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Association for Community Affiliated Plans

Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market

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Executive Summary

Wakely was retained by the Association for Community Affiliated Plans (ACAP) to conduct a qualitative and quantitative review of the effects of the recent short-term limited duration insurance (STLDI) proposed regulation on the ACA-compliant individual health insurance market.[1]

The Affordable Care Act (ACA) created an environment in which individuals could purchase coverage in the individual market (ACA-compliant individual market) without discrimination on the basis of health. Many of the additional provisions embedded in the ACA were designed to make the coverage more comprehensive or to enhance the stability of the ACA-compliant individual market. Recently, the Trump Administration has released a proposed regulation allowing individuals to enroll in STLDI plans for a longer time period than permitted by current regulation and also making it easier to renew coverage. Both of these proposed changes increase the availability and attractiveness of STLDI plans. The proposed regulation has the potential to increase market instability, market segmentation, and adverse selection in the ACA-compliant individual market because a substantial number of healthy members will likely migrate to STLDI plans.

This paper analyzed the proposed STLDI regulatory change and the potential effects it could have on the ACA-compliant individual market. We analyzed the impact using a variety of methodologies to develop a range of enrollment decreases and premiums increases within the ACA-compliant individual market. The scenarios were based on estimated impacts by the tri-agency departments[2], a comparison to ACA transitional enrollment[3], and 2016 ACA-compliant individual claims and membership data.

In the table below, Scenarios 1a, 1b, and 2 represent impacts in the first full year, 2019, of the proposed STLDI regulation. Scenarios 3a and 3b reflect total effects STLDI plans will have after an initial ramp up period (the "near term"), which we expect to occur after four to five years. In 2019, the proposed regulation to reduce limitations on STLDI plans is estimated to increase ACA-compliant individual market premiums by approximately 0.7% to 1.7% and decrease enrollment by approximately 2.7% to 6.4%, or between 396,000 to 826,000 people (Scenarios 1a, 1b, and 2). To compare, the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments), displayed in Scenarios 0a and 0b below, estimated the impact of the

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[1] If this paper is distributed to outside parties, the paper should be distributed in its entirety. Anyone receiving this paper should retain their own experts in interpreting its contents. The opinions expressed in this paper are those of the authors and do not necessarily reflect those of Wakely. This paper is intended to discuss the impact of STLDI plans on the ACA-compliant individual market; other uses may be inappropriate.

[2] The proposed regulation was submitted by the Departments of Treasury, Labor, and Health and Human Services.

[3] Transitional plans, also known as grandmothered plans, are non-ACA compliant plans that existed in 2013 and allowed to continue into 2014. See https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

STLDI regulatory changes on the ACA-compliant individual market would decrease enrollment between 100,000 and 200,000 people, for on-Exchange only. Note that Wakely's estimates apply to the total on and off-Exchange market. After issuers have time to fully implement and market STLDI plans (i.e., near term) the impact is larger, with an estimated premium increase of 2.2% to 6.6% and enrollment decrease ranging from 8.2% to 15.0% (Scenarios 3a and 3b).

Note, that these estimates are based on a market in which there is no individual mandate penalty. The repeal of the mandate tax has further compounded the impact of the proposed STLDI regulation change as individuals are no longer required to pay this penalty when enrolled in a STLDI plan and because higher premiums in the ACA-compliant individual market will drive more individuals to drop coverage. Details regarding the enrollment and premium impacts due to the removal of this tax can be found in Table 2. Federal policy makers should consider the effects of this proposed regulation on consumers and market stability before finalizing, and state policy makers should consider options to address these potential issues if the proposed regulation is implemented.

Table 1 - Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	**Proposed Rule Low**	**Proposed Rule High**	**Proposed Rule Adjusted Low**	**Proposed Rule Adjusted High**	**Transitional Enrollment**	**Individual ACA Claims Cost Data Low**	**Individual ACA Claims Cost Data High**
Year of Impact	**2019**	**2019**	**2019**	**2019**	**2019**	**Near Term**	**Near Term**
Estimate Performed By?	Tri-Agency [4]	Tri-Agency [4]	Tri-Agency, Wakely Adjusted	Tri-Agency, Wakely Adjusted	Wakely	Wakely	Wakely
Off-Exchange Population Included?[1]	No	No	Yes	Yes	Yes	Yes	Yes
Increase in Premiums[2]	0.3%	0.6%	0.7%	1.4%	1.7%	2.2%	6.6%
Decrease in Enrollment	-1.0%	-2.1%	-2.7%	-5.4%	-6.4%	-8.2%	-15.0%
ACA-Compliant Individual Enrollment, Prior to Impact of STLDI Plans[3]	9,730,000	9,730,000	14,730,000	14,730,000	13,000,000	13,000,000	13,000,000
Reduction of Members	100,000	200,000	396,000	791,000	826,000	1,070,000	1,948,000
ACA-Compliant Individual Enrollment, After Impact of STLDI Plans[3]	9,630,000	9,530,000	14,334,000	13,939,000	12,174,000	11,930,000	11,052,000

[1] The population includes only on-Exchange ACA-compliant individual membership within the proposed rule (scenarios 0a and 0b) analyses. Both on and off-Exchange membership are included within the additional scenarios. Because the proposed rule analyses do not account for effects of the off-Exchange market, there will be downstream impacts to market premiums.
. All scenarios reflect the repeal of the individual mandate.
[2] Scenarios 1a - 3a assume that members who leave the ACA-compliant individual market for STLDI coverage cost 25% less on average compared to enrollees that remain in the ACA-compliant individual market. Scenario 3b assumes this differential is 38%.

