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| To: | David Buono |
| From: | David Anderson MSPPM, Dr. Coleman Drake, Ph.D |
| Date: | December 1, 2019 |
| Re: | Comments on Pennsylvania 1332 Reinsurance Application |

This is a public comment for Pennsylvania’s proposed reinsurance waiver through the Affordable Care Act’s Section 1332. Mr. Anderson is a research associate at the Duke University Margolis Center for Health Policy. Dr. Drake is an assistant professor of Health Policy and Management at the University of Pittsburgh, Graduate School of Public Health. We have written extensively about the Affordable Care Act’s individual market with publications in leading peer-reviewed journals such as *JAMA Internal Medicine, Health Affairs, Health Services Research, The Journal of Rural Health*,and *Journal of Health Economics*. We also have written about the Affordable Care Act other publications, such as *The New York Times*, *Health Affairs Blog*, *Stat*, and *Morning Consult*.

We have two concerns with the proposed waiver that the Commonwealth of Pennsylvania has drafted. First, we believe that the Commonwealth should consider a state-specific risk-adjustment system once the waiver has been adopted. Not doing so will cause some insurers to effectively be paid twice for the risk they assume for some of their enrollees. Secondly, the projection that this reinsurance waiver will have no effect on the enrollment levels of the subsidized Marketplace population is wrong because reinsurance will alter net premiums.

Risk adjustment is designed to lead insurers to be risk agnostic. The current risk adjustment system used by the Center for Medicare and Medicaid Services is similar in some aspects to the CDPS risk adjustment system used by the Pennsylvania Department of Health and Human Services for Medical Assistance. In both cases, risk scores are associated with demographic and clinical diagnosis codes of covered individuals. The risk scores are summed and then averaged for each insurer before being normalized across the risk pool’s average risk. Funds are then transferred from insurers that assume below-average risk to insurers that assume above-average risk.

Pennsylvania is proposing a “caliper” approach to reinsurance with an attachment point below which claims are not eligible for reinsurance, as well as a reinsurance cap, above which claims are not eligible for further reinsurance. Pennsylvania will pay a proportion of the claims cost that lie between the attachment point and the reinsurance cap. A significant proportion of the individuals whose claims costs will quality their insurers for reinsurance payments will also have higher than average risk scores.

Three different insurers could have the same average risk score under the current risk adjustment system administered by CMS. The first insurer could cover a population with many low-cost chronic conditions, none of which will ever qualify an individual for reinsurance. The second insurer could cover enrollees that are mostly healthy with no chronic conditions and a modest number of enrollees with conditions that score moderately highly for risk adjustment. The latter group will all qualify for at least some reinsurance, and all of their conditions will not reach the reinsurance cap. The final insurer could cover a population that is overwhelmingly healthy but has a miniscule number of enrollees with extremely expensive conditions, such as history of core organ transplants or hemophilia. A significant proportion of these claims will be above the reinsurance cap.

These three insurers all have the same average risk score. However the three insurers will have very different net of risk adjustment and net of reinsurance claims expenses. The first insurer with many beneficiaries with modest risk scores will bear the entire cost of care with no reinsurance assistance. The second insurer with enrollees who have moderate claim expenses will receive some reinsurance funds. The third insurer which has a small number of enrollees with very high expenses will maximize their reinsurance receipts for a given risk score. The insurers are no longer agnostic to the health status of their enrollees. If the Commonwealth uses the federal risk adjustment system, insurers will have an incentive to attempt to market their plans to certain populations while minimizing plan attractiveness to other populations.

The Commonwealth should consider a new risk adjustment system that carves out reinsurance payments so that the risk adjustment system, in conjunction with reinsurance, transfers sufficient funds to pay for care to make insurers risk agnostic instead of risk aware. Risk-aware insurers either become risk seekers or risk avoiders, which is not a behavior the Commonwealth should encourage in the ACA-regulated markets.

