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How Lawmakers Should Deal with Obamacare Cost-Sharing-Reduction Payments

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Obamacare premiums took another big jump in 2018. Many attribute these increases to the Trump Administration's decision to terminate government payments to insurance companies, known as cost-sharing-reduction (CSR) subsidies.[1]

A closer look at the data, however, shows that premiums for Obamacare's exchange-based coverage in 2018 have once again risen at double-digit rates, even in plans that were entirely unaffected by the elimination of CSR payments. Providing CSR payments in 2018 will not dampen these premium increases. Nor do they address their underlying cause.

Background: Cost-Sharing-Reduction Payments

Obamacare provides two forms of income-based assistance: advanced premium tax credits (APTC) and CSR subsidies. Those with incomes between 100 percent and 400 percent of the federal poverty level (FPL)—$12,060 to $48,240 for an individual—are eligible to receive tax credits to pay a portion of their premiums.[2] These credits are refundable, meaning that they can be claimed as subsidies by people eligible for credits that exceed their federal income tax liability. The Affordable Care Act (ACA) provides for automatic appropriation of these payments.

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CSR subsidies are available to individuals with incomes between 100 percent and 250 percent of the FPL—$12,060 to $30,150 for an individual. The ACA requires insurers to provide more generous coverage (such as lower deductibles and coinsurance) to households in this income range.[3] It also authorizes CSR payments to insurers to compensate them for the costs of providing this richer coverage.[4]

Unlike premium subsidies, however, the ACA does not automatically appropriate CSR payments. Congress has never appropriated money for this program. The Obama and Trump Administrations nevertheless made them for four years. A federal judge ruled in May 2016 that it was unconstitutional for the government to continue these payments, but stayed her order pending appeal.[5] In October 2017, the Trump Administration announced that it would no longer make the payments absent a congressional appropriation.[6]

In approving 2018 premiums for Obamacare-compliant plans, most insurance commissioners allowed for the possibility that the federal government would terminate CSR payments. According to the National Association of Insurance Commissioners, regulators in 48 states approved greater premium increases to allow insurers to recover revenues that they would have received through federal CSR payments.[7] In 33 of those states, insurers were permitted to raise premiums only on Silver plans sold through health insurance exchanges.

In these states, the termination of CSR payments *only affected premiums for Silver plans*. Premium increases for other insurance products that Obamacare allows to be sold (Bronze, Gold, and Platinum plans) were unaffected by the cessation of CSR pay-

ments. Thus, premium increases for non-Silver coverage in these states is entirely the result of ongoing instability in the individual market, which is driven by the nature of Obamacare itself.[8]

Obamacare Premiums Spiked Even for Plans *Not* Affected by the CSR Cutoff

Some attribute the 2018 spike in Obamacare premiums to the decision by the Trump Administration to stop making CSR payments to insurers and are backing legislation to restore those payments in 2018.[9] The data tell a different story.

Original analysis of 2018 premium increases finds double-digit increases in premiums for plans that were unaffected by the withdrawal of CSR money. This analysis relies on an October 2017 National Association of Insurance Commissioners (NAIC) analysis of final rate submissions for the 2018 plan year.[10] The analysis reports how each state dealt with premium increase requests based on the loss of CSR funds. It identifies 33 states that required insurers to load the entire cost of foregone CSR funds onto Silver plans sold on the exchanges.

Next, the study used public-use files from the Centers for Medicare and Medicaid Services (CMS) that lay out 2018 premiums for individual coverage in the 39 states that use the healthcare.gov platform.[11] Of these states, 23 required that premium increases, needed to compensate for the loss of CSR payments, be applied exclusively to Silver plans sold through the exchanges.

Since these states did not permit similar adjustments to Bronze plan premiums, increases in those premiums are not attributable to the cutoff of CSR money. Table 1 presents premium increases for each of the 23 state's lowest-cost Bronze plan for a 40-year-old enrollee.

The median increase for the lowest-cost Bronze plan in 2018 was 16.41 percent. Of the 23 states, only two (Alaska and South Dakota) showed premium decreases. (Alaska is a unique case that is discussed below.) Three others (Alabama, Montana, and South Carolina) had premium increases of less than 5 percent. Premiums in the remaining 18 states rose by more than 13 percent, ranging from 13.29 percent (Illinois) to 57.13 percent (Nebraska).

None of these premium increases was associated with the termination of CSR funding and none would be affected by the appropriation of these funds for the 2018 plan year.

