Is copper the new bronze? Six things every health plan should know about HR 6311 and ACA risk pools

Jason Karcher, FSA, MAAA
Jeff Milton-Hall, FSA, MAAA

Milliman

1. Congress continues to introduce tweaks to the Patient Protection and Affordable Care Act (ACA). One such bill, HR 6311, could have major consequences for ACA plans if made into law.

Healthcare reform continues to be a significant topic in the national conversation. Although comprehensive reform of the ACA has slipped into the background for now, both Congress and the Trump administration continue to pursue tweaks to the healthcare system with the stated goal of expanding access to affordable coverage.[1]

One example of this trend is a bill titled "H.R. 6311 – Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018," passed by the U.S. House of Representatives on July 25, 2018, and (at the time of publication) currently under consideration in the U.S. Senate.[2] This bill introduces several changes that its sponsors say are intended to improve the utility of and access to health savings accounts (HSAs). The bill also includes a provision to expand access to the ACA's lowest cost catastrophic plans (which the bill refers to as "copper" plans) to everyone in the individual market, effective January 1, 2019. Previously, this plan type had only been available to the so-called "young invincibles" (i.e., individuals under the age of 30 who might desire a lower cost plan with lean benefits) and to those eligible for a hardship exemption on the basis of premium affordability.

The provision to expand access to catastrophic plans deserves additional attention. If made into law, H.R. 6311's expansion of catastrophic eligibility could provide an attractive new option for unsubsidized individuals seeking affordable coverage who are not currently eligible to buy these plans. Furthermore, if allowing more individuals to purchase catastrophic coverage brings additional enrollment into the single risk pool, this influx of presumably healthy individuals could lead to a more robust single risk pool. At the same time, the bill could disrupt the status quo for individuals already in catastrophic plans and for the issuers that offer them. For example, changing the composition or definition of the catastrophic risk pool to allow additional individuals to purchase catastrophic plans could lead to significant premium increases for these plans or losses for health plans offering catastrophic coverage (bringing the cost of offering catastrophic plans in line with that for bronze plans). Under certain circumstances, this provision could even lead to an outright bifurcation of the individual market into a higher cost market for sick and/or subsidized individuals and a lower cost market for healthier, unsubsidized individuals who can manage large deductibles. The specific outcome depends in large part on the resolution of a central ambiguity in the bill regarding the risk pool treatment of catastrophic plans: whether they would continue to be carved into a separate risk pool or merged with the single risk pool for metal plans. If this bill were to be made into law as written, the resulting uncertainty would have to be resolved through the rule-making process by the Department of Health and Human Services (HHS).

2. Catastrophic plans are a cost-effective alternative to standard "metal" coverage for a select few, and HR 6311 would make these plans available for all.

Under the ACA, most individuals who purchase qualified health plans (QHPs) must choose among four metal tiers, ranging from relatively lean bronze plans to relatively rich platinum plans. Due to the ACA's "single risk pool" requirements, issuers can only vary premiums among metal plans for a limited number of allowable rating characteristics (e.g., cost sharing, provider networks, and administrative costs), and specifically cannot vary premiums for health status differences addressed by the risk adjustment program.

However, there is a fifth class of plans (called catastrophic plans) that are targeted primarily at the youngest individuals, and for which some single risk pool requirements are loosened. These plans were created to provide a cost-effective way for young adults not eligible for subsidies to participate in the ACA markets.[3] With a largely prescribed benefit design, these plans provide minimal coverage[4] up to the highest allowable deductible amount ($7,900 for 2019). Currently, only consumers either under age 30 or eligible for a hardship exemption are permitted to enroll in these plans, and issuers are allowed to adjust premiums for these plans to reflect the expected impact

of these eligibility criteria.[5] Using the federal Actuarial Value (AV) calculator, catastrophic plan benefits provide consumers with a bronze level of coverage, but their premiums tend to be significantly cheaper than those of bronze and other metal plans due to their special risk pooling status (described in more detail in the following section). Indeed, as catastrophic premium levels are allowed to exist untethered to the morbidity level in the rest of the risk pool, they have come to reflect the relatively healthier population eligible for these plans and their lower utilization patterns.

Policymakers at both the federal and state levels have observed this price advantage. It may appear to provide an appealing alternative to the high cost of plans offered to the larger population: allow everyone to purchase the more cost-effective catastrophic plans rather than restricting eligibility to a select few.[6] However, as we discuss in the remainder of this paper, expansion to all ages undercuts the basis of this cost advantage, such that catastrophic plans may not be a sustainable option for affordable coverage for the general population.

