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ACA Hot Topics

By Kristi Bohn

Editor's note: This article is derived from a two-part Health Section podcast series in which Kristi Bohn, FSA, EA, MAAA, discussed recent policy changes to the Affordable Care Act (ACA) with Jackie Lee, FSA, MAAA, vice chairperson of the Health Section.

Updates to the ACA have been a hot topic for health actuaries for the past nine years. Some of those topics include cost-sharing reduction (CSR) subsidies, an ACA lawsuit in a Texas District Court, waivers for certain ACA provisions, revival of association and short-term health plans, and changes in the small group market. These will all be covered in a new study note that will become part of the exam curriculum for the health fellowship exams.

COST-SHARING REDUCTION SUBSIDIES

CSRs provide cost-sharing support to those whose incomes fall below 250 percent of the federal poverty limit. The support is accomplished via lower deductibles, out-of-pocket maximums, coinsurance and/or co-pays. Carriers who sell silver plans on the exchange must enhance all silver plan designs and, in turn, receive payments from the federal government based on enrollees' claims falling under the enhanced part of the design. This portion of lower-income subsidies has come under massive political pressure, with the Trump administration deciding that the federal government would no longer pay for CSRs beginning in the fall of 2017.

Many states reacted to this announcement by asking carriers, who are required by law to offer the enhanced silver designs on the exchange, to increase the on-exchange silver rates so that the silver premiums cover the actuarially equivalent amount of the CSR payments that they estimate will not be paid by the federal government. "Silver loading" is the common term used for this technique. If not able to load premiums for this required design subsidy, carriers would refuse to participate in the exchanges because they would lose money. Without exchanges, there are no premium tax credits (PTCs) or CSR subsidies, and most states' individual markets would fall apart entirely.

The general direction from most states is to place the premium load on the exchange silver plans only. This maximizes the premium tax credit subsidies for a state's residents and leaves the bronze and gold options at more affordable levels for those who do not qualify for PTC subsidies. The focus on exchange silver plans also improves the numerical accuracy of the load's estimation. The action to load premiums effectively changes the federal CSR support into federal premium tax credit support, and generally ends up costing the federal government more money than the CSR subsidy would have cost, because CSR subsidies are available only to those who select the exchange silver plan variants, while PTC subsidies are available on the purchase of all exchange plans.

Many states jointly filed lawsuits over the termination of CSRs. In late 2017, a court ruled in favor of the Trump administration. The court ruled that states' use of silver loading created an alternative mechanism for financial restitution, and thus states could not demonstrate financial harm. However, in August 2018, a settlement over the failure to pay CSRs was negotiated with Minnesota and New York. These two states can uniquely demonstrate financial harm because each state operates a basic health program where the state directly receives PTC and CSR subsidies and extends unique plans to its residents outside the individual market single risk pool. Also, in early September 2018, a federal judge ruled that the Trump administration's argument that the CSR reimbursement payments could not be paid because they were not funded did not withstand scrutiny. The judge ruled in favor of Montana Health CO-OP's claim that the $5 million it was owed was wrongfully withheld.

As of December 2018, the future of CSR payments was still in limbo. There are bills at Congress to force the restoration of CSR payments that could pass and be implemented without contention, especially given that the restoration would ironically save money. However, it is possible that stakeholders are willing to continue with the status quo, since many states are satisfied with the more beneficial financial outcome accomplished by silver loading. However, that stance could change quickly. While the 2020 Notice of Benefits and Payment Parameters (NBPP), or payment notice, did not prohibit states and carriers from silver loading for 2020, federal regulators indicated that this stance is likely to change for 2021 and beyond. If that occurs, expect more CSR controversy.

TEXAS LAWSUIT

Congress' many attempts to repeal the ACA have largely failed, likely due to Medicaid funding issues. However, the employer penalty associated with not providing health insurance has been delayed, the Cadillac tax (which charges employers for providing generous health coverage) has been delayed, and the individual penalty associated with not having health insurance has been reduced to $0 starting in 2019. The penalty language was not removed from the codified law; the numbers were

simply changed to zero. This may be an important point in the legal process.

In December 2018, a U.S. District Court judge in Texas ruled that the $0 penalty invalidates the entirety of the ACA. That would affect everything—even Medicaid, Medicare, small group, large group, self-insured plans, age 26 access and pre-existing conditions. In reaction to this, 16 states plus the District of Columbia filed for an expedited appeal to a higher court. Now that Democrats have control of the House, House Speaker Nancy Pelosi has stated that the House will use its power to compel the Justice Department to join in on the ACA's defense. The Justice Department previously declined to defend itself on this case, forcing the states to defend it on their own. These defending states have grown due to the midterm election, with some states switching sides entirely. The Department of Health and Human Services has stated that the Texas decision is not an injunction that halts the enforcement of the law and not a final judgment, so the federal government is still enforcing all aspects of the ACA and will not make any changes at this time.

