penalty. A brief numerical example illustrates the more complicated process.[20]

Figure 1 represents the 2017 premium environment. An individual is assumed to be at income level with a $200 maximum contribution[21] and a $500 premium subsidy.[22] The $500 subsidy could be used to purchase the desired level of coverage.

Figure 1
Premium Levels With CSR Funding (2017)

	Bronze	Silver	Gold	Platinum
Unsubsidized Premium	600	700	800	900
Subsidized Premium	100	200	300	400

Figure 2 represents the 2018 premium environment after the CSR change. The silver premium is increased to account for the lack of cost-sharing funding, and the new subsidy is $650. The individual would now have favorable choices of an additional $150 subsidy for a gold or platinum plan, or to use only $100 to obtain a bronze plan for free. It would be unwise to select the silver plan unless the actual CSR benefit was desired (typically beneficial between 100 percent and 200 percent of FPL).

Figure 2
Premium Levels Without CSR Funding (2018)

	Bronze	Silver	Gold	Platinum
Unsubsidized Premium	600	850	800	900
Subsidized Premium	0	200	150	250

The decisions presented in 2017 and 2018 are both straightforward, with 2018 being more attractive. Figure 3 considers the addition of a competitor in the marketplace that is priced 12 percent below the current issuer.

Figure 3
Unsubsidized Premium Levels Without CSR Funding (2019)

	Bronze	Silver	Gold	Platinum
Current Issuer	600	850	800	900
New Issuer	528	748	704	792

The premium subsidy is now calculated based on the gross premium of the new issuer. Figure 4 illustrates the resulting subsidized premiums, which are $102 higher to remain with the current issuer ($52 for the bronze plan). A change to the new issuer would result in premiums similar to the prior rates of the old issuer, but the individual may be unfamiliar with the new issuer or deem it less desirable. At higher income levels with higher net premiums, the availability of short-term plan options may also be a decision point. In general, competition in the ACA-subsidized markets gives consumers more choices, but it will complicate the decision making and may result in higher net premiums.

Figure 4
Subsidized Premium Levels Without CSR Funding (2019)

	Bronze	Silver	Gold	Platinum
Current Issuer	52	302	252	352
New Issuer	0	200	156	244

Additional regulatory changes allow for employer flexibility to utilize health reimbursement arrangements (HRAs) to procure individual coverage.[23] Employer migration of employees has been shown to add stability to individual markets.[24] An original guiding principle of the ACA was a “single risk pool” concept that would seek to close doors between various risk pools (i.e., individual and group) and enroll everyone in distinct risk pools. We have certainly drifted away from that ideal with the new HRA regulation, the 21st Century Cures Act, repeal of the individual mandate penalty and expansions of alternative options. It remains to be seen whether these markets will play nice together, but resistance to the concept is much less than it was five years ago.[25]

A more holistic view of 2019 yields an interesting perspective on the individual ACA market and the viability of the ACA as a whole. In a sense, the 2018 changes made the market even more attractive to people who were already relatively more attracted to it, and the 2019 changes provided exit opportunities for those whose regulatory path to an ACA internal solution was less clear. Calling this a multipronged solution seems like a stretch, but effectively the two large segments of eligible ACA enrollees have benefited from either of these actions.

This is useful to understand, because while we as insurance professionals may view all of this as a clunky mess lacking any real design, consumer sentiment is of more interest to Congress than fidelity to insurance or structured policy principles. The catalyst for ACA repeal is identical to the impetus for the ACA itself, and that is a critical mass of people who don’t have a reasonable health insurance solution in the marketplace of last

resort. Relatively speaking, people eligible for ACA markets are happier than they have ever been (at least those who are good at math are), and we see that in the polling results.[26] This all bodes well for a more stable market, and there are more improvement opportunities in 2020 for states that are interested.

2020: STATE FLEXIBILITY AND SETTLING MARKETS

Section 1332 of the ACA created opportunities for waivers in commercial markets that allow states to bypass some of the marketplace requirements, mandates and benefit requirements constructed by the ACA.[27] Beginning in 2017, this section explicitly allowed states to pursue the ACA's objectives in innovative ways, with federal approval and within limits. Specifically, states can use the federal funds provided through the ACA and redistribute them in a more efficient, equitable manner to provide incentives and create broader market appeal.

Regulatory guidance was first issued by the Obama administration in December 2015. Relative to new guidance in October 2018,[28] the prior guidance limited states' abilities to innovate. A notable requirement was that the guardrail measurements were required to be met not only on an average enrollee basis, but on certain subsets of the population as well. These restrictions have effectively limited state waivers to reinsurance and restrained the market improvement opportunities available to states. The recent flexibility granted for state innovation waivers signals opportunity to enhance market attractiveness within the ACA framework.[29] States should begin work now if they want to pursue a Section 1332 waiver for 2020.

The year 2020 also represents the first pricing year for which issuers will have a full year of experience in the new CSR world. Although the market dynamics are always evolving, with issuer changes and risk adjustment challenges, premiums will be developed from a post-CSR risk mix. Unless a surprising number of new regulatory changes are introduced as we approach 2020, we should expect a settling of markets and more stability at the federal level. Of course, this could be offset by vigorous state-level activity.

ONWARD

The individual market continues to evolve. Without fail, "government intervention drives marketplace changes, which, in turn, creates a recurring need for more government intervention."[30] The individual market remains small yet important. It is often a last resort for those seeking health insurance, and it is the only major medical insurance option available to individuals without coverage through government programs or their employers. It must be developed and maintained in a way that is attractive to both insurers and consumers.

The grand legislative efforts to repeal the ACA have failed, prompting an abundance of regulatory activity that has largely been viewed with suspicion but has been beneficial thus far. Additional changes for 2019 were regarded by some as volatile, but issuers have not responded with market exits or high rates as some expected. States will take various approaches over the next few years, some trying to retain the original ACA model with an individual mandate and discouragement of non-ACA-compliant plans. Other states will utilize Section 1332 to reallocate the subsidies and correct some of the unintended consequences of the law. We should look forward to more stability at the federal level, but more variations at the state level.

As mentioned, the ACA environment is as calm as it has ever been. There is some concern that two lingering lawsuits in particular could create some waves. The more recent (and higher profile) case challenges the constitutionality of the ACA based on severability of the individual mandate tax from other ACA mechanisms. The older case, and likely of more actuarial interest, concerns the equity of the ACA risk adjustment methodology.[31] If the market is left undisturbed by the legal environment, we will find out if the current satisfaction in both segments of the bifurcated market will endure.

In Part I, I wrote that "we should be encouraged that any proposed ACA market change will be heavily scrutinized."[32] That has largely held true, but I would like to see the scrutiny turn from reactionary to reflective. The immediate negative reaction to the Section 1332 guidance is a good example; states have real opportunities to improve their marketplaces that have not existed in the past.[33]

As actuaries, we can facilitate the progress toward a reflective perspective as we offer our collective insights to help sustain the challenging individual market. If you are interested in being a part of this endeavor or just staying abreast of the latest dynamics, please join the Individual/Small Group Subgroup discussion[34] as we journey onward. ■

The views expressed herein are those of the author alone and reflect information as of December 2018. They do not represent the views of the Society of Actuaries, Axene Health Partners LLC or any other body.

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ENDNOTES

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34 Links to all of the SOA listservs are available online at *https://www.soa.org/News-and-Publications/Listservs/list-public-listservs.aspx*. Click "Join" to be added to any of the discussion lists.