Our second concern is that we believe the estimate of no enrollment loss among the subsidized population of the initial actuarial analysis is incorrect. The report states:

*Table 4… demonstrates how enrollment in Pennsylvania’s individual market would be expected to change assuming a reinsurance program resulting in a total average reduction to premium rates equal to between 4.9% and 7.5% (i.e., relative to the premium rates that would otherwise be charged under the baseline) were to be implemented starting in 2021. As shown, the impact of the reinsurance program on the volume of enrollees receiving APTCs in 2021 is expected to be minimal as the net premium rates paid by those enrollees (i.e., net of APTCs) are, on average, mostly insulated from changes in gross premium rates.*

Subsidized buyers are fundamentally insulated from changes to gross premiums *only for the silver benchmark plan*. Lower gross premium levels where the reduction is a uniform percentage tends to reduce the difference between the benchmark premium and plans priced below the benchmark plan1. These differences are known as *premium spreads*. Smaller premium spreads increase net premiums for individuals who purchase plans priced below the benchmark. This will lower enrollment.[[1]](#footnote-1),5 Furthermore, the smaller premium spread will decrease the availability of plans priced at zero dollars net of subsidy. Our forthcoming research in *Health Affairs* shows that zero-dollar net-of-subsidy premiums being available is associated with double-digit increases in enrollment for lower-income enrollees.[[2]](#footnote-2)

Pennsylvania can learn from Colorado’s experience with reinsurance and its proposed public option. Colorado has adopted a reinsurance proposal that will produce a larger savings in gross premium percentage than the Pennsylvania proposal. However, the change in premium spreads affected by the public option will increase net premiums for many subsidized buyers even if they actively shop.[[3]](#footnote-3)

Furthermore, Colorado, in an attempt to lower gross premiums, will be instituting a multi-carrier public option that will lower premiums and decrease the premium spread of the least expensive plan relative to the benchmark plan. An analysis by Mr. Anderson and Mr. Billy Wynne of Wynne Health Group found that the net premium of the least expensive plan would increase if the gross premium of the benchmark plan dropped[[4]](#footnote-4)

*Our analysis suggests that introduction of a single public option plan in each rating area of Colorado would reduce the contribution a sample subsidized consumer would need to make to the premium of the lowest-cost plan in each metallic tier by 40.0 percent to 73.4 percent. Introduction of multiple public option plans in each rating area would, by contrast, decrease net premium contributions by 6.5 percent for the lowest-cost gold plan while increasing the contribution required for bronze and silver plans by 15.7 and 0.7 percent, respectively*.

Plans that are priced below the benchmark plan’s premium become less affordable for subsidized buyers when there is a uniform percentage decrease in premium levels. This is particularly concerning because individuals on the margin of enrolling in the Marketplaces are concerned about the net premiums of the lowest cost plans—that is, those below the benchmark plan’s premium2. Any policy change that increases the net premiums of the lowest cost plans is therefore likely to reduce overall Marketplace enrollment, particularly among lower-income populations that are most sensitive to premium changes and healthier individuals that have lower demand for health insurance.[[5]](#footnote-5) A decrease in enrollment among healthier individuals is especially concerning given the implications for the overall individual market risk pool of lower-risk enrollees leaving the market.

We urge the Commonwealth to conduct a more thorough actuarial analysis that considers the distribution of plan enrollment among subsidized buyers. We anticipate that tens of thousands of enrollees will face higher net premiums in a “with waiver” world, and that some of these enrollees will elect to go uninsured in response to higher net premiums.

1. Drake C, Abraham JM. Individual market health plan affordability after cost-sharing reduction subsidy cuts. Health Services Research [Internet]. 2019 [cited 2019 Nov 18];54(4):730–8. Available from: <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13190> [↑](#footnote-ref-1)
2. Drake C. Anderson D. Terminating The Cost-Sharing Reduction Subsidy: The Impact On Marketplace Zero-Dollar Premium Plans And Enrollment. Health Affairs 2020 Forthcoming [ cited 2019 Nov 18] [↑](#footnote-ref-2)
3. Colorado’s reinsurance program has been lauded as a way to reduce health care costs. Here’s the fine print. – The Colorado Sun [Internet]. [cited 2019 Nov 18]. Available from: <https://coloradosun.com/2019/11/01/colorado-reinsurance-health-premium-increases/> [↑](#footnote-ref-3)
4. A Single Public Plan Option Versus a Multiplan Approach: A Colorado Case Study | Health Affairs [Internet]. [cited 2019 Nov 18]. Available from: <https://www.healthaffairs.org/do/10.1377/hblog20190828.810494/full/> [↑](#footnote-ref-4)
5. Tebaldi, Pietro, Estimating Equilibrium in Health Insurance Exchanges: Price Competition and Subsidy Design under the ACA (August 11, 2017). Becker Friedman Institute for Research in Economics Working Paper No. 2017-05. Available at SSRN: <https://ssrn.com/abstract=3020103> or [http://dx.doi.org/10.2139/ssrn.3020103](https://dx.doi.org/10.2139/ssrn.3020103) [↑](#footnote-ref-5)