[3] The baseline ACA-compliant individual market membership, prior to impacts due to the repeal of the individual mandate and STLDI plan regulation change, in scenarios 0 and 1 are based on higher on and off-Exchange estimates. These estimates align with CBO assumptions. Scenarios 2 and 3 rely on smaller on and off-Exchange baseline estimates. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[4] See note above regarding the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments) proposed rule. Further detail is described within the quantitative section of the report.

Introduction

On October 12th, 2017, President Trump signed an executive order instructing the Federal government to promulgate regulations that would, among other things, make it easier for individuals to receive coverage through STLDI plans. STLDI plans do not have to follow the ACA market reform rules that were instituted in 2014 to protect consumers. These rules prevent insurance companies from denying coverage or charging more to individuals with pre-existing conditions and contain many requirements regarding benefit designs to maintain adequate coverage. Since STLDI plans do not have to cover costly members with pre-existing conditions and also offer less generous benefits, the premiums are far lower than plans that follow the market reform rules (ACA-compliant plans).

A proposed regulation was released by the Trump administration on February 28th, 2018, which proposes to extend the maximum coverage period for STLDI plans from approximately 3 months to 364 days. Additionally, policyholders will be able to renew and reapply for STLDI coverage much more easily than before, and can potentially extend coverage beyond the proposed 364 day maximum limit. In turn, STLDI plans will become more attractive for certain individuals and enrollment in such plans is expected to increase.

If the proposed regulation change is implemented, a portion of lower cost members are expected to migrate from the ACA-compliant individual market to STLDI plans. Consequently, the ACA-compliant individual market risk pool would contain a greater proportion of sick people (this effect is also known as adverse selection). This impact to the ACA-compliant individual market is further worsened due to the repeal of the individual mandate, which will be in effect beginning in 2019, creating more adverse selection through additional individuals choosing to migrate to a STLDI plan or remain uninsured. As adverse selection increases, premiums will also increase to cover the rising average claims costs. The higher premiums in turn make it less likely that healthy individuals will enroll and stay enrolled, which creates a loop of higher premiums, causing greater adverse selection, which, in turn, again leads to higher premiums. When this cycle continues unfettered it is called a 'death spiral,' which results in market collapse.

It is important to note that the concept of a death spiral is less applicable to subsidized enrollees given the current structure of premium subsidies (tax credits). Individuals eligible for premium tax credits are insulated from market premium increases as the amount of premium owed is a function of their income, not overall premium. Consequently, as premiums increase, subsidized individuals will not have their out-of-pocket costs increase. Therefore, this subsidy structure shelters some individuals from these large rate increases, making them more likely to remain in the ACA-

compliant individual Exchange market. Unsubsidized enrollees, however, directly bear the full brunt of premium increases. The dynamics of premium increases and worsening morbidity does directly affect them and their ability to afford health insurance. Significant adverse selection within the unsubsidized population may still impact issuer participation or lead to a death spiral.

Additionally, instability driven by the high churn of membership, rising claims costs, and uncertainty of market risk will deter some issuers from offering coverage, which has been witnessed in the ACA-compliant individual market in recent years. In the initial years of the ACA, 2014 and 2015, market forces (such as attempts to gain market share, uncertainty regarding the number of young and healthy individual entering the market, competitor positioning, etc.) drove premium rates very low, to an unsustainable level, in many states. As the markets corrected over the next few years (due to financial losses, instability in the market, and unexpected loss of risk corridor funding) numerous issuers exited the ACA-compliant individual market, leaving many consumers with one or few options. The issuers that remained charged higher premiums. Higher premiums increase the likelihood of unsubsidized enrollees choosing lower cost STLDI plans.

This is not to say that all enrollment in STLDI plans will come from the current ACA-compliant pool. It can also be expected that some individuals who are or will become uninsured (further exacerbated by the repeal of the individual mandate effective 2019) will also choose to purchase STLDI plans. The IRS reports that for the 2015 benefit year (2016 tax filing season) 6.5 million people paid the individual mandate penalty. Additionally, 12.7 million people claimed one or more health care coverage exemptions to avoid having to pay the mandate penalty.[4]

Due to data limitations, this analysis will focus on the impacts that the STLDI regulation change will have on the ACA-compliant individual market and the behavioral effects of those currently in the individual market. As discussed, the projected effects of STLDI plans are after accounting for the repeal of the individual mandate. The proposed STLDI plan regulation will also have effects, both direct and indirect, on other coverage cohorts, such as the uninsured.

Short-Term Limited Duration Insurance Plans: Differences from ACA-Compliant Plans

STLDI plans are designed to fill temporary coverage gaps. Historically, their benefits and cost-sharing differed from ACA-compliant plans in a number of key aspects. The Commonwealth Fund recently noted that STDLI plans do not have a ban on rating for or excluding coverage for pre-existing conditions, do not provide any of the ten essential health benefits[5] (e.g., prescription drug

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[4] https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf
[5] https://www.healthcare.gov/glossary/essential-health-benefits/

coverage), and do not have cost-sharing requirements.[6] Below is a listing of some specific differences between the two coverage options:

- Many STLDI plans have deductibles of $7,000 to $20,000 for three months of coverage, compared to ACA-compliant plans which are for a year of coverage and legally cannot exceed an amount preset by the Secretary (for example, deductibles for ACA-compliant individual plans were essentially capped at the maximum out of pocket amount of $7,150 in 2017).[7]

- The American Academy of Actuaries notes that many STLDI plans have coverage limits of $1 million while ACA-compliant plans do not have annual limits.[8]

- At the time of renewal or purchase, STLDI plans can exclude coverage for any condition developed in the prior coverage period. Individuals not only can be excluded due to illness when they initially purchase the coverage, but if re-occurring or chronic conditions occur while individuals have STLDI, then they would be unlikely to be covered again at the time of renewal. This is different from even pre-ACA individual market coverage, in which additional underwriting was not conducted at renewal.