SECTION 1332 WAIVERS

Starting in 2017, states had the option to apply for an Innovation Waiver under Section 1332 of the ACA, which permits a state to waive certain ACA provisions. Provisions that can be adjusted via a Section 1332 waiver include essential health benefits, actuarial value, single risk pool, cost-sharing reduction design, premium tax credit design, network adequacy, small group definition, and the individual and employer shared-responsibility requirements and penalties. Regulation of network adequacy is primarily at the state level already, so that type of waiver is unlikely. Further, the Small Business Health Options Program (SHOP) is defunct in most states, and states' laws and enforcement on small group definitions are recognized federally without the need for a waiver. States have already been able to implement their individual mandate penalties without waivers. To date, most states have used Section 1332 waivers to achieve pass-through of PTC funding. Such a pass-through is needed to encourage state subsidy programs, since state premium subsidies would generally imply less federal premium tax credit support. The PTCs are based on the second-lowest silver plan premium. Without a waiver, if the premium is reduced, the premium tax credits are reduced.

There are four guardrails that must be met for a Section 1332 waiver to gain federal approval.

- **The comprehensiveness standard.** The waiver must provide coverage that is at least as comprehensive as would be provided absent the waiver.

- **The affordability standard.** The waiver must not reduce the affordability of coverage.

- **The coverage standard.** The waiver must provide coverage to at least a comparable number of residents as would be provided absent a waiver.

- **The federal deficit standard.** The waiver must not increase the federal deficit.

As of December 2018, the following states have approved waivers in place: Hawaii for the small group market, and Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin for the individual market. Colorado, Idaho, New Hampshire and North Dakota have waiver applications that are still in process at the time of this writing. Idaho's strategy is unique in that it takes advantage of many types of waivers, while other states have generally proposed or adopted a similar approach, as discussed later. Several states were not successful in either gaining complete federal approval or making it through their own state's legislative process, including California, Iowa, Louisiana, Massachusetts, Ohio, Oklahoma and Vermont. Some of these states would have achieved approval but withdrew their applications due to parts of the applications that were not allowed.

The most common structure of the individual market Section 1332 waivers has been to reintroduce a reinsurance mechanism that provides subsidization support for high cases burdening the individual market, similar to the federal reinsurance mechanism that was in place nationally between 2014 through 2016. External financial support of reinsurance allows carriers to reduce premium rates based on the actuarial expectation of the value

of the reinsurance support. Because premiums are reduced due to state financial support, federal PTC subsidies are reduced. As such, the state files the waiver in advance to retrieve a pass-through of federal regulators' expectations of savings, but illustrating the state's own estimation of those federal savings. This pass-through of federal funds also contributes to the reinsurance program's funding source.

This strategy is somewhat misnamed as "reinsurance" because reinsurance generally implies two or more entities swapping risks at a fair market value. In the case of these so-called reinsurance programs, the external source of program funding is essential; creating more affordable and, thus, sustainable markets is the main goal. The amount of the state's appropriation for the subsidy plays a prominent role, regardless of whether the financing comes from general tax revenue or assessments on carriers and/or providers in other markets. Some of the states that failed to receive waiver approval missed this point. While federal PTC can be redistributed, it cannot increase in the aggregate.

In November 2018, CMS eased its interpretations of each of the four guardrails and provided sample template waiver concepts for states. New concepts included converting PTC pass-through funding into account-based subsidy programs, spreading PTCs differently by income and age, allowing PTCs to subsidize plans that are not sold through the exchange, allowing PTCs to subsidize plans that are not sold through the individual market and using a high-risk pool. Some of these concepts will be contested through the courts.

In the future, it is expected that Section 1332 waivers will become even more common because many states are very concerned over the sustainability of their individual markets and believe their individual markets will disappear in full or partially (particularly in rural areas) without an easement of ACA rules and regulations. However, some states believe the Section 1332 regulations and guidance do not provide enough flexibility, whether due to the guardrails, the limited topics that are waivable, the administrative and financial burden to the state, or the time and resources needed to gain federal approval. A few states, like perhaps Idaho, may attempt to change the laws applicable in their states, without seeking federal approval under a Section 1332 waiver.

REVIVAL OF ASSOCIATION HEALTH PLANS AND SHORT-TERM HEALTH PLANS

The Trump administration issued an executive order in the fall 2017 requiring its agencies to re-evaluate the ACA's prior restrictive guidance on association health plans and short-term health plans. The Final Rules were released and eased the federal requirements in order to make these plans more widely available. Short-term plans moved from a three-month to a 12-month maximum length, possibly renewable for up to three years. Association health plans may now accept working owners who do not have employees, and may use geographic or other grounds as a basis for common interest. If an association chooses to use any of these new federal allowances, though, the association must then rate all of its members on the same basis. In other words, health conditions and past claims experience cannot play a role in rating this new track of association health plans.

In late March 2019, the U.S. District Court for the District of Columbia ruled in *New York v. U.S. Department of Labor* that the Final Rule on association health plans exceeded the Department of Labor's authority by not focusing on plans arising from employment relationships. While industry awaits the Department of Labor's formal response to this ruling, many state regulators may react by delaying approvals for association health plans that take advantage of the expanded allowances found in the Final Rule.

