To: Council for Affordable Health Coverage

From: Avalere Health

Date: August 18, 2014

Re: Estimated Impact on the Federal Deficit and Insurance Premiums from Creating a New Health Plan Tier with an Actuarial Value Level of 50 Percent

Summary

The Council for Affordable Health Coverage requested Avalere Health to estimate the impact on the federal deficit of a legislative proposal that would allow a new type of plan tier for consumers in the new health insurance marketplace as well as small employers. Plans on this new tier would have an actuarial value (AV) of 50 percent. As originally passed in the Affordable Care Act (ACA), commercial health insurance plans in the individual and small group markets must cover at least 60 percent of the estimated health costs of enrollees starting in 2014.

We estimate that creating a new tier with an AV of 50 percent would reduce the federal deficit by $0.3 billion between FY 2015 and FY 2024. This estimate assumes that the new tier would be available to consumers starting in plan year 2016. The reduction is due to a net $5.8 billion decrease in subsidies paid by the federal government for individuals in the new health insurance marketplace, primarily due to an increase in the estimated number of employers who will offer affordable coverage to employees. Counteracting this reduction in federal spending is an estimated $5.5 billion decrease in revenues collected by the federal government, again primarily due to fewer employers paying the employer mandate penalty.

We also estimate that the premium for the new plan with a 50 percent AV would be nearly 18 percent lower than the premium for an average bronze tier plan in 2016. The lower premium would result in a slight increase in estimated enrollment in the new marketplace.

Estimated Effect on the Federal Deficit from Creating 50% AV Tier

	Billions of Dollars, by Fiscal Year											
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2015-2019	2015-2024
Change in federal spending	0.0	-0.3	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-0.8	-0.8	-2.1	-5.8
Change in federal receipts	0.0	-0.3	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-2.0	-5.5
Net effect on federal deficit	**0.0**	*****	**-0.1**	**-0.1**	**-0.1**	*****	*****	*****	*****	*****	**-0.1**	**-0.3**

* represents less than $50 million

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Background

Sections 1302(d)(1) and 1302(d)(2) of the Affordable Care Act (ACA) created four specific levels, or tiers, of coverage that commercial health insurance plans must offer starting in 2014. Plans in each tier must cover a specific level of coverage of the estimated costs of the essential health benefits determined by the Secretary of Health and Human Services (HHS). The ACA defined the four tiers as follows: platinum plans will cover 90 percent of costs; gold plans will cover 80 percent of costs; silver plans will cover 70 percent of costs; and bronze plans will cover 60 percent of costs. In addition, unless a plan meets the definition of catastrophic coverage, it must cover a minimum of 60 percent of the costs of enrollees to be approved by HHS. These restrictions apply to both the employer and individual market for health insurance.

Starting in 2014, people who enroll in health insurance plans in the individual market via the new health insurance marketplace will be eligible for federal subsidies to offset the insurance premium if their income is above 100 percent and below 400 percent of the federal poverty limit (FPL). The level of subsidy is based on the premium of the second lowest silver plan in the enrollee's market, and varies based on the specific income of the enrollee. Individuals can pay additional out-of-pocket to "buy-up" to gold or platinum plans, or they can pay lower out-of-pocket to "buy-down" to bronze plans.

The Society of Actuaries (SOA) estimates that over 8 million people with employer-sponsored coverage will lose that coverage due to the ACA changes.[1] Of this group, the SOA estimates slightly over 50 percent will enroll via the individual marketplace. The Congressional Budget Office (CBO) estimates that over 75 percent of enrollees in the marketplace will receive a federal subsidy, although it is uncertain whether this many individuals who previously had employer-sponsored insurance will qualify for the federal subsidies.[2] CBO also estimates the average federal subsidy for enrollees in the marketplace will be $4,410 in 2014.