- Additionally, ACA rating rules, such as age and gender restrictions, do not apply so these plans can charge higher premiums for individuals who have health conditions or can charge more based on a person's sex.

- STLDI plans do not have to follow Medical Loss Ratio[9] (MLR) restrictions so fewer premium dollars go to paying medical coverage and instead go to administration and profit. Historically, these ratios have been much lower in STLDI plans (for example the largest insurer of STLDI products in 2016 had a MLR below 50%, far below the 80% required MLR in the ACA-compliant individual market).[10]

- Individuals in STLDI plans would be at risk for rescission. Rescissions are retroactive cancellations of coverage, often occurring after individuals file claims due to medical necessity. While enrollees in ACA coverage cannot have their policy retroactively cancelled, enrollees in STLDI plans can. According to Georgetown University, reports

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[6] http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans
[7] Ibid.
[8] http://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf
[9] The ACA requires that all issuers spend at least 80% of premium revenues on medical costs.
[10] http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans

suggest issuers offering STLDI plans have been aggressive at using rescissions to shift their liability onto consumers.[11]

The difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools[12] and risk segmentation. As the American Academy of Actuaries notes, “Noncompliant plans would likely be structured to be attractive to low-cost enrollees through fewer required benefits, higher cost-sharing, and premiums that vary by health status”.[13] Given the regulatory flexibility, STLDI plans would attract healthier enrollees, removing them from the ACA-compliant risk pool, increasing risk selection, and further increasing premiums, continuing the downward spiral. Over time the difference between the two risk pools would increase and escalate the instability and uncertainty in the ACA-compliant individual market.

Context: Changes Since 2014

Evolution of Regulations on STLDI plans

Following the full implementation of the ACA requirements in 2014, marketing of STLDI plans changed. In particular, they were marketed as alternatives to ACA coverage, with STLDI plans being renewed indefinitely (generally every three months). This allowed individuals to stay in STLDI plans if both the plan and consumer wished to extend coverage. The result was that enrollment in STLDI plans increased from 1.0 million to 1.5 million member months between 2013 and 2015.[14]

In the fall of 2016, the Obama Administration introduced rules to limit the duration individuals could stay enrolled in STLDI plans to no more than three months (including renewals). The rules also required that application materials include clear language stating that the coverage did not meet standards—known as minimum essential coverage—exempting individuals from the mandate penalty. The Administration noted that these plans could have limitations for consumers, for the above stated reasons, and they could produce adverse selection in the ACA risk pool. The Administration did not ban the sales of these products because “the individual shared responsibility provision…provides sufficient incentive to discourage consumer from purchasing multiple successive short-term, limited duration insurance policies”.[15]

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[11] http://chirblog.org/state-options-to-respond-to-executive-order-on-short-term-plans/
[12] In the ACA-compliant market premiums are set in reference to a state’s entire risk mix for all enrollees in ACA-compliant plans. A worsening ACA-compliant risk pool would affect all ACA-compliant premiums (excluding the effects of APTCs)
[13] ibid
[14] https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26162.pdf
[15] ibid

Individual Mandate in the ACA

The individual mandate ("shared responsibility provision") was designed to reduce risk selection. The requirement has a tax penalty for individuals that can afford insurance but choose not to purchase coverage. The result of the policy was that incentives exist for healthy individuals to enroll in ACA-compliant coverage, as individuals that enrolled only in STLDI plans for more than three months would still be required to pay the mandate penalty. Individuals that were uninsured for less than three months were exempt from the mandate penalty, and STLDI plans were meant to serve as a backstop for individuals who might need just a short-term policy to fill such a short gap. While some criticized the mandate penalty as being too small, it did still have effects on the ACA-compliant individual market. For coverage relating to the 2015 benefit year, approximately 6.6 million people paid about $3 billion in individual responsibility payments or about $457 per tax household.[16]

However, these incentives will change starting in 2019. In December of 2017, President Trump signed into law a bill that, among other things, would effectively repeal the individual mandate.[17] Repealing the mandate resulted in both direct and indirect effects that will serve to make the STLDI plans popular. First is that by repealing the mandate, the total cost to consumers of being covered by STLDI plans will be lower since individuals only have to pay the premiums and not both the premiums and the mandate penalty. In other words, repealing the mandate should increase enrollment in STLDI plans. Secondly, by repealing the mandate, ACA premiums will be higher due to an increase in adverse selection,[18] therefore increasing the premium differential between ACA-compliant plans and STLDI plans. The larger the premium difference between the two types of plans, the greater the popularity of STLDI plans, creating a continued cycle of adverse selection.

