

REDUCING PREMIUMS AND EXPANDING ENROLLMENT IN THE INDIVIDUAL HEALTH INSURANCE MARKET

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Executive Summary

The Affordable Care Act (ACA) has successfully extended coverage to many people who had no access to health coverage prior to 2014. However, many people are faced with unaffordable or unattractive options if they have moderate incomes and do not have access to employer or publicly sponsored health coverage.

We prepared this report for the BlueCross and BlueShield Association to discuss options that would help to improve the individual market and make individual health coverage more affordable to a broader portion of the population. It contains three sections. The first section is this executive summary. In Section 2, we provide an overview of the individual health insurance market and its current challenges. In Section 3, we discuss options available to help improve this market, and we use our micro-simulation model to illustrate the impact these proposals could have on the market. For details regarding the Oliver Wyman Healthcare Reform Micro-Simulation Model (HRMM) and the methods underlying our estimates, please see [this link](#).

Our primary findings are the following:

- The ACA led to a significant increase in the number of people covered under the individual market through 2015, but enrollment has declined since then, especially among non-subsidized enrollees. At the same time, insurers participating in the individual market experienced significant financial losses through 2016 and then increased premiums in an effort to stem those losses.
- Market improvement proposals currently under consideration include age-adjusted premium subsidies, enhancing cost sharing reductions, enhancing benefits insurers provide to low-income insureds through cost sharing reductions, \$15 billion per year for a reinsurance program, improved outreach and marketing efforts, and the elimination of the 9010 HIT fee. Our analysis shows that each of these could help increase enrollment in the individual market and would increase federal spending marginally.
- Specifically, we find that these provisions, combined, would increase enrollment by roughly 4.2 million individuals in the ACA market, reduce the nationwide

average premium by approximately 33%,¹ and increase federal spending by \$10.2 billion annually, when considering federal outlays for external funding, APTCs, and marketing and outreach spending, but without the impact of lost revenue from the elimination of the 9010 HIT fee.²

¹ The nationwide average premium estimate includes demographic and geographic changes in the ACA risk pool.

² CBO estimated a loss in revenue of \$12.7 billion in fiscal year 2019 due to the elimination of the tax on insurance providers in calendar year 2019. See Table 3: <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/rulescommitteeprint115-55-c.pdf>

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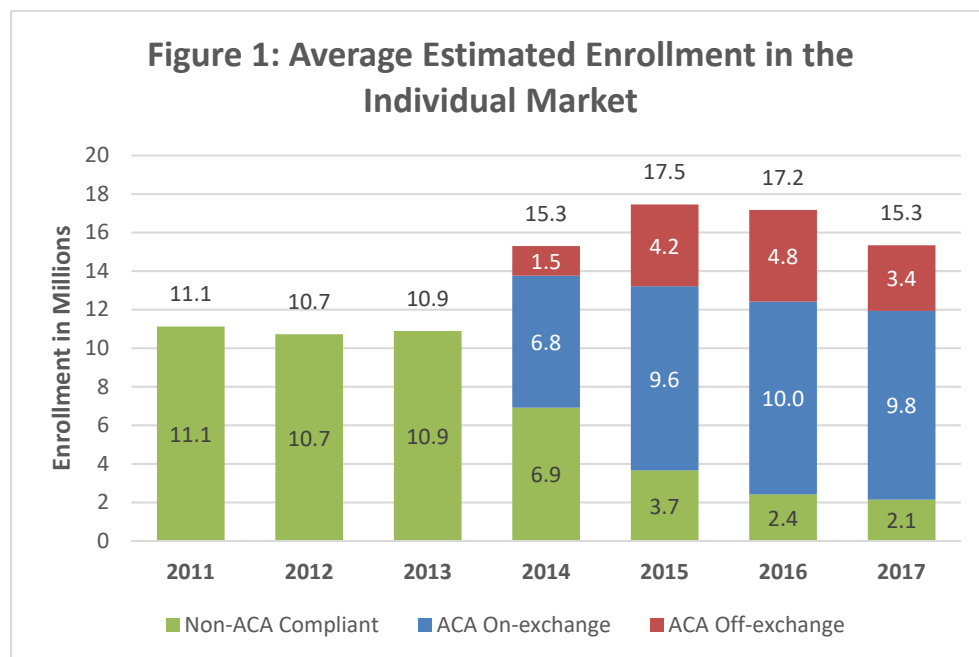
Overview of the Individual Market

The ACA fundamentally changed the operation of the individual health insurance market.³ Enrollment in the individual market increased initially from pre-ACA levels of approximately 10.9 million enrollees in 2013 to 17.5 million in 2015. This was followed by declines in the number of enrollees in 2016 and 2017 (see Figure 1). Most of the decline in 2017 was among the non-subsidized, off-Exchange enrollees in ACA-compliant plans. On-Exchange enrollment remained relatively stable. Most of the on-Exchange enrollees are eligible for premium subsidies (APTCs) that largely shield them from premium increases. However, off-Exchange enrollees are not eligible for APTCs. As a result, these individuals must absorb, in full, any rate increases as discussed below. About 2.1 million or 14% of the total enrollees in 2017 had transitional or grandfathered plans (referred to here as non-ACA compliant plans) which are closed blocks of business with declining enrollment.^{4,5}

