

AHCA STATE STABILITY FUND WOULD GIVE MORE MONEY TO STATES WITH LIMITED INSURANCE COMPETITION

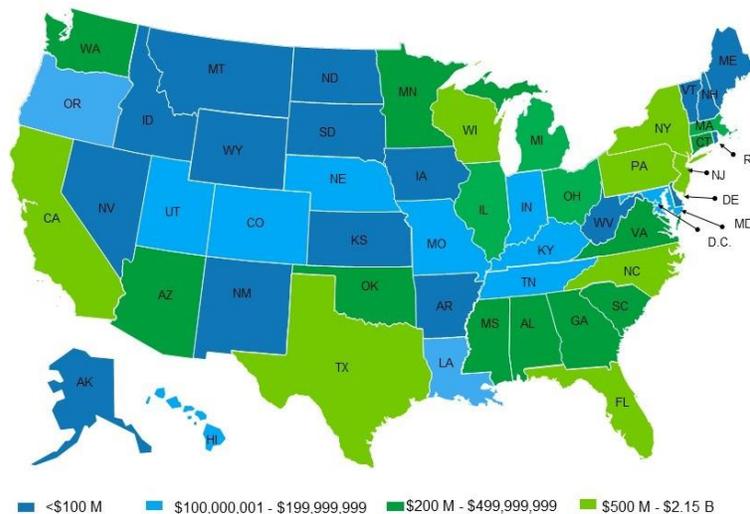
New research from Avalere finds that under the American Health Care Act (AHCA), large states as well as those states with fewer insurers offering plans in the individual and small group markets could receive the most money from the federal government to help stabilize their markets. As currently drafted, the AHCA’s Patient and State Stability Fund would allocate \$100 billion over 10 years to help states stabilize their insurance markets.

The funds would be distributed based on two calculations. The first 85 percent of the funds would be distributed according to the share of that state’s insurance claims as a percentage of the nation —i.e., states with more people with insurance and higher medical costs would receive more money compared to states lower overall enrollment and spending.

The remaining 15 percent of the funds would be distributed solely to states that either have seen an increase in the number of uninsured from 2013 to 2015 living below the poverty line (\$12,060 for an individual in 2017), and/or have [less than three participating health insurers selling coverage in their exchange market in 2017](#). The stability funds would be distributed to states on a yearly basis.

“The fund is designed to help stabilize state insurance markets,” said Caroline Pearson, senior vice president at Avalere. “As such, it directs a greater share of money towards those states with low plan competition, where there is a risk that the market could collapse.”

Figure 1. Estimated State Stability Funds, 2018



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According to Avalere experts, the allocation methodology means that states like California, Florida, and New York could receive the greatest amounts of money. However, states like North Carolina, Arizona, Alabama, Oklahoma, and South Carolina could receive disproportionately high amounts of money given the lack of health insurer participation on their exchanges in 2017.

Many of the stability funds may be used to improve affordability and access to coverage in the individual market specifically. On a per capita basis, when compared to the state's individual market enrollment in 2015, the funding levels vary widely (table 1). They range from a high of \$1,830 in the District of Columbia to a low of \$220 in Montana. This is, in part, due to the fact that the formula for allocating the money is not explicitly tied to the size of a state's individual markets.

The AHCA provides states with options for how to use the funds, including providing financial assistance for high cost individuals, incentivizing insurer participation in their markets, reducing the cost of insurance, promoting access to preventive services, and reducing out-of-pocket costs for patients. In its recent score of the AHCA, the Congressional Budget Office (CBO) estimated that a combination of the Stability Fund and other changes in the market would reduce premiums by 10 percent below current law projections by 2026.

“Reinsurance could be an important tool for states with limited competition or significant price increases to make coverage more affordable by lowering premiums,” said Chris Sloan, senior manager at Avalere. “States with high-functioning, competitive markets might use the money to increase subsidies or reduce cost-sharing for enrollees.”