Implications of New Regulations

On February 28, 2018, the Trump administration released a proposed regulation which would relax current limitations on STLDI plans.[19] The regulation, among other things, proposes two key changes. The first amends regulations so that the maximum coverage period for STLDI plans is now 364 days. This is an increase of approximately 9 months relative to current regulations. The second key change makes it easier for policyholders to renew or reapply for coverage beyond the

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[16] https://www.irs.gov/pub/irs-soi/17sprbul.pdf
[17] https://www.vox.com/policy-and-politics/2017/11/14/16651698/obamacare-individual-mandate-republican-tax-bill. The penalty for the individual mandate was set at $0. For brevity will refer to this change as mandate repeal.
[18] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[19] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance

364-day limit.[20] Both of these actions are designed to increase the availability and attractiveness of STLDI plans.

The most direct impact the regulation has is the likelihood of removing healthy and young individuals from the ACA-compliant individual market. The regulation itself notes that short-term limited duration insurance is likely to attract young or healthy individuals. The proposed regulation notes that removing healthy individuals from the ACA risk pool results in higher premiums for those without premium subsidies and higher Federal costs due to the increased subsidy levels as a result of the worsening risk pool and higher premiums.

Consumers who switch to STLDI plans may also be harmed. As the regulation notes "… consumers who switch to such policies (STLDI plans) from ACA-compliant plans would experience loss of access to some services and providers and an increase in out-of-pocket expenditures related to such excluded services…"[21] Additionally, consumers may be harmed as STLDI plans would still not be considered minimum essential coverage and so they would not be protected if their STLDI coverage were to lapse. For example, if an individual was diagnosed with a serious medical condition mid-year and therefore unable to afford the new higher premium at the time of renewal,[22] or experienced a coverage rescission, the person would be unable to get access to ACA coverage via a special enrollment period (SEP). While this does have the benefit of protecting the ACA risk pool, it could lead to individuals having spells of no coverage and higher levels of uncompensated care. And the ACA-compliant risk pool would still ultimately bear the expenses of delayed coverage once the consumer is finally able to enroll during open enrollment.

States do retain significant authority in regulating STLDI plans, which will affect the impact from state to state. According to the Urban Institute, eight states currently have regulations that would limit STLDI expansion.[23] These limitations mostly take the form of how long an individual can consecutively have coverage in a STLDI (e.g., a STLDI can only provide coverage for a maximum of three months and not be renewed). The proposed regulation would not preempt state law on STLDI plans, but it also does not require states to regulate STLDI plans.

In the proposed regulation, HHS provided an impact analysis of the effects of STLDI plans on the ACA-compliant individual market. They estimated that between 100,000 and 200,000 members would exit the Exchanges to take up coverage in STLDI plans in 2019, further increasing the morbidity of the ACA-compliant risk pool, premiums, and Federal expenditures via higher

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[20] https://www.healthaffairs.org/do/10.1377/hblog20180220.69087/full/
[21] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance
[22] While not included in the analysis, there have been several Congressional proposals making renewal of STLDIs easier for consumers. If approved, this would directionally increase enrollment in these plans and premium increases in the ACA market.
[23] https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

premium subsidies (advanced premium tax credits – APTC). In the next section, we will examine potential effects of the proposed regulation on the ACA-compliant individual market.

Analysis of Proposed Regulations

Case Study: Tennessee

The unique case of Tennessee's individual market may provide a preview of the effects on the ACA-compliant individual market of offering non-ACA products. Due to a 1993 law, the state allows the Tennessee Farm Bureau to sell coverage to individuals. This coverage is not exclusively provided to farmers but is generally available to all Tennesseans and is similar to the type of plans that existed in the pre-ACA world. As a matter of state law, the coverage is not considered insurance. As a result, when the ACA's key provisions, such as guaranteed issue and not denying coverage based on pre-existing conditions, came into the effect, they did not apply to the Tennessee Farm Bureau plans. This allowed the Tennessee Farm Bureau to continue to sell new coverage options that compete against ACA-compliant plans.

The Tennessee Farm Bureau has been very successful at attracting and keeping healthy enrollees. According to one report, in 2017 they covered as many as 73,000 enrollees (this includes 50,000 "grandfathered plans" and 23,000 enrollees that have signed up since the ACA market reform rules went into effect).[24] To put these numbers into context, in 2017, approximately 200,000 members, on average, were enrolled on-Exchange for the first half of 2017.[25] While we do not yet have the average total ACA-compliant individual market enrollment for 2017, 73,000 Farm Bureau enrollees likely would represent approximately a quarter of the total "individual market" (Farm Bureau coverage plus ACA-compliant market) in 2016.[26]

A Society of Actuaries paper analyzed the risk mix in ACA plans in 2015[27] and found that, excluding Arkansas,[28] Tennessee's ACA-compliant individual market had the worst risk score (or relative measure of how costly individuals are in the ACA-compliant market) of any state in the country. Tennessee had an adjusted risk score of 2.80 while the national average was 2.31.[29] To further the instability within the ACA-compliant individual market, Tennessee also has

[24] http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/
[25] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf
[26] Using the 2016 June 30th Report, Wakely estimated the size of the Tennessee's ACA individual market using billable member months. If one were to combine both the individual market and Farm bureau into a singular risk pool, the Farm Bureau's 73,000 enrollees would represent 26.7% of the total market
[27] https://www.soa.org/research-reports/2016/relative-risk-aca-market/
[28] Arkansas was excluded since its ACA risk pool includes Medicaid expansion beneficiaries.
[29] The SOA adjusted risk scores for differences in age and actuarial value to better differences between states due to health differences.

experienced large rate increases. All three of the major issuers increased rates in 2017 in excess of 40%.[30] Overall the second lowest cost silver plan increased 278% between 2014 and 2018.[31] This is the largest increase of any Healthcare.gov state. At the end of 2016 one issuer (United) exited the market and several issuers reduced their footprint. The situation was so dire the Insurance Commissioner characterized the Exchange market as "very near collapse."[32]

As can be seen in the Tennessee case study, allowing products that underwrite to directly compete with ACA products will increase risk selection in the ACA-compliant individual market. Healthier individuals migrated to the less expensive (underwritten) products which caused morbidity to increase in the ACA products, resulting in premium increases, issuer exits, and overall uncertainty in the market.