³ <https://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html>

⁴ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>

⁵ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>

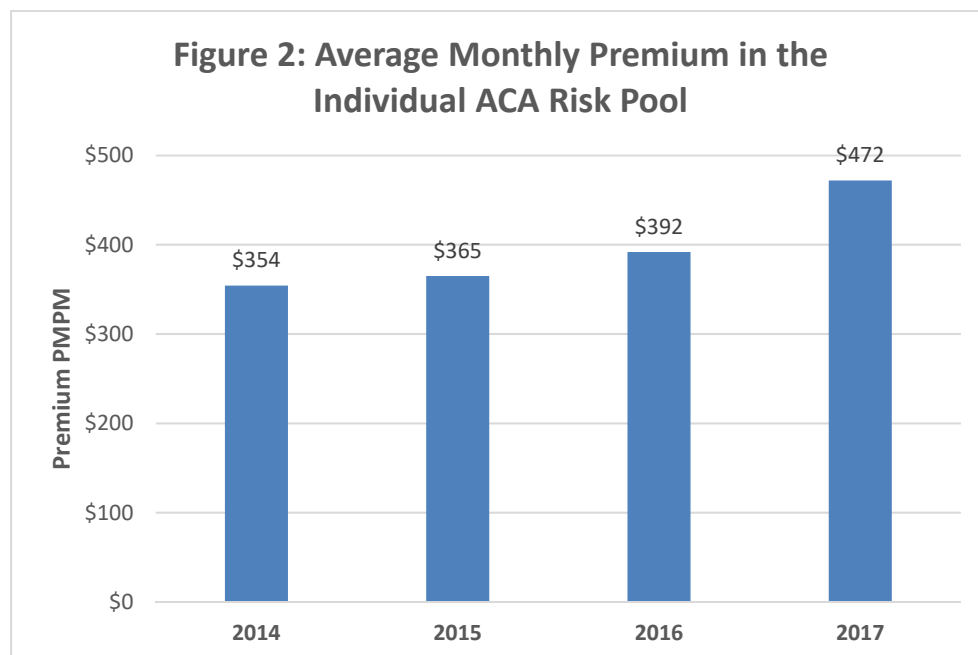


Source: Member months statistics from Statutory Reporting, CMS Summary of Risk Adjustment Transfers, CMS Effectuated Enrollment reports and MLR rebate reports; Excludes student, mini-med or other non-major medical coverage types.

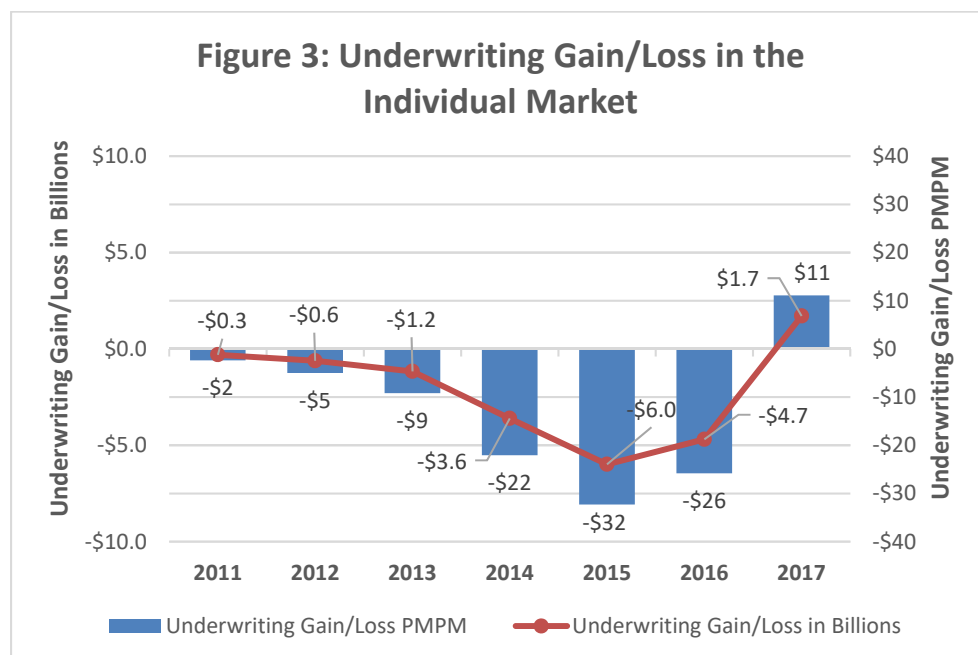
In Figure 2, we show the nationwide average premium per member per month (PMPM) in the ACA individual market from 2014 to 2017. In 2017, the average premium increased by more than 20%, to \$472 PMPM (\$5,664 per year). The primary reason for this increase was the losses issuers were experiencing in this market (Figure 3). As a note, average premiums are significantly higher in the ACA market than in the pre-ACA market, as we discuss in prior work.⁶

⁶ https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August2017/Market_Stabilization_Report.pdf, see Figure 1 in this link

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Source: CMS Summary Report on Risk Transfer Payments 2014-2017; national average enrollment weighted premium; Individual excluding Catastrophic and Merged markets; premium is pre-subsidies.