Besides the federal subsidies for individual insurance, the ACA also included individual and employer penalties related to health insurance. For individuals, there will be a penalty of $95 per adult and $47.50 per child (up to $285 per family) or 1 percent of family income in 2014. This penalty increases each year. Individuals or families are exempt from this mandate if they are opposed to health insurance due to religious reasons, if they are an undocumented immigrant, if they are not required to file a federal tax return, or if they have to pay more than 8 percent of their income for health insurance. CBO estimates that 75 percent of individuals who do not purchase health insurance will qualify for an exemption from the individual mandate penalty.[3] For employers, there is a penalty of $2,000 per full-time employee if the employer does not offer the minimum level of coverage (60% AV), or a penalty of $3,000 per full-time employee receiving subsidies via the marketplace if the cost of the employer's coverage is deemed unaffordable.

There have been several analyses of the estimated premium increase for enrollees who previously received coverage via the individual market and the effects of premium increases on

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[1] Society of Actuaries. "Cost of the Future Newly Insured under the Affordable Care Act (ACA)". March 2013. Available at http://www.soa.org/News-and-Publications/Newsroom/Press-Releases/ACA-Driven-Changes/.
[2] Congressional Budget Office. "Effects of the Affordable Care Act on Health Insurance Coverage – April 2014 Baseline". April 2014. http://cbo.gov/publication/43900.
[3] Congressional Budget Office. "Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update". June 2014. Available at http://cbo.gov/publication/45397.

continued coverage.[4] One study found that over 80 percent of enrollees in the individual market had coverage that was at or below the current bronze AV level of 60 percent.[5] Due to the increases in costs in 2014 for some people in the individual market, some individuals may react by dropping coverage, especially people who do not qualify for federal premium subsidies. In addition, while estimates from HHS suggest that only 6 percent of the small group market enrollment is in plans that cover 60 percent or less of estimated costs, the American Academy of Actuaries note that this is the group of employers may be more likely to drop coverage in 2014 or later rather than face the increased costs of providing coverage.[6]

Introducing a new tier in 2016 may cause some individuals who have already enrolled in a marketplace plan to re-evaluate their prior choice, while also attracting other individuals who are expected to enroll for the first time in a marketplace plan that year. Several studies have looked at the effect of plan choice by individuals who are required to make an active decision regarding their health plan each year versus individuals who are passively reassigned to their existing plan. One study found that many individuals choose a plan that is appropriate for their expected risks if required, but do not shift to a more appropriate plan if they are passively kept in their existing plan.[7] Another study found that individuals who were required to make an active choice each year were nearly 50 percent more likely to choose a lower cost option.[8] HHS has been relatively non-committal to date regarding the ability of plans to automatically (i.e., passively) renew existing enrollees.

Avalere Health has prepared this analysis for the Council for Affordable Health Coverage upon the request of, and with financial support from, a subset of the Council's members.

Data Sources

We used the following data sources to develop our estimate:

- "Cost of the Future Newly Insured under the Affordable Care Act (ACA)". Society of Actuaries, March 2013. Available at http://www.soa.org/News-and-Publications/Newsroom/Press-Releases/ACA-Driven-Changes/
- 2013 Current Population Survey (CPS) March Supplement
- "Effects of the Affordable Care Act on Health Insurance Coverage – April 2014 Baseline". Congressional Budget Office, April 2014. Available at http://www.cbo.gov/publication/43900.
- "Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update". Congressional Budget Office. June 2014. Available at http://cbo.gov/publication/45397.
- "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation". Department of Health and Human

[4] Center Forward. " Impact Analyses in Six States of the Patient Protection and Affordable Care Act". May 2013. Available at http://www.center-forward.org/acaimpact/.
[5] Gabel, Jon R., et. al. "More than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014". Health Affairs. May 2012. Available at http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.full
[6] American Academy of Actuaries. "How Will Premiums Change Under the ACA?" Issue Brief. May 2013. Available at http://www.actuary.org/files/Premium_Change_ACA_IB_FINAL_050813.pdf.
[7] Handel, Benjamin R. "Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts". American Economic Review, 103(7): 2643-82.
[8] McDevitt, Roland D. et. al. "Risk Selection into Consumer-Directed Health Plans: An Analysis of Family Choices within Large Employers". Health Services Research, 49(2): 609-627.