3. Catastrophic plans' cost-effectiveness hinges on their special status in the ACA as currently implemented.

While the lean benefit design of catastrophic plans plays a part,[7] the primary driver of the cost effectiveness of these plans is their special status with respect to ACA single risk pool requirements. In addition to the relatively straightforward impacts of enrolling a younger population that would otherwise subsidize older individuals enrolled in metal plans (via the 3-to-1 age slope), HHS carved catastrophic enrollees into a separate risk pool for the purpose of the ACA risk adjustment program. This allows issuers to charge lower premiums for catastrophic plans compared to bronze plans with similar benefits and to avoid otherwise substantial risk transfer payments between the young, predominantly healthy catastrophic plan population and the older, sicker population in the general risk pool.[8]

4. HR 6311 eliminates key underpinnings of this special status, beginning January 1, 2019.

Under current policy, HHS treats catastrophic plans differently from other individual market ACA-compliant plans in terms of risk adjustment and premium development. However, this differential treatment is not enshrined in law. The separate treatment of catastrophic plans for risk adjustment purposes arose during HHS' rule-making process. Noting that catastrophic plan eligibility is limited by Section 1302(e) of the ACA, HHS justified the separate treatment of the risk pool based on the "unique characteristics of this population."[9]

Because HR 6311 removes the specific eligibility criteria in 1302(e) beginning January 1, 2019, this justification may no longer be valid. Additionally, HR 6311 re-asserts the inclusion of catastrophic plans in the individual market single risk pool. The resulting ambiguity regarding the continued special status of catastrophic plans with respect to risk adjustment and allowable rating factors would have to be resolved either through legislative revisions prior to being signed into law or subsequently through the federal rule-making process. In such a case, HHS may either need to find a new justification for carving these plans out of the single risk pool for risk adjustment and premium rating or combine the risk pools. We explore both scenarios in the remaining two sections of this paper.

5. One potential outcome is to bifurcate the individual ACA market, with consequences for all plans.

If HR 6311 were to become law without changing the special treatment of catastrophic plans with respect to risk adjustment and premium rating, then the ACA individual markets could be bifurcated, as healthier, unsubsidized members of all ages migrate to the lower cost catastrophic plans, leaving primarily sicker and subsidized enrollees in the metal plan risk pool.

An increase in the average age of the catastrophic risk pool combined with the ACA's 3-to-1 age rating requirement would almost certainly result in premium increases for those who currently purchase catastrophic coverage.[10] Rising premiums could lead to selective lapses among current enrollees in the catastrophic plan risk pool, which would exacerbate the problem. In addition, out-migrations could put upward pressure on the morbidity in the metal plan pool, which could drive up the cost of standard metal coverage as well. All told, there could be a substantial disruption of ACA markets and the character of the risk pools if HR 6311 is adopted. In short, one likely outcome would be rising premiums for the entire individual ACA market.

6. Another potential outcome is to bring catastrophic plans into the single risk pool, eliminating their primary cost advantage, and exposing health plans to significant rating risk.

Alternately, if HR 6311 were implemented in such a way that the catastrophic and metal plans are included in a single risk adjustment pool, the most likely outcome is relatively limited disruption of the general pool with a substantial increase in the cost of coverage for catastrophic plans, while giving issuers little to no time to adjust rates to cover the additional costs. Indeed, the catastrophic plans would have benefits close to the bronze level while no longer enjoying the special treatment that supported lower premiums.

To estimate these impacts, we simulated the average risk transfer that would occur if 2017 ACA individual and catastrophic risk pools were merged, holding all else equal (e.g., enrollment and plan premiums). Based on 2017 risk adjustment results published by HHS,[11] catastrophic risk pools account for approximately 1% of total ACA individual market enrollment. If risk adjustment pools were merged in each state, we estimate the average metal plan would receive a transfer equal to 0.3% of its premium, or $1.50 per member per month, whereas the average catastrophic plan would pay a transfer equal to 69% of its premium, or $126 per member per month. While this estimate excludes the impact of any shifting of enrollment into the catastrophic pool from the metal pool, the new risk adjustment obligation would require substantial catastrophic plan premium increases. Many individuals currently enrolled in catastrophic plans may choose to drop coverage entirely or seek non-ACA compliant short-term limited-duration insurance (STLDI) rather than face such steep premium increases.[12]

If this happens for plan year 2019, issuers will likely either raise 2019 premium rates (if allowed to do so) or else risk a flood of enrollment into catastrophic plans, leading to significant financial losses on these plans in 2019. The November 2013 "fix" that allowed non-ACA-compliant transitional policies to remain outside of the single risk pool when issuers had assumed otherwise offers a cautionary example of another late-breaking change that affected the operation and profitability of ACA marketplaces.[13] The policy to permit renewal of non-ACA-compliant transitional policies resulted in a substantial population of healthier individuals who were expected to subsidize the cost of more expensive enrollees instead remaining outside of the ACA single risk pool. As the policy was implemented after plan enrollment had already started, issuers in states that elected to allow these renewals were unable to adjust rates for the 2014 benefit year, and many issuers experienced significant losses that they were unable to recoup.[14]

In the long run under HR 6311 (i.e., beyond 2019), due to the reduction or elimination of most remaining distinctions between catastrophic and bronze plans, catastrophic premiums could be expected to stabilize close to premium levels for their bronze cousins.