Source: Underwriting gain/loss divided by member months statistics from Statutory Reporting - Supplemental Health Care Exhibit. Excludes California's DMHC filers.

While the rate increases in 2017 helped issuers stem their losses from participating in the ACA marketplace, premiums in the individual ACA market increased substantially, particularly for the non-subsidized population (those with incomes greater than 400% of the federal poverty level (FPL) or \$100,400 for a family of four in 2019).⁷

In Figure 4, we show how much a family with a household income of 401% FPL with two parents age 50 and two children under age 14, would have to pay, on average, for ACA coverage for the lowest cost silver plan⁸ and cost sharing⁹ after accounting for federal taxes.¹⁰ The family would have to spend a total of \$33,472 for their ACA coverage and cost sharing, or about 33% of pre-tax income, and would have only half of their gross income available for all other expenses after accounting for taxes and health insurance costs. In comparison, typical family coverage provided by private employers is estimated to cost the employee about \$5,824¹¹ on a pre-tax basis and provides coverage with lower cost sharing estimated at \$4,377.¹² The same family would have about \$69,000 in disposable income after accounting for the cost of health insurance and taxes as shown in Figure 5, which is about 36% more income than if the family were covered in the individual ACA market.

⁷ <https://aspe.hhs.gov/poverty-guidelines>

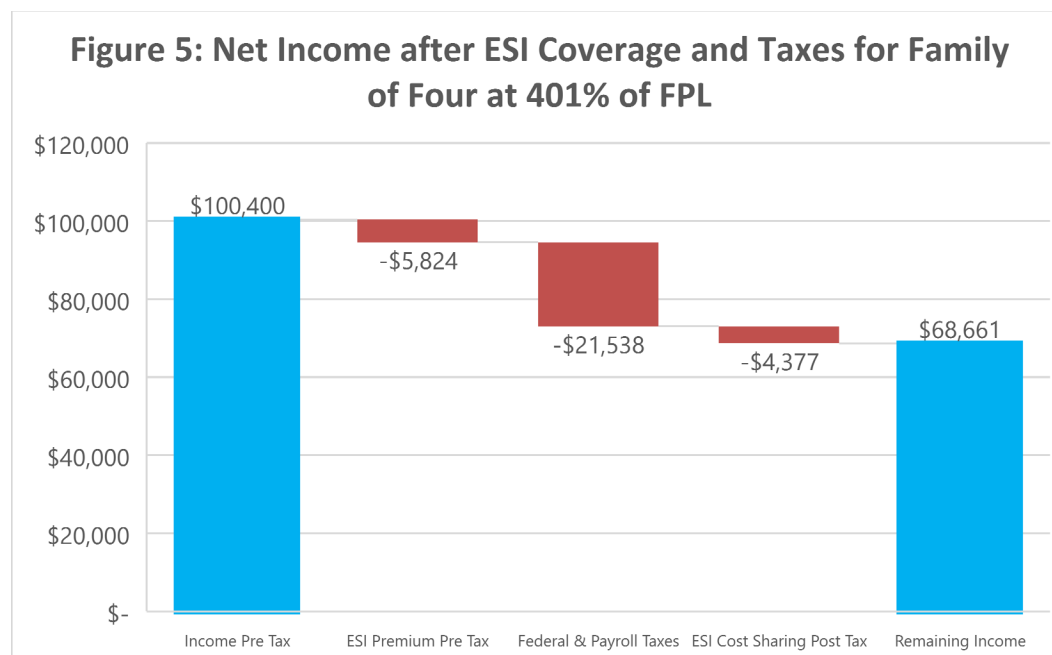
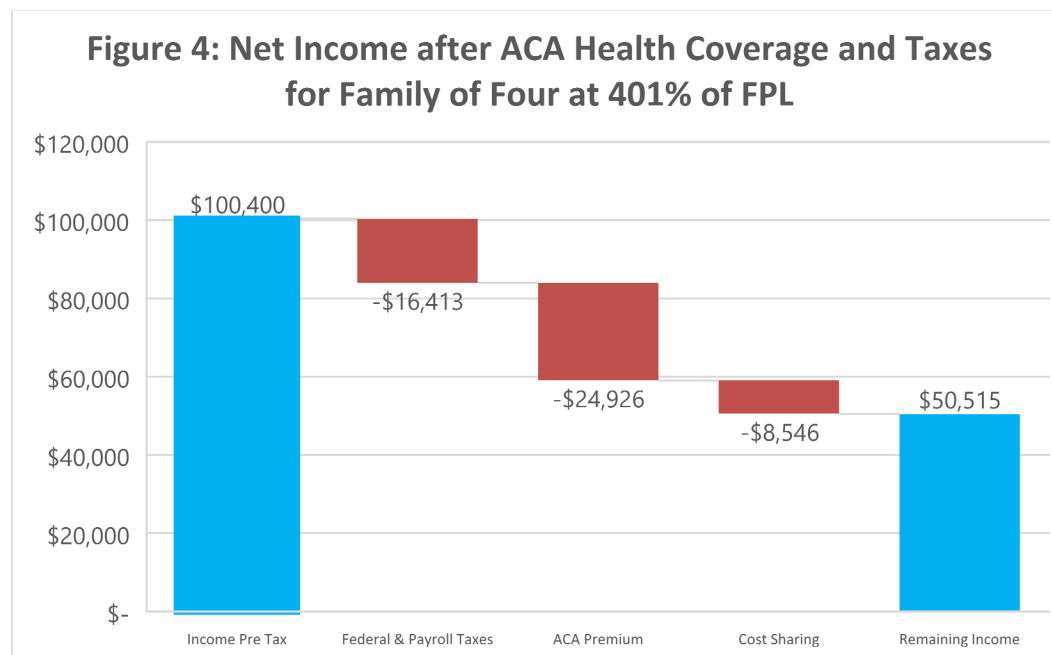
⁸ Estimated at \$24,926 based on Oliver Wyman calculations using the 2019 individual market landscape file based on the premiums for lowest cost silver plan coverage in each county in the 39 states with a federally facilitated marketplace: <https://www.healthcare.gov/health-plan-information-2019/>