Services, February 2013. Published in the Federal Register, vol. 78, no. 37, pages 12834-12872. Available at http://cciio.cms.gov/resources/regulations/.
- "Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands on Nongroup Health Insurance". Urban Institute, March 2013. Available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404637.
- Actuarial Value Calculator. Published by the Department of Health and Human Services, February 2013. Available at http://cciio.cms.gov/resources/regulations/.
- McDevitt, Roland D. et. al. "Risk Selection into Consumer-Directed Health Plans: An Analysis of Family Choices within Large Employers". Health Services Research, 49(2): 609-627.

Assumptions and Methodology

Estimates of individual health insurance market with current AV requirements

- **Distribution of individual market covered lives by AV tier**: We started with estimates from the SOA regarding the expected distribution of lives in the individual market by age and income. We calibrated this distribution by coverage tier such that the overall average subsidy for 2016 enrollees matched the estimated average subsidy from the CBO. After these adjustments, we estimate that 5 percent of enrollees will be in platinum plans, 9 percent will be in gold plans, 71 percent will be in silver plans, and 15 percent will be in bronze plans. In addition, we estimate 44 percent of enrollees will be under the age of 45, while 56 percent will be between 45 and 64. Finally, we estimate 79 percent of enrollees will have income below 400 percent of the FPL.
- **Estimated 2016 premiums for individual coverage**: The SOA has estimated the average medical & pharmacy cost in associated with covered lives in the individual market will be approximately $4,900 per year. This amount does not include any administrative costs and does not account for the AV of a specific plan, and reflects a more diverse risk pool than the estimated enrollees in the marketplace. In order to account for these factors, we increased this medical cost by approximately 14 percent. We next assumed the average individual plan met the medical loss ratio (MLR) requirement of 80 percent, which led to a pre-AV premium of approximately $7,000 per year. Applying the average distribution of lives by AV type (described above), we estimate the average 2016 premium across all plans types in the individual market will be approximately $6,400 per year.
- **Subsidies in the individual marketplace**: After calculating the premium for individual coverage by age, income, and coverage tier, we next estimated the federal subsidy for each of these groups. We determined the average subsidy for each age group by comparing the maximum allowable subsidy to the estimated silver premium for the specific age. We applied this maximum subsidy against the estimated premium for each age/income/tier group to determine the total subsidies that would be paid. Using this process, we estimate the average subsidies by tier in 2016 will be as follows: platinum $3,900; gold $4,000; silver $5,200; and bronze $4,150. On a weighted basis, the average subsidy is $4,830. Note that the subsidy is highest for silver plans, as we expect a significant number of lower-income individuals to select silver plans in order to receive the cost-sharing subsidies in addition to the premium subsidies.