While illustrative of the overall dynamics of how non-ACA products may affect the ACA risk pool, the Tennessee experience may not be directly comparable in the short-term because of the Tennessee Farm Bureau's long history in the state, large pre-ACA enrollment, and significant advertising presence. The aforementioned dynamics of the Tennessee experience are largely qualitative in nature; in the next section, we will provide quantitative analyses on the potential effects STLDI might have on the ACA-compliant individual market.

Quantitative Analyses

The reintroduction of underwriting and rescissions at a larger scale are not immediate; for many issuers, it may take some time to implement (the proposed regulation estimates only 160,000 people are currently enrolled in STLDI plans). Furthermore, it may take time to market the products to individuals. To control for the fact that the effects of STLDI plans should grow over time, we have analyzed the effects of STLDI plans both in the short term (scenarios 1 and 2 below) and the near term (scenario 3 below).

Neither sets of analyses account for potential reduction in issuer participation and competition. As enrollment shrinks and morbidity increases, fewer issuers may be willing to provide coverage, which again may result in higher premiums. In the extreme case of a bare county (no ACA-compliant issuer coverage) the results would be catastrophic for enrollees in those areas. Consequently, these analyses can be considered to underestimate the impact as enrollment losses and premium increases could be higher if the resulting issuer behavior was accounted for.

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30 https://www.healthinsurance.org/tennessee/
31 https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf
32 https://www.tennessean.com/story/money/industries/health-care/2016/08/23/insurers-get-approval-for-2017-obamacare-rates/89196762/?from=global&sessionKey=&autologin=

Scenarios 0 and 1 – Extension of Proposed Regulation Regulatory Impact Analysis (2019 Impact)

As part of the proposed regulation, the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments or simply tri-agency) estimated the impact of the STLDI regulatory changes on the ACA-compliant individual market. In particular, they estimated that between 100,000 and 200,000 people would leave the Exchanges and enroll in STLDI plans. This shift of young and/or healthy individuals to STLDI products was estimated to increase premiums in the ACA-compliant individual market 0.3% to 0.6%, on average nationwide. Note, these impacts are specific to year 2019. The tri-agency estimates are shown in Scenarios 0a and 0b in the table below.

However, there are a number of reasons to believe the tri-agencies' estimate may be understated. First, the tri-agencies' estimate that the relative morbidity of those that leave ACA coverage for STLDI plans compared to those that stay in ACA coverage is 75% (meaning those that are expected to leave cost 25% less on average compared to average enrollees that remain in the ACA-compliant individual market). Other estimates of the morbidity of individuals that leave the ACA-compliant individual market on a relative basis are lower.[33] For example, using CBO's analysis of the mandate repeal, Wakely estimated that CBO assumed a morbidity differential of individuals leaving due to the mandate repeal as approximately 62% (meaning those that are expected to leave cost 38% less on average compared to average enrollees that remain in the ACA-compliant individual market). In other words, individuals leaving the ACA-compliant risk pool could be healthier/less costly than what the tri-agency's rule assumed. The larger the difference in health status between those that leave the ACA-compliant risk pool versus those that stay results in larger premium increases in the ACA-compliant market. Second, and more important, the tri-agency's analysis does not include the ACA-compliant individual off-Exchange market. As part of the single risk pool, off-Exchange ACA enrollees should be included in the total impacts. Since off-Exchange ACA enrollees are all unsubsidized, they are directly affected by premium increases and, therefore, more likely to exit the ACA-compliant individual market for STLDI plans compared to the subsidized population.

For Wakely's modeling of scenario 1, we assumed a 75% morbidity differential to align with the Federal impact analysis.[34] Also, we adjusted the tri-agency's results to include the ACA-compliant individual off-Exchange market. To estimate what proportion of the off-Exchange membership would exit for STLDI coverage, we used the tri-agency's estimated percent of unsubsidized on-

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[33] Https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[34] While the morbidity difference is likely around 75%, it could be lower, a point that is explored later in the analysis. The larger the morbidity difference, the larger the premium impact.

Exchange enrollees that would migrate to STLDI plans. To estimate the size of the ACA-compliant individual off-Exchange market, we relied on the same CBO analysis that the tri-agencies relied on to estimate the effects of the mandate repeal.[35] Please note that the tri-agencies' analysis does not specifically state the methods and assumptions used to arrive at their estimated number of people who would transition to short-term duration plans. Nor was it indicated what difference in assumptions were used to develop the low and high scenario results.

By using the tri-agency's initial findings and adjusting for off-Exchange membership, we estimate that, after accounting for the removal of the individual mandate, the entire ACA-compliant individual market would further decrease by between 400,000 enrollees (scenario 1a) and 790,000 enrollees (scenario 1b). The high and low scenarios were also modeled in the tri-agency's report. This represents 2.7% to 5.4% of the total estimated ACA-compliant individual market in 2019 (based on membership after no individual mandate). Updating the membership component of the tri-agency analysis to include off-Exchange membership results in an estimated premium increase of 0.7 to 1.4% in 2019, significantly higher than the tri-agency's estimates.