However, both Final Rules did not pre-empt states' existing and emerging insurance laws on these same topics. Many state regulators are concerned, as the ability for association health plans and short-term health plan carriers to select healthier individuals and groups out of the risk pools would only add to the affordability and instability problems these markets face. Further, some short-term carriers do not have a great track record when it comes to claims payment timing and coverage, while some association health plans have an even worse record when it comes to solvency and fraud. Many states are actively working to ramp up their laws to ensure consumer protections and solvency. Some states are passing new laws to disallow short-term and association health plans, or at least limit them based on a review of best practices existing in other states. Other states are actively working to simply assert and communicate the laws already in place.

Carriers' actuaries are likely adjusting individual and small group rates upward starting in 2019 to anticipate worse risks remaining in these two risk pools due to healthier people leaving and joining short-term health plans and association health plans. As a regulator, I often request that such items be quantified so I can assess the reasonability of the attribution; actuaries often fail to heed this request. The Congressional Budget Office and the Government Accountability Office produce excellent references when laws and guidance change, but particularly focus on the effect on federal budgets. These are useful sources to quantify the long-run effect, but the stakeholder viewpoint will need to be changed. From the perspective of a state's budget, these federal actions will have a long-run

effect that could be both negative and positive. For states with a basic health program or a Section 1332 reinsurance program, while individual market premiums will go up, this does not necessarily mean the state would have to pay for more actual high cases while the pass-through funding will go up to support the program. These programs can deliver more money. At the same time, this affects actual people who already find the individual market unaffordable if they do not receive federal premium tax credits.

SMALL GROUP MARKET

Carriers offering plans in the small group markets are concerned over the direct and indirect threats newly presented by the repeal of the individual mandate and the potential increase of association and short-term health plans. As individual market rates rise, many self-employed individuals and very small employers have already re-evaluated their ability to instead purchase health insurance through the small group market. This trend will be exacerbated by the repeal of the individual mandate and the rise of association and short-term health plans, which will cause individual market rates to rise further or even cause some regions' individual markets to disappear completely in the coming years. The higher rates and underwriting risks placed on the individual market boil over to a burden on the small group market's rates and underwriting risk.

For plan years 2018 and beyond, CMS decided it would no longer operate the small group exchange, the Small Business Health Options Program (SHOP), as it had in the past. The main reason is that SHOP failed to enroll enough membership to warrant the administrative effort and cost involved. For plan years 2018 and beyond, the federal exchange role and burden will be relatively minimal: basically showcasing plans and prices, performing plan certifications, providing a call center, processing employer appeals and assisting with small business tax credit. The federal version of SHOP will no longer determine employee and employer eligibility, perform premium aggregation, provide employers and carriers with enrollment and premium reporting, or provide governance over employee appeals. Federal SHOP user fees will be $0. States that do not use the federal SHOP will vary in their own service levels. Over time, it is likely that most states will either revert to the federal SHOP or follow suit in reducing the technical support offered due to the lack of scale that the small group exchange business provides.

The 21st Century Cures Act of 2016 provided small employers with a new opportunity to offer a tax-free benefit called a qualified small employer health reimbursement arrangement (QSEHRA), which enables small employers to finance individual market purchases through a new type of account. The Cures Act's QSEHRA allowance provides an exception to the previous prohibition of employers simply providing compensation conditioned on the purchase of individual market health insurance and then attempting to treat the compensation as if it were a tax-advantaged employer health plan. While the individual market's high level of rates and narrow networks will likely protect small group carriers from material levels of pricing risk due to small employers opting to leave to adopt QSEHRAs, these types of accounts could be attractive to small employers with lower compensated workforces eligible for premium tax credit subsidies. This new option also presents unique design and strategic considerations for any state that subsidizes or revises the individual market in order to address affordability and market stability, since there is often a stability and rate implication of those efforts on the state's small group market. In November 2018, the Trump administration released proposed rules that could expand this strategy to large employers.

STUDY NOTE

The curriculum team has difficulty keeping the new study note for the health fellowship exams up to date when it comes to the Affordable Care Act. It is particularly difficult to do that concisely because coverage of the many changing topics would require multiple issue briefs and long papers. Every few months when the note is revisited, a few new paragraphs are added to keep it up to date. The study note is meant to provide a brief update on many topics that affect the individual market and health actuaries' work, and it provides a short history of what is different since the 2014 implementation of the individual markets' massive changes. The note does not address Medicaid and Medicare topics at all. It only briefly covers small group, large group and self-insured topics, though the rules affecting those markets, and the markets themselves, have been relatively stable for the past five years. That said, the study note is about 15 pages long, so a lot has changed in the past five years, particularly in the individual market.

One cannot look at the Affordable Care Act itself, which passed in March 2010, or the initial implementation guidance, and understand how the market is actually working in practice today. It is important to keep this in mind when discussing the law and taking into account insurance and public policy risks; many who do not work in this area may not be aware of the law's continuous evolution since its passage. ■

Kristi Bohn, FSA, EA, MAAA, is a regulator at the State of Minnesota Department of Commerce. She can be contacted at *kristi.bohn@state.mn.us*.