Table 1: State level funding, population, and per capita amounts



State	2018 Dollars Allocated (in millions)	Funding Ranking	2016 Population (in millions)	Population Ranking	Per Capita: 2015 Individual Market
Alabama	393	14	4.86	24	\$1,320
Alaska	45	44	0.74	48	\$1,350
Arizona	428	12	6.93	14	\$900
Arkansas	64	42	2.99	33	\$300
California	2,115	1	39.25	1	\$700
Colorado	165	28	5.54	21	\$360
Connecticut	361	15	3.58	29	\$1,490
Delaware	37	47	0.95	45	\$720
District of Columbia	102	34	0.68	49	\$1,830
Florida	831	3	20.61	3	\$410
Georgia	247	21	10.31	8	\$340
Hawaii	129	31	1.43	40	\$1,810
Idaho	46	43	1.68	39	\$260
Illinois	453	10	12.8	5	\$520
Indiana	139	30	6.63	17	\$370
Iowa	78	38	3.13	30	\$330
Kansas	91	36	2.91	35	\$410
Kentucky	173	26	4.44	26	\$750
Louisiana	142	29	4.68	25	\$470
Maine	41	45	1.33	42	\$420
Maryland	178	25	6.01	19	\$480
Massachusetts	406	13	6.81	15	\$1,100
Michigan	448	11	9.93	10	\$790
Minnesota	296	18	5.52	22	\$740
Mississippi	236	22	2.99	32	\$1,270
Missouri	168	27	6.09	18	\$370
Montana	24	50	1.04	44	\$220
Nebraska	126	32	1.91	37	\$740
Nevada	85	37	2.94	34	\$450
New Hampshire	33	48	1.33	41	\$450
New Jersey	572	7	8.94	11	\$1,160
New Mexico	92	35	2.08	36	\$920
New York	1,190	2	19.74	4	\$1,060
North Carolina	743	4	10.15	9	\$860
North Dakota	38	46	0.76	47	\$520
Ohio	486	9	11.61	7	\$850
Oklahoma	319	16	3.92	28	\$1,320
Oregon	187	23	4.09	27	\$620
Pennsylvania	529	8	12.78	6	\$590
Rhode Island	69	41	1.06	43	\$1,100
South Carolina	314	17	4.96	23	\$970
South Dakota	75	39	0.86	46	\$870
Tennessee	181	24	6.65	16	\$410
Texas	705	5	27.86	2	\$380
Utah	105	33	3.05	31	\$370
Vermont	20	51	0.62	50	\$510
Virginia	265	20	8.41	12	\$440
Washington	293	19	7.29	13	\$560
West Virginia	72	40	1.83	38	\$1,010
Wisconsin	637	6	5.78	20	\$1,770
Wyoming	30	49	0.58	51	\$660



METHODOLOGY

To calculate the share of the Patient and State Stability Fund allocated to each state in 2018, Avalere used the allocation methodology outlined in the AHCA proposed bill. The bill allocates 85 percent of each year's funding by the amount of each state's incurred claims in 2015 as reported in the annual 2015 Medical Loss Ratio filings. Avalere used the total 2015 incurred claims across all markets to distribute 85 percent of the funds. The remaining 15 percent are also allocated by share of 2015 incurred claims, but only for those states that have fewer than three participating issuers on their 2017 exchange and/or have seen an increase in the number of uninsured individuals in poverty from 2013 to 2015. Avalere used its tracking of issuer participation in the 2017 exchange states and the 2013 and 2015 American Community Survey (ACS) estimates of uninsured individuals in poverty. Importantly, actual implementation of the formula would vary based on future regulatory guidance. These numbers represent an estimate based on the language of the proposed AHCA.

Data for figure 1 are based on the Centers for Medicare & Medicaid Services. 2015 Medical Loss Ratio Reporting Public Use File. Population statistics in table 1 come from the Census Bureau.

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