Scenario 2 – Transitional Enrollment as Guide (2019 Impact)

To provide further sensitivity testing, Wakely used a second methodology to estimate the effects of STLDI plans on the ACA-compliant individual market in 2019. In this analysis, we varied our assumptions regarding the estimated size of the ACA-compliant individual market from the baseline in the tri-agency's analysis assumed in scenario 1. In 2017, the off-Exchange market decreased in size severely.[36] Consequently, we assumed the size of the off-Exchange market may be smaller than the CBO estimate relied on in scenario 1. The result was an overall baseline individual ACA-compliant enrollment of 15.0 million (both on and off-Exchange) compared to 18.1 million as assumed in scenario 1.

As discussed, scenario 1 aligned with CBO assumptions of both baseline enrollment (on and off-Exchange) and effects of the mandate. A smaller off-Exchange in the baseline could imply that the mandate repeal enrollment effects are correspondingly lower. To avoid biasing the analysis (i.e., smaller off-Exchange and larger mandate repeal effect), we used all of the key CBO projected inputs. If we aligned both the on and off-Exchange market size in scenario 1 with what

[35] Theoretically, off-Exchange enrollees would also be at risk for leaving the ACA risk pool due to the mandate repeal. However, since the tri-agency analysis included the full effect of the mandate repeal (3 million) on-Exchange it would be inappropriate to double count these losses off-Exchange as well.

[36] http://www.markfarrah.com/healthcare-business-strategy/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx

was used for scenario 2, the expected premiums effects of STLDIs are 0.9% and 1.8%, respectively, higher than they otherwise would have been in scenario 1.

Given the smaller enrollment baseline, we used the Office of the Actuaries' estimated enrollment loss due to the mandate repeal (or 2 million), which is less than the CBO estimated enrollment loss.[37] Finally, we relied on the experience of transitional enrollment to estimate the demand for STLDI plans. In 2014, the Obama Administration allowed individuals that had 2013 (i.e., pre-ACA) coverage to continue enrollment in their current plans—often referred to as "grandmothered" plans and known as "transitional" plans for the purposes of this analysis. The Brookings Institute estimated that approximately 1.6 million people who had initially purchased non-ACA coverage before the mandate went into effect in 2014 maintained their non-ACA transitional coverage rather than choosing to be uninsured or purchase ACA-compliant coverage.[38]

While not a perfect proxy, STLDI plans do represent a non-ACA coverage alternative, similar to how transitional plans functioned as a non-ACA coverage option for many Americans in 2014. Furthermore, not every state allowed transitional plans to exist. States that intervened to protect the ACA-compliant individual market and disallow transitional plans may similarly map to states that will intervene to protect the ACA market from STLDI plans, which would decrease the STLDI market compared to the transitional plan market in 2014. One difference between transitional plans and STLDI plans that may impact take-up is that in STLDI plans, individuals would have to undergo underwriting at renewal; individuals in transitional plans did not undergo underwriting. Also, transitional plans are more generous than STLDI plans and so may attract a somewhat different population mix. Individuals that were enrolled in transitional policies in 2014 may have since dropped coverage and may not be enrolled in the ACA-compliant individual market— thus shifting from different coverage or uninsured status.

To account for the more stringent enrollment requirements for STLDI plans and differences compared to transitional plans, as detailed above, we reduced the number of people in transitional plans by 50% to create a proxy for the potential STLDI market. The results of this scenario estimate that 830,000 people out of 13 million total enrollees, representing 6.4% of enrollment, may exit the ACA-compliant individual market. We again assumed a 75% morbidity differential of enrollees migrating to STLDI plans from the ACA-compliant individual market. This would result in a premium increase of 1.7%. Although this scenario is intended to estimate the impact in 2019, there is some sensitivity in the potential STLDI market. In increasing the assumption that the potential STLDI market is approximately 50% of the transitional market, the STLDI market may begin to converge to a nearer term estimate. This assumes, similar to scenario 3, that it will take

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[37]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf
[38] https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf

issuers longer to develop STLDI products compared to the pre-ACA products that had been in place for quite some time.

Scenario 3 – Individual ACA Claims Cost Analysis (Near Term Impact)

The final methodological approach we used was to examine health status and metal level in the ACA-compliant individual market as a proxy for an enrollee's propensity to shift from an ACA plan to a STLDI plan. This estimate should be considered a near term estimate, in four to five years, as the full impact of the proposed regulation is not immediate; it will take a few years for the full effect of STLDI plans to be felt on the ACA-compliant individual market. It will take time for issuers to develop STLDI products and (re)build the necessary operations to underwrite. In 2019, as illustrated in scenarios 1 and 2, not enough time has lapsed for issuers to have the operational capabilities to fully implement STLDI plans. Therefore, scenario 3 estimates are larger than the initial two.[39]

Wakely used a proprietary dataset of nationwide 2016 ACA-compliant individual market enrollees that consists of approximately 6.4 million members. We grouped individuals into one of three categories listed below to determine those who would be most likely at risk of switching from ACA-compliant coverage to STLDI coverage, referred to as the "at risk" group.

Category 1. Individuals enrolled in lower metal level plans. Lower metal levels were defined as catastrophic, bronze, and silver regular (no cost-sharing reduction variant) plans.