⁹ Estimated at \$8,546 based on premium of \$24,926 * 80% loss ratio / 70% actuarial value of silver plan * 30% of member cost sharing.

¹⁰ Calculated after subtracting \$8,732 in federal taxes (based on 2019 Federal income standard deduction of \$24,400 for married couples filing jointly with 12% marginal tax rate) and \$7,681 for Social Security and Medicare taxes (7.65% of \$100,400 in income) with no state income tax.

¹¹ Workers contribution to Family Coverage, All Plans in 2018, Figure A on Page 10 of the 2018 Employer Health Benefits Report, Kaiser Family Foundation trended at 5% to 2019: <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>

¹² Estimated at \$4,377 based on the 2018 ESI Coverage Cost of \$19,616 * 1.05 trend * 85% loss ratio / 80% actuarial value of ESI plan * 20% of member cost sharing.



Consistent with recent experience, we expect that non-subsidy enrollment in the individual ACA market will continue to decline. The elimination of the mandate penalty in 2019 reduces the “cost” of being uninsured, especially for the healthier and younger

population.¹³ New regulations for short-term limited duration plans and association health plans could provide alternative coverage options which might be more affordable compared to the ACA coverage, but which would also be limited to a healthier population.^{14,15} Continuing enrollment declines in the ACA market among the healthier population will likely lead to future premium rate increases, further destabilizing the market, increasing federal cost for premium subsidies, and reducing plan choices and competition among carriers.

In Section 3 of this report, we suggest that policymakers consider a set of proposals that would make ACA coverage more affordable and ensure access to comprehensive health coverage, regardless of the individual's health status.

¹³ <https://www.healthcare.gov/fees/fee-for-not-being-covered/>

¹⁴ <https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-final-rule>

¹⁵ <https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans>

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Market Improvement Proposals

In this section, we will discuss important market improvement proposals, and we provide analysis of the projected impact of these proposals. The list of proposals we outline here is not exhaustive. For example, we have not included a federally enforced mandate requirement like the recently repealed mandate, even though we believe that would be an effective mechanism to help improve this market.

