

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ASSOCIATION FOR COMMUNITY
AFFILIATED PLANS, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF
TREASURY, et al.,

Defendants.

Civil Action No. 18-cv-2133

DECLARATION OF MARGARET A. MURRAY

I, Margaret A. Murray, hereby declare as follows:

1. I have personal knowledge of the following facts, and if called as a witness I could and would testify competently as to their truth.

2. I am the Chief Executive Officer of The Association for Community Affiliated Plans (ACAP). In that capacity, I am familiar with the full scope of ACAP's operations. I have led ACAP since its inception in 2001.

3. ACAP is a national trade association of 62 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals, including over 700,000 Marketplace enrollees in ACA-compliant Qualified Health Plans. Sixteen of ACAP's SNHP members offer Qualified Health Plans or a Basic Health Plan option on the Marketplaces in 2018.

4. ACAP's mission is to strengthen not-for-profit Safety Net Health Plans in their work to improve the health of lower-income and vulnerable populations. ACAP's vision is to

improve the health and well-being of lower-income and vulnerable populations and the communities in which they live.

5. ACAP submitted comments to the government in response to the proposed STLDI Rule. Attached as Exhibit A is a true and correct copy of ACAP's comments. As part of the comment process, ACAP engaged an actuarial firm, Wakely Consulting Group (Wakely), to analyze the impact of the proposed STLDI Rule. Attached as Exhibit B is a true and correct copy of the report prepared by Wakely, which was also submitted as an attachment to ACAP's comments.

6. The Wakely report states that "the difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools and risk segmentation. . . . 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."

7. Wakely's analysis estimates that in the near term (four to five years) the STLDI Rule will result in 1,070,000 to 1,948,000 individuals leaving ACA-compliant individual enrollment plans, leading to a 2.2% to 6.6% increase in average premiums in those ACA-compliant plans.

8. ACAP members are particularly at risk of having their customers attracted away by lower-cost STLDI plans that are not required to comply with ACA regulations, since ACAP members by definition primarily serve low-income communities, where individuals are uniquely sensitive to price and may be less sophisticated about the exact details of various health insurance

products. With the increased morbidity of ACAP members' risk pools, resulting increases in premiums, and low-income customers therefore being priced out of the market, ACAP members would face a downward spiral and even the risk of bankruptcy.

9. An important facet of this problem for ACAP members is consumer confusion. Because health literacy is low throughout America—and particularly in the lower-income communities served by ACAP members—it will be difficult for ACAP members to explain to consumers why they should purchase ACA compliant plans when STLDI plans carry a lower sticker price; that is, that the real costs of STLDI plans take effect only when a patient gets sick or has an accident and needs care. The STLDI Rule's requirement that STLDI contracts and applications contain a disclaimer that “[t]his coverage is not required to comply with certain federal market requirements for health insurance” is insufficient to put customers on notice of this distinction. The resulting customer confusion will result in a loss of business for ACAP members, as consumers are drawn in by lower up-front premiums of ACA-noncompliant STLDI plans.

10. The timing of the STLDI rule also harms ACAP members. The deadline for ACAP members to submit their applications to have plans included in the Marketplaces for 2019 was June 20, 2018. But the STLDI Final Rule was not promulgated until August 3, 2018, after ACAP members' 2019 plans were required to be finalized. ACAP members invested substantially in putting together the details of those plans, without the knowledge that formerly illegal STLDI plans would be available during the November-December 2018 open enrollment period. The effective date of the STLDI Rule—October 2, 2018—therefore upsets the settled expectations of ACAP members and harms them by putting them at a competitive disadvantage in an open enrollment season that is only weeks away.

11. I have read the declaration of Kenneth Janda, President and CEO of Community Health Choice, Inc. (Community) in this case. Community is one of ACAP's 62 member organizations. Fifteen of ACAP's other member organizations are similarly situated to Community in that they provide Marketplace coverage to low-income individuals, many of whom lack sophisticated knowledge of health insurance products and are therefore vulnerable to being lured away from Marketplace plans by STLDI products, if the STLDI Rule goes into effect. These ACAP members will therefore face similar harms to those attested to by Mr. Janda.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on September 28, 2018, at 3:58pm.

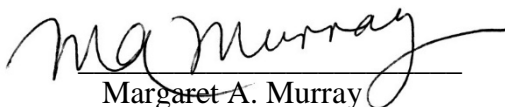

Margaret A. Murray

Exhibit A



ACAP
Association for Community
Affiliated Plans

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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

April 20, 2018

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury

Preston Rutledge, Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Randy Pate, Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically via: www.regulations.gov

RE: CMS-9924-P

Dear Acting Commissioner Kautter, Assistant Secretary Rutledge, and Deputy Administrator and Director Pate:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments regarding the proposed rule on *Short-Term, Limited-Duration Insurance*.

ACAP is an association of 61 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals, including over 700,000 Marketplace enrollees. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. Sixteen of ACAP's Safety Net Health Plan members offer qualified health plans (QHPs) or a Basic Health Plan option in the Marketplaces in 2018.

Summary of ACAP's Comments

ACAP has chosen to respond to the impact the proposed Short-Term, Limited-Duration Insurance rule that are particularly relevant to both Safety Net Health Plans (SNHPs) and the consumers they serve. Specifically, our comments are focused so as to ensure business stability



for SNHPs and to not place undue burden or harm on consumers, in particular the low-income and vulnerable populations that are traditionally served by SNHPs.