The Root Causes of Obamacare Premium Increases

Although the Administration's decision to terminate CSR payments has affected premiums for some plans, it is not the root cause of premium increases. Insurers in most states have substantially raised 2018 rates for policies that are unaffected by the CSR funding cutoff. These premium increases are more likely related to other factors, including declines in the number of people with individual coverage,[12] the worsening of the insurance pool,[13] and the withdrawal of insurers from the exchanges.

Throughout the summer of 2017, concerns grew that there would be "bare" counties in 2018—those in which no insurer would offer a product on the exchanges. Regulators scrambled to find companies willing to sell in these counties and ultimately were successful.[14] But one of four beneficiaries lives in a county where only a single insurer remains in the exchange.[15] This lack of competition in a substantial number of markets likely contributes to higher rates.

These problems are an inherent consequence of Obamacare's design flaws. Restoring CSR funding in 2018 would solve none of them.

Legislative Efforts Fall Short

Congress is considering two measures in response to the Trump Administration's decision to end CSR payments: the Bipartisan Health Care Stabilization Act, authored by Senators Lamar Alexander (R–TN) and Patty Murray (D–WA),[16] and the Lower Premiums Through Reinsurance Act, introduced by Senators Susan Collins (R–ME) and Bill Nelson (D–FL).[17] Both bills would give billions of federal dollars to insurers in 2018, imposing new costs on taxpayers.

Alexander–Murray Bill. The bill's main provision would appropriate CSR payments to insurers for 2018 and 2019. Since insurers already have raised their premiums to compensate for the loss of CSR payments, the bill would result in double payments. To correct for this, the measure gives state regulators 60 days to develop plans to claw back premium increases that were established to compensate insurers for lost CSR money.

The Congressional Budget Office (CBO) does not believe that these rebate mechanisms will be entirely successful. If CSR money is appropriated for 2018, the CBO has written that "federal costs in

2018 would be higher with funding for CSRs because premiums for 2018 have already been finalized and rebates related to CSRs would be less than the CSR payments themselves."[18]

Insurers already have priced the loss of CSR payments into their 2018 premiums. Providing CSR payments would compensate insurers a second time. Recouping these double payments will require states to play a game of "pay and chase" with insurers. It is a game that, according to the CBO, states will not win.

The Alexander–Murray bill also would allow insurers to sell a new category of ACA-compliant product—Copper plans—policies that would cost less and provide less-generous coverage than Bronze coverage.[19] It also would make it easier for states to receive waivers from certain ACA regulatory requirements. The creation of Copper plans does not entail additional federal subsidies to the insurance industry, and the CBO believes that legalizing the sale of these policies would reduce federal spending. More important, it would provide consumers with an additional choice, one that is more affordable than existing Obamacare policies. These provisions are very small steps in the direction of offering consumers more affordable health insurance options. Congress should go much further.

Collins–Nelson Bill. The Collins–Nelson bill would make it easier for states to obtain waivers to establish risk-mitigation programs. It would provide a total of $4.5 billion—$2.25 billion in 2018 and $2.25 billion in 2019—to states that establish reinsurance or "invisible high-risk pool" programs to compensate insurers for the cost of certain large claims.[20]

The bill would allow insurers to shift to the taxpayer the costs of large medical claims covered under their policies. Each state would be eligible to seek a waiver that would allow it to spend new federal money to compensate insurers for a portion of the cost of such claims.

As with the Alexander–Murray bill, insurers would receive a double payment in 2018: First, they would collect higher premiums (and higher premium subsidies) to cover the cost of large medical claims; then they would submit those large medical claims to the state, which would use federal money to reimburse at least part of the cost.

Successful state reinsurance programs require neither double payments nor additional federal spending. Budget-neutral risk-mitigation programs can help hold down premiums without imposing additional costs on taxpayers.

Alaska illustrates this point. In July 2017, the federal government approved a waiver that authorized the state to use existing federal premium subsidies to help finance a state pool to pay medical claims

TABLE 1

Premiums for Lowest-Premium Bronze Plans

Figures are for a 40-year-old enrollee.