Permanent External Funding for a Reinsurance Program

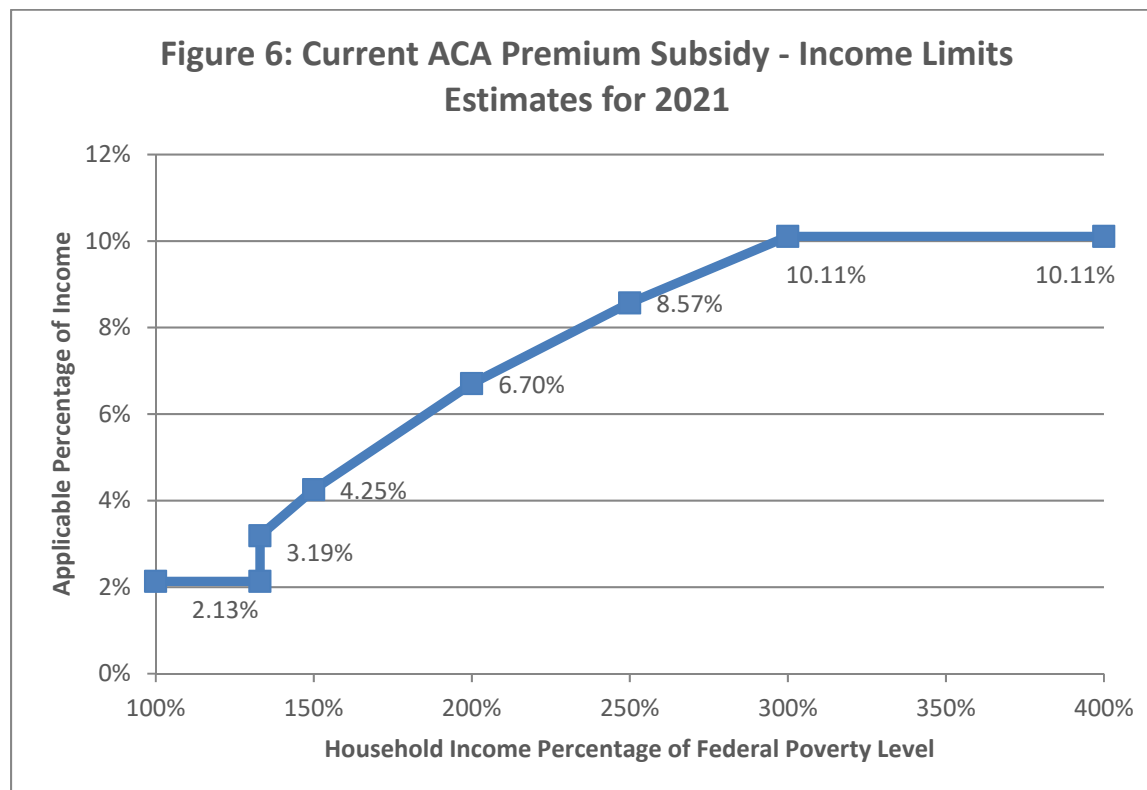
High premiums discourage enrollment of the healthier and younger population, and that, in turn, leads to even higher premiums for remaining enrollees.¹⁶ This is especially a problem for individuals who do not qualify for premium subsidies or tax incentives, such as contract employees, early retirees, or the self-employed. The transitional reinsurance program that ended in 2016, was effective in lowering premiums in the non-group market,¹⁷ and our micro-simulation modeling shows that lower premiums resulting from this external funding would attract more non-subsidized individuals and a younger and healthier population. In addition, a significant portion of the cost of the external funding will be offset by APTC savings as premiums decline.

Age Adjusted Premium Subsidies

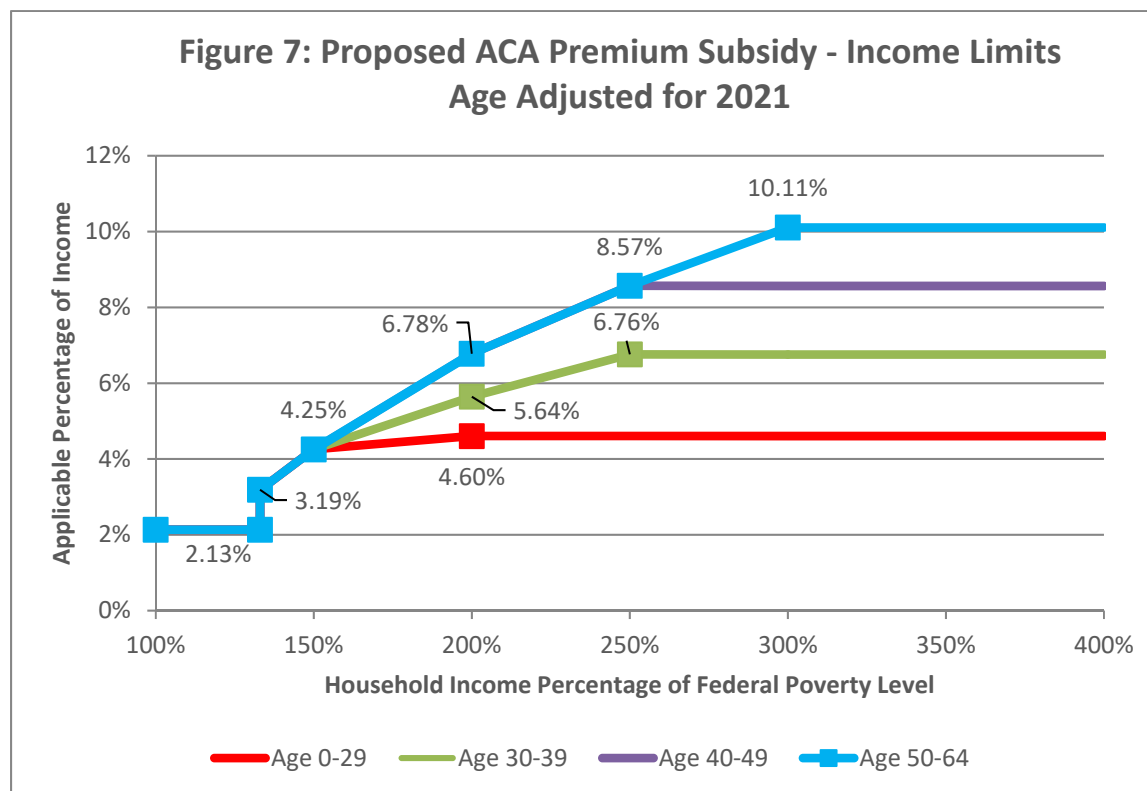
Under the ACA, premium subsidies are structured to limit the enrollees' premium expenditure on a sliding scale relative to their household's income between 100% and 400% of FPL. Most households above 400% and below 100% of FPL do not qualify for premium subsidies. Figure 6 shows the maximum percentage of income projected for coverage year 2021 an individual or household must pay towards the cost of coverage for the second-lowest-cost silver plan. Because ACA premiums can vary by age based on a 3:1 age curve, at a given income, older enrollees receive a larger subsidy than younger enrollees. As the older population has a stronger preference for protecting their assets and using health care services, the current subsidy structure is more attractive to an older population and leads to an older, unbalanced risk pool.