Category 2. Individuals who were unsubsidized.

Category 3. Individuals who had lower cost sharing (copay, deductible, coinsurance) spending levels. Lower spending levels were defined as less than the average cost of a STLDI plan premium as identified by the tri-agency's rule ($124 average monthly premiums in the fourth quarter of 2016). Since females would likely to be charged higher than males (due to the underwriting process in STLDI plans), different premium levels were assumed by gender.[40]

Based on the criteria defined above, we identified that approximately 36% of enrollees within the individual dataset fell into both Categories 1 and 3. Then, based on the 36% of enrollees, we estimated different propensities for shifting coverage from the ACA-compliant individual market to the STLDI market by also taking Category 2, the unsubsidized population, into account as

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[39] Please note that in reality the ACA-compliant individual market will experience large churn between STLDI plans as those that become unhealthy will shift to the ACA-compliant individual market and those who consider themselves healthy shift out.

[40] The ACA requires plans to conform to a particular level of actuarial value (i.e., metal levels). Wakely only used enrollees that were in catastrophic, bronze, or non-CSR silver plans. Individuals that selected these plans could be considered to have revealed preferences for lower premiums and less cost-sharing protection. Lower spending levels were identified as having less claims cost than an average STLDI plan as noted in the tri-agency regulation ($124).

subsidized members are much less likely to drop ACA-compliant individual market coverage. We adjusted the data as follows:

- Two scenarios, high and low, were modeled to produce a range of estimates.
- All individuals enrolled off-Exchange and members in catastrophic plans on-Exchange (unsubsidized, within Category 2) would be most likely to drop or shift coverage. In the low scenario, we assumed a majority of these members would dis-enroll from the ACA-compliant individual market. In the high scenario, we assumed 100%.
- Individuals enrolled on-Exchange in bronze and regular silver metal level plans are less likely to drop, since a larger portion of these members are likely to be eligible for subsidies. For these plans, in the low scenario, we assumed 80% of the unsubsidized members would dis-enroll from the ACA-compliant individual market and none of the subsidized enrollees would drop coverage. In the high scenario, we assumed 100% of the unsubsidized and a small portion of the subsidized members, based on the tri-agency's analysis in scenario 1b, would exit the ACA-compliant individual market.
- By accounting for all three categories listed above, the at risk group ranges from 20% to 26% of total market enrollees, based on the high and low scenarios. These percentages represent the proportion of members, based on the 2019 estimated ACA-compliant individual market membership prior to mandate repeal, that will leave due to combined impacts of the removal of the individual mandate and the proposed changes to the STLDI regulation.
- Applying the enrollment decrease percentages to the ACA-compliant market enrollment, pre-repeal mandate, would equate to approximately 3.0 to 3.9 million enrollees in high and low scenarios.

Because the identified at risk group would be largely the same population that would be at risk for becoming uninsured due to the effective individual mandate repeal, we reduced the potential pool of enrollees by the expected enrollment loss due to the mandate repeal, as estimated by CMS' Office of the Actuary, or 2.0 million enrollees.[41] This produced the proportion of enrollees that are estimated to shift into STLDI coverage. The initial at risk group includes members that may drop coverage due to the repeal of the individual mandate or may have disenrolled in 2017 or 2018. The data has not been adjusted from 2016; therefore, our estimates reflect higher bounds. This results in an estimated 1.0 to 1.9 million individuals who would ultimately be at risk for shifting from ACA-compliant individual plans to STLDI plans in the near term.

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[41]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

It should be noted that in a world where mandate repeal has stronger effects, the marginal effect of STLDI plans may be less. This is because enrollees who are healthier are more likely to be uninsured. The extent to which mandate repeal has less of an effect, there is a larger pool of ACA individuals that may shift to STLDI plans.

In the high and low scenarios, the same post-mandate repeal enrollment baseline as assumed in scenario 2 was used (i.e., an ACA-compliant individual market of 13 million enrollees). The low scenario assumes that the relative morbidities of those that leave for STLDI plans compared to those that stay in ACA coverage is 75%, whereas the high scenario decreases the morbidity differential to 62%. It is possible that in the event of large enrollment decreases, the morbidity differential between those that stay and those that leave could be large. To account for the potential of more extreme morbidity differences we used a larger difference in health status in the high scenario. The final impact results in an enrollment decrease of 8.2% to 15.0% in the ACA-compliant individual market and a 2.2% to 6.6% increase in premiums. Again, these assumptions show a near term impact of four to five years. The table below includes enrollment for the ACA-compliant individual market (both on and off-Exchange) in total and for subsidized enrollees, premium impacts, and enrollment impacts. Enrollment levels are estimated prior to the repeal of the individual mandate. Then, enrollment and premium impacts are re-estimated based on the repeal of the individual mandate, and again after the proposed STLDI regulation change. Both the loss of the individual mandate and proliferation of STLDI plans would impact the unsubsidized market much more drastically than the subsidized market. The combined impact of both the repeal of the mandate and the easing restrictions on STLDI plans would result in premium increases of 20.5% to 26.3% higher than they otherwise would have been.