STATE	2017	2018	CHANGE
Alaska	$703.00	$526.00	-25.18%
Alabama	$308.36	$323.40	4.88%
Arkansas	$238.70	$277.88	16.41%
Florida	$243.57	$278.12	14.18%
Hawaii	$244.25	$278.12	13.87%
Iowa	$229.73	$278.12	21.06%
Illinois	$269.07	$304.82	13.29%
Louisiana	$291.88	$333.15	14.14%
Maine	$295.44	$337.01	14.07%
Michigan	$192.15	$218.57	13.75%
Montana	$319.30	$333.99	4.60%
Nebraska	$309.02	$485.55	57.13%
New Hampshire	$309.02	$391.04	26.54%
New Mexico	$199.87	$293.16	46.68%
Nevada	$216.22	$301.62	39.50%
Ohio	$204.53	$244.07	19.33%
Pennsylvania	$206.57	$243.24	17.75%
South Carolina	$316.10	$319.84	1.18%
South Dakota	$350.19	$346.15	-1.15%
Texas	$187.94	$255.72	36.06%
Utah	$227.51	$302.76	33.08%
Virginia	$245.82	$327.48	33.22%
Wisconsin	$209.59	$250.08	19.32%
MEDIAN INCREASE			16.41%

SOURCE: Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Health Insurance Exchange Public Use Files (Exchange PUFs)," https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html (accessed December 15, 2017).

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incurred by "residents with high risk"—those whose health status made it likely that they would run up significant medical bills. The program met the ACA's statutory waiver criteria because it did not require additional federal spending. Instead, the state deployed existing federal resources to finance a pool that helped pay large medical claims. Shifting this risk to the pool resulted in lower premiums for 2018. These lower premiums, in turn, reduced the costs of providing federal subsidies, thus rendering the program budget neutral.

As Table 1 shows, the program appears to be working. In contrast to the trend in most other states, premiums for the lowest-cost Bronze plan in Alaska dropped by roughly one-fourth, reducing federal spending on premium subsidies.

The results of the Alaska reinsurance waiver are promising. Other states may wish to pursue similar waivers for 2019. Congress should consider amending the ACA statute to facilitate the implementation of such waivers. Both the Collins–Nelson and the Alexander–Murray bills propose useful changes along these lines.

Lawmakers should recognize that reinsurance arrangements can succeed without the expenditure of additional federal money. Alaska's reinsurance waiver met the statute's budget-neutrality requirement. Congress should encourage risk-mitigation waivers, but it should not allocate additional money for these programs.

Recommendations: Regulatory Relief to Offer More Affordable Coverage

1. **Congress should not fund CSRs for 2018 or appropriate additional money for state risk-mitigation waivers.** With 2018 premium hikes already approved, and open enrollment concluded in most states, there is no reason to give insurers this money. Doing so for 2018 will result in double payments to these companies and unnecessary costs to the federal government.

2. **Congress should make it easier for states to obtain waivers from certain Obamacare regulatory requirements.** The ACA's regulatory regime has damaged the individual and small-group markets. Families and businesses that used to be able to afford policies no longer can. The federal government broke these insurance markets; it should give states flexibility to repair at least some of the damage. Congress should pursue provisions such as those in the Alexander–Murray and Collins–Nelson bills that encourage state innovation by making the federal waiver process at least marginally more workable and rational.

3. **Congress should repeal Obamacare and give consumers more health coverage choices.** Obamacare's system of taxes, burdensome regulation, mandates, and government spending have increased costs for consumers while restricting their choices. Obamacare insurance regulations require insurers to offer consumers an unattractive product at an unattractive price. Congress should recognize the effect of these regulations on the affordability of individual policies, particularly among families that do not qualify for subsidies. Lawmakers also should explore ways to give states more regulatory control over these markets, waiving federal rules that prevent insurers from offering products that people are willing to buy at a price that they are willing to pay. While both Alexander–Murray and Collins–Nelson take steps in this direction, Congress should do much more to ensure that consumers have a broad choice of affordable health insurance coverage.

Conclusion

Calls to fund CSRs and other payments to insurers in 2018 are rooted partly in a fundamental misunderstanding of why Obamacare premiums continue to rise. Although premium increases are to some degree attributable to the Administration's cancellation of CSR payments, premium increases were considerable even for policies unaffected by the Administration's decision.

Lavishing billions of federal dollars on the insurance industry in 2018 is misguided policy. Insurers have secured another round of rate hikes and, with them, billions more in federal premium subsidies. Nor are federal dollars necessary for a state to operate a successful risk-mitigation program, as Alaska has shown.

Trying to rush CSR and reinsurance payments out the door in 2018 will result in wasteful and unnecessary spending, and is more likely to create confusion than to produce the predictability lawmakers seek.