¹⁶ Finkelstein, A., Hendren, N., and Shepard, M., "Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts," NBER Working Paper 23668, August 2017.

¹⁷ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>



Modification of the subsidy structure, where the maximum percentage of income is determined not only by FPL but also by the age of the oldest member of the household, would make coverage more attractive to a younger population, thereby improving the morbidity of the risk pool. In Figure 7, we show a proposed age adjusted subsidy structure. Households where the oldest member's age is between 50 and 64 would receive the same subsidy as under current law. Households where oldest member is younger than 50 with incomes between 150% and 400% would be required to pay a lower percentage of their income towards the cost of coverage than under current law.



Cap on ACA Premium Spending above 400% of FPL

Households with income above 400% of FPL do not qualify for any premium subsidies under current law. As discussed in Section 2, a family with two adults age 50 and two children under age 14 and income of \$100,400 (401% of FPL) would have to pay on average \$24,926 for the lowest cost silver plan in the ACA marketplace in 2019 excluding cost sharing. This is roughly 25% of their gross income, and 30% of their post-tax income.

As an alternative, we modeled the market assuming a cap of 12% of household gross income on the cost of coverage in the ACA marketplace. This modification would make coverage much more affordable for a large segment of the population that currently finds coverage unaffordable. It would also help to insulate insureds from large rate increases and reduce the size of the uninsured population. We have assumed in our modeling of the 12% cap provision that it would not the impact or alter the availability of private, employer-sponsored coverage significantly. We chose a 12% cap to provide a minimum amount of financial protection to families that otherwise would not qualify for

premium assistance while being high enough to avoid significantly affecting the employer sponsored coverage.¹⁸

Improved Treatment of CSR Plans

Households with incomes between 100% and 250% of FPL are eligible for ACA plans with reduced member cost sharing (ranging from 6% to 27% of the allowed claim cost). Households between 250% and 400% of FPL can use premium subsidies to purchase the benchmark, silver plans with expected member cost sharing around 30% without the need to spend a higher share of income, as shown in Figure 6. Here, we modeled the impact of providing coverage that has at least an 80% actuarial value to individuals with incomes between 200% and 300% of FPL to reduce the burden of high patient cost sharing on the lower income population, and we have assumed CSR payments are fully funded.

Improved Funding for Exchange Outreach and Marketing

Greater awareness about coverage options among the eligible population through marketing and advertising can lead to higher enrollment in the ACA.¹⁹ Additionally, it motivates a healthier population to enroll and can help reduce premiums and the average federal spending on premium subsidies per enrollee.²⁰ We estimated that increasing the current CMS marketing and outreach budget from \$20 million to \$160 million would increase the ACA enrollment by roughly 5% in the 34 individual markets served by the Federally-facilitated Marketplace (FFM), based on our analysis of published research on the impact of outreach and marketing.

Section 9010 Fee Tax Moratorium

The reinstatement of health insurer tax (HIT) is estimated to result in an increase in premiums of roughly 2.2% in 2020 and subsequent years.²¹ A moratorium on the HIT would help reduce premiums and provide more stability to the individual, ACA market.

As we describe below, we modeled each of these market improvement proposals, and together they lead to an increase in ACA enrollment of roughly 4.2 million individuals in 2021, reduce the nationwide average premium by approximately 33%, and cost the

¹⁸ In 2018, only 3% of workers in Large Firms (more than 200 workers) and 14% of workers in Small Firms (3-199 workers) contributed \$12,000 or more annually towards family coverage, see Figure 6.14 on Page 91 of the 2018 Employer Health Benefits Report, Kaiser Family Foundation.

¹⁹ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1507>

²⁰ https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_Issue_Brief.pdf

²¹ <https://health.oliverwyman.com/2018/08/new-analysis--how-the-acas-hit-will-impact-2020-premiums.html>

federal government an additional \$10.2 billion when considering the \$15 billion for the reinsurance program premium subsidies, and marketing/outreach spending.²²

Healthcare Reform Micro-Simulation Model Results

We used our HRMM to estimate the impacts of the market improvement proposals on enrollment, average premiums and federal spending. Table 1 shows the main assumptions employed in the baseline and market improvement scenarios.