Limitations

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Jason Karcher and Jeff Milton-Hall are actuaries with Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the American Academy of Actuaries to issue this report and render the actuarial opinion contained herein. In preparing this whitepaper, we relied on the text of HR 6311, "Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018," as passed by the US House of Representatives on July 25, 2018, and portions of the US Code of Laws and Code of Federal Regulation related to the ACA, as of August, 2018. To the extent that the referenced federal and state regulations are modified as a result of legislative or regulatory action, the statements and conclusions in this whitepaper may require modification. Our interpretations of the proposed regulation should not be relied on as legal interpretations. In addition, readers of this paper should not interpret this paper as an endorsement of any particular legislative or regulatory action by Milliman or the authors. The views expressed in this paper are made by the authors and do not represent the collective opinion of Milliman, Inc. The estimates presented here represent our best estimates based on the stated assumptions and the information available to us at the time of publication; actual results will vary. Emerging experience and market developments should be monitored and adjustments made as deemed necessary.

Other noteworthy features of HR 6311

In addition to the catastrophic eligibility changes that are the subject of this paper, HR 6311 proposes several other notable changes to current health insurance law, primarily to the rules governing HSAs:

- Line up maximum HSA contributions with the statutory maximum out-of-pocket amount.
- Allow both spouses to make catch-up contributions to the same HSA.
- Allow individuals old enough to be eligible for Medicare Part A to make contributions to an HSA.
- Allow individuals enrolled in an HSA-eligible health plan to use an HSA to pay for services incurred while enrolled in the plan up to 60 days prior to establishment of the HSA.
- Allow health flexible spending arrangements (FSAs) to roll over unused funds into future years, making them more HSA-like.
- Extend the current moratorium on the ACA's health insurer fee for 2019 through the end of 2021.
- Allow ACA-compliant bronze and catastrophic plans to be HSA-eligible even if the plans do not meet current limitations on deductibles and out-of-pocket maximums.

Footnotes

1 Fritz Busch, Erik Huth, Nick Krienke, and Jason Karcher discuss President Trump's Executive Order on Healthcare Choice and Competition in America in "Law and Executive Order: A look at how President Trump's executive order on healthcare impacts the ACA's small group and individual markets." November 2017. Retrieved on August 15, 2018, from http://www.milliman.com/uploadedFiles/insight/2017/law-and-order.pdf.

2 "H.R. 6311: Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018." July 26, 2018. Retrieved on August 15, 2018, from https://www.congress.gov/bill/115th-congress/house-bill/6311.

3 Catastrophic plans are not eligible for premium subsidies (i.e., advance premium tax credits) under the ACA because they are explicitly excluded from the definition of "qualified health plan" in 26 USC 36B(c)(3)(A). HR 6311 leaves this statutory provision unchanged, and since it is part of the US Code of Laws, it cannot be changed through the federal rule making process.

4 Catastrophic plans cover preventive services and at least 3 primary care visits prior to reaching the deductible.

5 See 45 CFR §156.80(d)(2)(v).

6 In addition to the U.S. House bill, Colorado passed a law in May 2018 that paves the way to apply for a waiver of ACA catastrophic plan age and hardship limitations in the state if certain conditions could be met https://leg.colorado.gov/bills/sb18-132.

7 Under each federal actuarial value calculator dating back to 2014, the catastrophic plan design has offered a bronze-level actuarial value.

8 Based on the final Centers for Medicare and Medicaid Services (CMS) 2017 risk adjustment report, catastrophic plans would have paid about as much into the risk adjustment pool as bronze plans if the catastrophic and metal pools were merged.

9 "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014." March 11, 2013. Retrieved on August 15, 2018, from https://www.federalregister.gov/documents/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014.

10 Based on open enrollment data published by HHS for 2016, we estimate the resulting demographic impact to be in the range of 5% to 15%, assuming that the health status of new enrollees is otherwise consistent with those currently in the catastrophic risk pool. If the new catastrophic enrollees have higher morbidity, the required premium impact would be even larger.

11 See Appendix A of "Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year." Centers for Medicare and Medicaid Services. July 9, 2018. Retrieved on August 16, 2018, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-State-Averages.xlsx.

12 Jason Karcher and Nick Ortner discuss federal regulations enabling expanded access to non-ACA-compliant short-term limited duration policies in "The terms, they may be a-changin'." April 2018. Retrieved on August 15, 2018, from http://www.milliman.com/uploadedFiles/insight/2018/primer-short-term-medical-plans.pdf.

13 Letter dated November 14, 2013. Retrieved on August 15, 2018, from https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

14 "A financial post-mortem: Transitional policies and the financial implications for the 2014 ACA individual market" by Erik Huth and Jason Karcher. July 2016. Retrieved on August 15, 2018, from http://www.milliman.com/uploadedFiles/insight/2016/2263HDP_20160712(1).pdf.

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe. milliman.com

CONTACT

Jason Karcher
jason.karcher@milliman.com

Jeff Milton-Hall
jeff.milton-hall@milliman.com

FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE:

Visit our reform library at milliman.com/hcr
Visit our blog at healthcaretownhall.com
Follow us at twitter.com/millimanhealth