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Endnotes

1 "Payments to Issuers for Cost-Sharing Reductions," memo from Acting HHS Secretary to Administrator of the Centers for Medicare and Medicaid Services, October 12, 2017, https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf (accessed December 15, 2017).

2 26 U.S. Code 36B.

3 42 U.S. Code 18071(a)(2).

4 42 U.S. Code 18071(c)(3)(A).

5 *House v. Burwell*, United States District Court for the District of Columbia, Civil Action 14-1967, May 12, 2016, http://www.scotusblog.com/wp-content/uploads/2016/05/HofR-challenge-to-ACA-DCt-5-12-16.pdf (accessed December 15, 2017).

6 News release, "Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments," U.S. Department of Health and Human Services, vOctober 12, 2017, https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html (accessed December 15, 2017).

7 National Association of Insurance Commissioners, "Final Rate Submissions for 2018: Dealing with CSR Uncertainty," October 24, 2017. This document presents the NAIC's summary of state laws as of the date of publication. Although it was prepared just eight days before the open-enrollment period, it is possible that states that had not provided for rate increases as of that date may subsequently have changed course.

8 All ACA-compliant plans must meet numerous regulatory requirements, including coverage of "essential health benefits." They differ by actuarial value (AV), a measure of a plan's generosity. A Silver plan, for example, must have an AV of 70 percent. That means that, for the "standard population," the policy will pay claims that total 70 percent of covered, in-network services. The higher the AV, the richer the coverage. A Bronze plan has an AV of 60 percent, while a Platinum plan's AV is 90 percent.

9 News release, "Alexander: Bipartisan Bill Will Help Stabilize Individual Health Insurance Market, Then Lower Premiums," Office of Senator Lamar Alexander, October 17, 2017, https://www.alexander.senate.gov/public/index.cfm/pressreleases?ID=E46ED49D-672B-4224-BE6A-6970F149F42F (accessed December 15, 2017).

10 National Association of Insurance Commissioners, "Final Rate Submissions for 2018: Dealing with CSR Uncertainty."

11 These files can be accessed at Centers for Medicare and Medicaid Services, "The Center for Consumer Information & Insurance Oversight: Health Insurance Exchange Public Use Files (Exchange PUFs)," https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html (accessed December 15, 2017).

12 For the decline in the individual and fully insured group market see, Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation *Issue Brief* No. 4743, July 26, 2017, http://www.heritage.org/health-care-reform/report/2016-health-insurance-enrollment-private-coverage-declined-medicaid. That trend appears to have accelerated in the individual market through the first quarter of 2017. Mark Farrah Associates, "A Brief Look at the Turbulent Individual Health Insurance Market," July 19, 2017, http://www.markfarrah.com/healthcare-business-strategy-print/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx (accessed December 15, 2017).

13 The high cost of ACA products has repelled many of those who are in reasonably good health. As premiums have trended higher, higher numbers of healthy people have fled the market, leading insurers to charge higher premiums to those who remain. The result is a pool that disproportionately consists of people who are more expensive to insure. American Academy of Actuaries, Individual and Small Group Markets Committee, "An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes," January 2017, https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf (accessed December 15, 2017). The report cited other reasons for high premiums, including an unstable regulatory environment, and underlying medical trend.

14 Dylan Scott, "There Are No More Counties Without Any Obamacare Plans," Vox, August 24, 2017, https://www.vox.com/health-care/2017/8/24/16199620/voxcare-no-counties-without-obamacare (accessed December 15, 2017).

15 McKinsey & Company, "Insights into the 2018 Individual Exchange Market," November 30, 2017, http://healthcare.mckinsey.com/2018-exchange-insights (accessed December 15, 2017).

16 As of December 14, the Alexander–Murray bill had not been formally introduced, but the text of the measure was posted at help.senate.gov, https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20TEXT.pdf (accessed December 15, 2017).

17 S. 1835.

18 Congressional Budget Office, "Bipartisan Health Care Stabilization Act of 2017," October 25, 2017, p. 5, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/bipartisanhealthcarestabilizationactof2017_0.pdf (accessed December 15, 2017).

19 These plans would have an actuarial value (AV) of 50 percent.

20 Reinsurance and "invisible high-risk pools" are relatively similar arrangements. There are several ways in which these arrangements can operate. One method is for the issuer to pass along the costs of claims above a certain level or within a certain corridor. For example, a reinsurer might pay 90 percent of the costs of medical claims between $50,000 and $250,000.