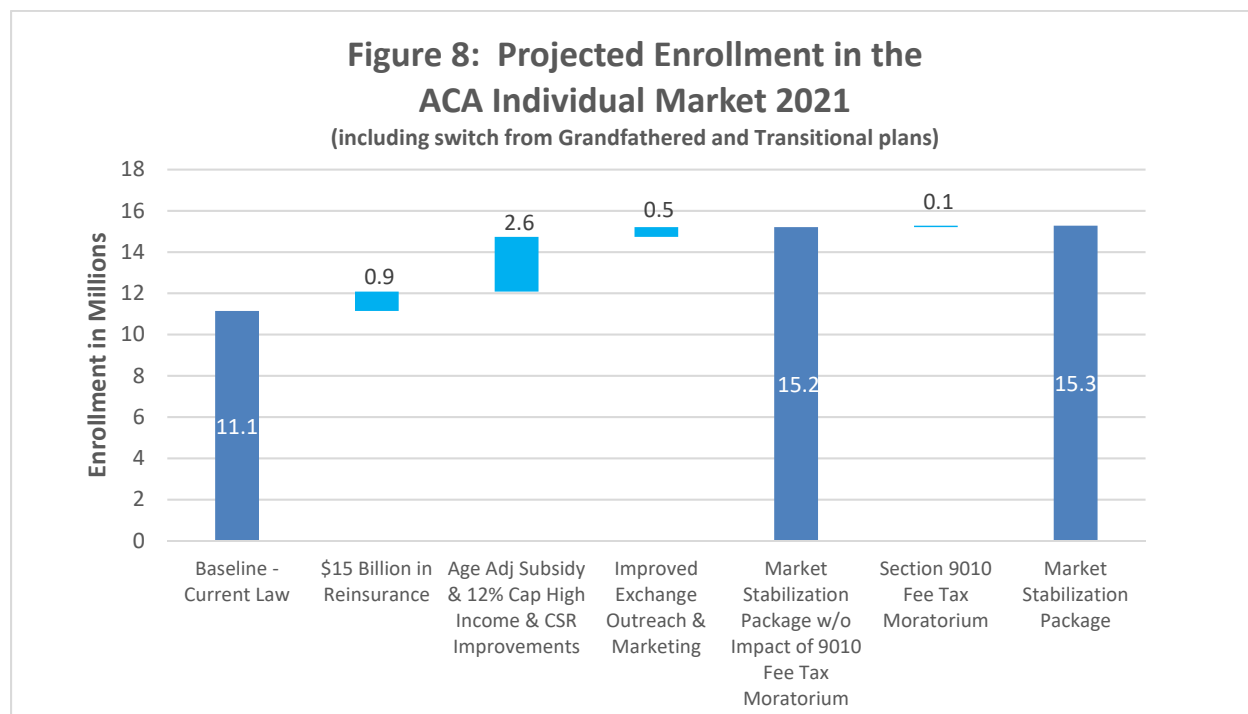
Table 1 - Assumptions for Baseline and Market Improvement Scenarios

Item	Baseline / Current Regulation Scenario	ACA Market Improvement Scenario
APTC methodology under current ACA regulations	Yes	Modified age adjusted APTC percentage factors up to 400% of FPL; flat 12% gross income cap for silver premium above 400% FPL
CSR methodology under current ACA regulations	Yes	Enhanced CSR plan available at 80% actuarial value for households with income between 200% and 300% of FPL, and fully funded
ACA Shared Responsibility Payment (Mandate)	No	No
Transitional policies allowed	Yes, through 2021	Yes, through 2021
9010 HIT Fees Collected	Yes	No, 2.20% premium impact in 2021
Reinsurance Program	No	Yes, \$15 billion per year
CMS Budget for Outreach, Marketing and Navigators in 34 FFM States	At 2019 funding level, about \$20 million	Funding is increased to 2017 levels, about \$167 million
All other ACA regulations	Unchanged	Unchanged

In Figures 8 through 10 we show the impact of the market improvement proposals described above on enrollment, market average premiums, and federal spending on APTCs, external funding and marketing/outreach, respectively. We did not include any

²² Excluding impact on federal expenditure and revenues like reduced Exchange user fees through lower premiums, loss of the HIT revenue, etc.

other revenue effects in Figure 10. We estimate that the market improvement proposals we modeled would increase the ACA-compliant individual market enrollment by about 4.2 million enrollees, or roughly 38%. This estimate includes about 0.6 million enrollees switching from non-ACA compliant plans to ACA-compliant plans. The provisions would reduce the nationwide average premium by 33% and would increase federal spending by about \$10.2 billion annually for the budget items we included. The market provisions without the impact from the elimination of the 9010 HIT fee would increase enrollment by roughly 4.1 million individuals in the ACA market, reduce the nationwide average premium by approximately 31%, and increase federal spending by \$12.4 billion.