Effects of adding a 50 percent AV tier on the individual health insurance market

- **Change individual market covered lives:** The SOA estimates that approximately 6 percent of the current individual market will drop coverage after the effect of the ACA, primarily due to the new cost of individual coverage. The SOA also estimates that approximately 0.5 percent of individuals with employer-sponsored insurance will become uninsured starting in 2014. Combined, this equals approximately 1.3 million individuals who currently have health insurance but will drop coverage, likely due to the cost of insurance. We estimate adding a new 50 percent AV tier in the individual market will result in approximately 350,000 additional individuals enrolling in this market due to the lower cost plan. We estimate over 50 percent of this increase in enrollment will be individuals who do not qualify for federal subsidies because their family income is above 400 percent of the FPL. We estimate approximately 50 percent of existing marketplace enrollment in bronze plans will shift into the new, lower cost tier, as well as nearly 75 percent of new enrollees who would have otherwise selected a bronze plan.
- **Effect of change in enrollment on 2016 premiums**: Data from HHS demonstrates that individuals who enroll in health insurance plans with lower AV coverage have lower medical costs than average. This is likely due to the effect of increased cost sharing limiting utilization combined with a generally healthier population. To determine the effect of increased enrollment at lower AV coverage, we calculated the estimated change in medical costs from the different distribution of enrollment by AV coverage. We estimate the total cost of coverage in the individual marketplace will decrease by approximately 2 percent due to the higher enrollment in lower AV plans. Specific to plans on the new 50 percent AV tier, we estimate the average premium will be $4,600, nearly 18 percent lower than the average bronze tier premium with a 60 percent AV requirement.
- **Effect on individual market subsidies:** Since the overall cost of coverage in the marketplace will be lower due to the increased enrollment in the new 50 percent AV tier, the federal subsidies for coverage will also be lower. We assume the maximum premium (based on income levels) will remain the same, but the cost of the silver plan will be lower, resulting in a lower total subsidy amount. Applied to our assumed distribution of enrollment by age/income/tier, we estimate the average 2016 federal subsidy will be 1.0 percent lower under this proposal lower relative to current expectations.
- **Effect on individual penalties**: The CBO estimates that only 25 percent of people who do not purchase an insurance plan will be required to pay the individual mandate penalty, and that the average penalty paid by individuals for lack of health insurance coverage in 2016 will be approximately $1000. We assume that approximately 50 percent of the individuals who gain coverage due to the lower AV would have paid the penalty if they had remained uninsured, resulting in lower revenues for the federal government.

Effects of adding a 50 percent AV tier to the small group health insurance market

- **Effect on enrollment in employer-sponsored health insurance**: The SOA estimates approximately 3 percent of individuals with employer-sponsored insurance will lose their coverage and either shift to individual coverage or become uninsured. Of this group, SOA estimates 84 percent of them will enroll in the individual marketplace. Evidence to

date suggests some of these employers will drop coverage due to the increased costs for covering at least 60 percent of the healthcare costs. We estimate that, if the minimum AV for group coverage is also lowered to 50 percent, approximately 4 percent of these individuals in the individual marketplace will no longer lose their employer-sponsored insurance in 2016. We note this increase represents approximately 0.1 percent of the current employer-sponsored market.

- **Effect on subsides and costs in the individual market:** We estimate the increase in employer-sponsored coverage will have two effects on the remaining individual marketplace coverage. First, it will decrease the total federal subsidies paid, as these people will have affordable coverage from their employers. Second, it will slightly offset the expected change in the total cost of the individual market described above. We assume that individuals who move to employer coverage at a 50 percent AV will have lower-than-average medical costs. As such, we estimate the total cost of coverage in the individual marketplace will increase by 0.3 percent relative to the effect described above. Combined, we estimate the costs in the individual marketplace with a 50 percent AV tier will be 0.6 percent lower than under current policy.
- **Effect on taxable wages from non-dropped coverage**: The increase in employer-sponsored coverage will result in lower taxable wages. We estimate the average premium for employer-sponsored insurance will be slightly less than $5,000. We also estimate the increased enrollment will primarily be among individuals with average incomes, resulting in a marginal tax rate of 21 percent.
- **Effect on individual and employer penalties:** Finally, we estimate the increase in employer-sponsored coverage will result in both fewer individuals paying the individual mandate penalty as well as fewer employers paying the employer mandate penalty.
    - Regarding the individual penalty, the SOA estimates that less than 0.5 percent of individuals who currently have employer-sponsored coverage will become uninsured in 2014. We apply the same ratio as described above regarding the effect of the 50 percent AV on the individual marketplace to estimate the decrease in individuals who would have to pay the individual mandate penalty.
    - Regarding the employer penalty, we assume the decline in subsidized enrollment in the individual marketplace will result in fewer employer penalties.