Table 2 - Effects of STLDI Proposed Regulation on ACA-Compliant Individual Market Risk Pool (Different Scenarios)

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	**Proposed Rule Low**	**Proposed Rule High**	**Proposed Rule Adjusted Low**	**Proposed Rule Adjusted High**	**Transitional Enrollment**	**Individual ACA Claims Cost Data Low**	**Individual ACA Claims Cost Data High**
Year	**2019**	**2019**	**2019**	**2019**	**2019**	**Near Term**	**Near Term**
Estimate Performed By?	Tri-Agency[5]	Tri-Agency[5]	Tri-Agency, Wakely Adjusted	Tri-Agency, Wakely Adjusted	Wakely	Wakely	Wakely
Off-Exchange Population Included?[1]	No	No	Yes	Yes	Yes	Yes	Yes
Baseline, with enforcement of Individual Mandate							
Individual Total Enrollment[2]	13,130,000	13,130,000	18,130,000	18,130,000	15,000,000	15,000,000	15,000,000
Individual Subsidized Enrollment	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000
Baseline, with removal of Individual Mandate							
Increase in Premiums	10.0%	10.0%	10.0%	10.0%	5.8%	5.8%	5.8%
Reduction of Members[3]	3,400,000	3,400,000	3,400,000	3,400,000	2,000,000	2,000,000	2,000,000

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	**Proposed Rule Low**	**Proposed Rule High**	**Proposed Rule Adjusted Low**	**Proposed Rule Adjusted High**	**Transitional Enrollment**	**Individual ACA Claims Cost Data Low**	**Individual ACA Claims Cost Data High**
Individual Total Enrollment	9,730,000	9,730,000	14,730,000	14,730,000	13,000,000	13,000,000	13,000,000
Individual Subsidized Enrollment	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000
Scenario, Impact of STLDI Plans							
Increase in Premiums[4]	0.3%	0.6%	0.7%	1.4%	1.7%	2.2%	6.6%
Reduction of Members	100,000	200,000	396,000	791,000	826,000	1,070,000	1,948,000
Decrease in Enrollment	-1.0%	-2.1%	-2.7%	-5.4%	-6.4%	-8.2%	-15.0%
Individual Total Enrollment	9,630,000	9,530,000	14,334,000	13,939,000	12,174,000	11,930,000	11,052,000
Individual Subsidized Enrollment	8,112,000	8,102,000	8,112,000	8,102,000	8,122,000	8,122,000	8,122,000
Total Impacts due to Removal of Individual Mandate and STLDI Plans							
Increase in Premiums	10.3%	10.6%	10.8%	11.6%	7.6%	8.2%	12.8%
Reduction of Members	3,500,000	3,600,000	3,796,000	4,191,000	2,826,000	3,070,000	3,948,000
Decrease in Enrollment	-26.7%	-27.4%	-20.9%	-23.1%	-18.8%	-20.5%	-26.3%

[1] The population includes only on-Exchange ACA-compliant individual membership within the proposed rule (scenarios 0a and 0b) analyses. Both on and off-Exchange membership are included within the additional scenarios. Because the proposed rule analyses do not account for effects of the off-Exchange market, there will be downstream impacts to market premiums.
[2] The baseline ACA-compliant individual market membership, prior to impacts due to the repeal of the individual mandate and STLDI plan regulation change, in scenarios 0 and 1 are based on higher on and off-Exchange estimates. These estimates align with CBO assumptions. Scenarios 2 and 3 rely on smaller on and off-Exchange baseline estimates. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[3] The reduction in members due to the repeal of the individual mandate in scenarios 0 and 1 are based on CBO assumptions, as assumed within the proposed rule analyses. Scenarios 2 and 3 rely on a smaller reduction in members due to the repeal of the individual mandate, as assumed by the Office of the Actuaries'. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[4] Scenarios 1a - 3a assume that members who leave the ACA-compliant individual market for STLDI coverage cost 25% less on average compared to enrollees that remain in the ACA-compliant individual market. Scenario 3b assumes this differential is 38%.
[5] See note above regarding the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments) proposed rule. Further detail is described within the quantitative section of the report.

Conclusion

In 2016, the Obama Administration enacted a regulation that limited enrollment in STLDI plans. Individuals were not allowed to enroll in STLDI plans for more than three consecutive months. This was done to prevent STLDI enrollment from harming the ACA-compliant risk pool and to limit consumer's exposure to underwriting, rescissions, annual limits, and other harmful policies that were in effect prior to the ACA in 2014. In February of 2018, the Trump Administration proposed to reverse the Obama era regulation to make it easier for individuals to stay enrolled in STLDI plans. While it would provide healthy individuals access to cheaper, less generous coverage, it would also increase premiums for individuals in the ACA risk pool. The effective repeal of the mandate starting in 2019 introduces additional uncertainty into the ACA risk pool and is expected to increase the morbidity of the risk pool.

The combination of removing restrictions on STLDI plans and repealing a mandate penalty for individuals that sign up for these plans should increase the attractiveness of STLDI plans to current ACA enrollees. Using a variety of scenarios, Wakely estimates that STLDI plans will have an adverse effect on the ACA individual market and that the effect will grow with time. The impact in 2019 is estimated to increase premiums 0.7% to 1.4% and decrease enrollment by 2.7% to 5.4% in the ACA-compliant individual market. In the near term, once the STLDI market has had a chance to expand, we estimate that premiums for ACA-compliant individual enrollees could be 2.2% to 6.6% higher and enrollment 8.2% to 15.0% lower. The STLDI regulation change combined with the repeal of the individual mandate will further exacerbate the impacts and increase premiums from 10.8% to 12.8% and decrease enrollment from 20.9% to 26.3% (based on 2019 and near term estimates).