**Figure 9: Projected Market Average Premium in the ACA
Individual Market 2021**
(pre subsidies for Silver coverage)

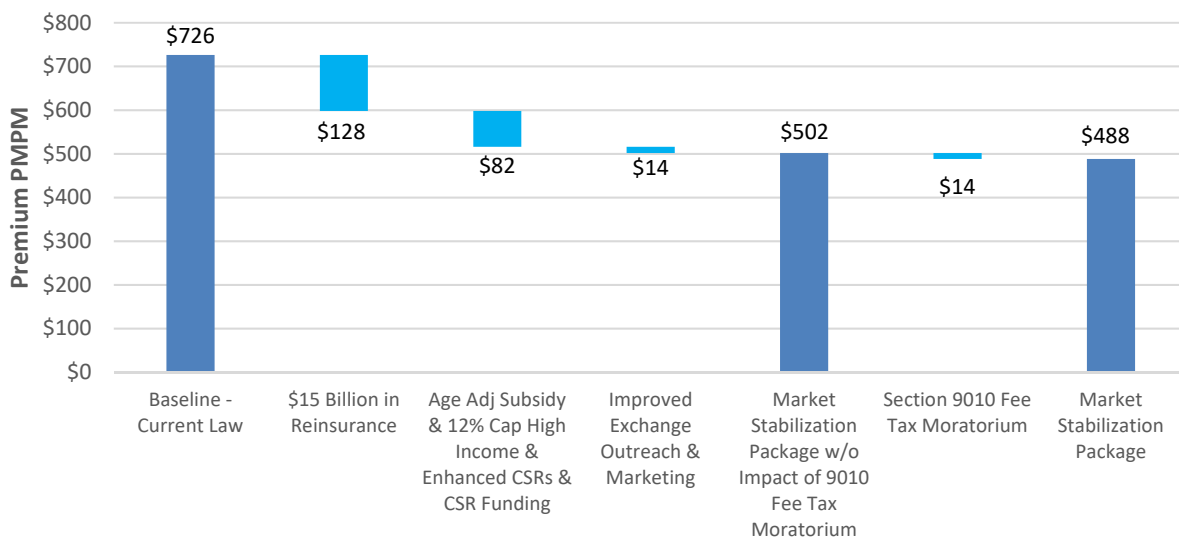
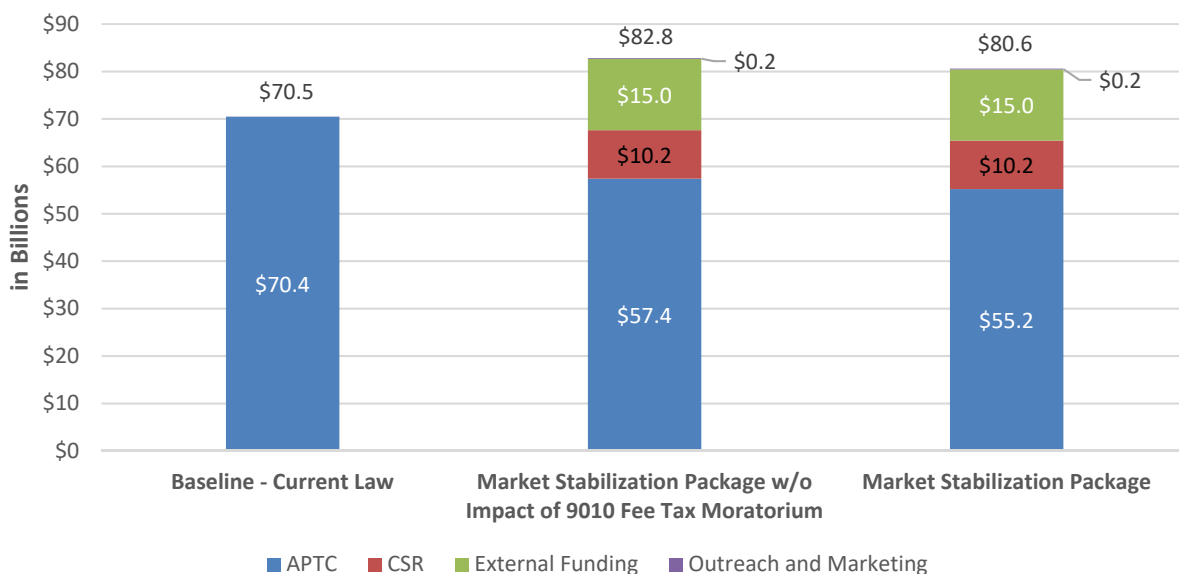


Figure 10: Projected Federal Funding in 2021
Excluding impact of Exchange user fees, 9010 HIT fee or other



Report Qualifications, Assumptions and Limiting Conditions

We prepared this report for the BlueCross and BlueShield Association for the purposes stated herein. This report is not to be used for any other purpose.

In this work, we have relied on publicly available data and information without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data and information we relied upon are both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

Our conclusions are based on data and information that we believe are appropriate for these purposes, and on the estimation of the outcome of many contingent events. Our estimates make no provision for extraordinary future events not sufficiently represented in historical data on which we have relied, or which are not yet quantifiable.

The sources of uncertainty affecting our estimates are numerous and include items such as changes in policies beyond those modeled here such as changes in outreach and advertising, changes in taxes, and changes in federal and state funding.

While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events and are subject to economic and statistical variations from expected values. We have not anticipated any extraordinary changes to the legal, social, or economic environment that might affect the results of our modeling. For these reasons, no assurance can be given that the emergence of actual results will correspond to the projections in this analysis.

The authors of this report are members of the American Academy of Actuaries and meet that body's Qualifications Standards to perform this work and render the opinions expressed in this report.

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