ACAP would also like to emphasize that the comments herein support SNHPs in their efforts to serve their communities, which they are generally well-acquainted to by way of their experience serving Medicaid enrollees. We believe there is a careful balance that must be struck in order to support issuers in the Marketplace while at the same time not instituting policies that would have a deleterious impact on consumers.

ACAP previously commented in support of the previous Administration's proposed rule to limit short-term, limited duration insurance (STLDI) to three months or less. Our comments on this proposed regulation are in the same vein, as we believe STLDI coverage should be used as it was originally intended—to fill short-term, temporary gaps in coverage—and not as an alternative to meaningful individual health insurance coverage. ACAP encourages the Administration not to finalize this rule and has a number of specific comments addressed herein. In particular, we wish to draw attention to the following recommendations from our comments:

- **Duration:** ACAP objects to the Departments' proposal to permit STLDI coverage for up to 364 days and urges the Departments to ensure that short-term coverage is truly short-term. ACAP urges the Departments to establish that the policy term for any STLDI plan must end by December 31 of that calendar year.
- **Renewability:** ACAP objects to the Departments' proposal to change the language surrounding extensions "with or without the issuer's consent" to simply "without the issuer's consent." Specifically, ACAP objects to any renewals of STLDI coverage, much less a streamlined renewal process.
- **Impact:** ACAP rejects the Departments' estimates of the impact of the proposed rule and instead wishes to submit for the record a full actuarial analysis produced by the Wakely Consulting Group, which is included as Appendix A herein.
- **Disclosure Statement:** ACAP appreciates the Departments' proposal to require a continued disclosure statement on all contract and application materials. We urge the Departments to also require a disclosure statement on marketing materials and to change the wording of the proposed disclosure statement to make it clear that STLDI coverage does not comply with the federally-mandated ACA requirements.
- **Effective Date:** ACAP urges the Departments not to institute an effective date for the proposal prior to January 1, 2020.



Expanded Comments

As the Administration notes in its proposed regulation, STLDI coverage “is not individual health insurance coverage.” We believe that for this reason, among others, STLDI coverage should not be marketed as an alternative to ACA-compliant coverage, as it simply is not a meaningful alternative. Additionally, the proposed regulation, especially when combined with recent other regulations recently finalized by this Administration, will have a deleterious impact on the individual market single risk pool – thus impacting the business stability for SNHPs offering individual market products.

First and foremost, STLDI plans do not represent meaningful coverage as they may rate based on age, gender, and health status, and deny selected benefits to individuals based on their health status or cost. Such plans also tend to have extraordinarily high deductibles (often well above the ACA-compliant maximum), no annual or lifetime limits for consumers; further, they are not required to follow medical loss ratio (MLR) requirements, and regularly engage in rescissions. The confluence of these factors means that they are focused primarily on profits rather than providing needed care to enrollees. Such skimpy benefit packages will undoubtedly lead to an increase in uncompensated care to boot. STLDI plans offered in recent years have had a medical loss ratio below 50% and/or deductibles of \$20,000 for each three months of coverage. Historically, issuers offering such coverage have been notoriously unscrupulous—often rescinding coverage as soon as individuals file substantial claims. This issue continues to remain pervasive, as evidenced earlier this month by a recent \$5 million, multi-state settlement by one such STLDI issuer in response to its business practices.¹

For these reasons, we object to expanding access to STLDI coverage in its entirety. We respond to the specific issues raised in the regulation, with expanded detail, below.

COVERAGE DURATION

The Departments request feedback on the appropriate length of short-term, limited duration insurance. While the Departments have proposed up to 364 days, we believe that is, by definition, not “short-term.” We supported previous efforts to limit such coverage to 3 months or less and would argue that is a reasonable timeframe for such coverage—and certainly no longer than 6 months.

Additionally, while there is an argument to be made regarding the need for STLDI coverage as an option for consumers outside the annual open enrollment period or who do not have access to

¹ <http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/upload/nr036HCCLifeSettlement.pdf>



ACA-compliant coverage through a special enrollment period, such options should not go beyond the end of the calendar year so that consumers will have the full set of coverage options that are available during open enrollment. For this reason, we encourage the Departments to require, as part of the final rule, that regardless of duration, any such STLDI coverage must end by December 31st of a given year, in order to better align consumers with the individual market open enrollment period so that they have a full plethora of coverage options to choose from.

ACAP objects to the Departments' proposal to permit STLDI coverage for up to 364 days and urges the Departments to ensure that short-term coverage is truly short-term. Additionally, regardless of when such a policy is effectuated, ACAP urges the Departments to establish that the policy term for any STLDI plan must end by December 31 of that calendar year. STLDI coverage is meant to fill temporary gaps in coverage and as such should not be viewed as an alternative to comprehensive, meaningful health insurance coverage.

RENEWABILITY

The Departments also request comment on under what conditions issuers should be permitted to continue STLDI coverage for consumers for 12 months or longer. Again, by definition, we argue that issuers should not be permitted to renew STLDI coverage, as it immediately ceases to be of “limited duration.”

The proposed regulation’s considerations surrounding renewability are twofold. The proposed language would effectively permit extensions of coverage of 12 months and beyond *with* the issuer’s consent. It seeks information on the conditions under which issuers should be permitted to allow coverage for 12 months or longer and whether there should be an expedited or streamlined reapplication process. We urge the Departments to reject both of these options. By permitting coverage to be extended based on the issuer’s consent, the impact on the individual market risk pool will be even more striking, as issuers will choose to permit renewals for only the healthiest, least-risky, or least-expensive consumers. There is already a level of self-selection by young or healthy consumers enrolling in STLDI coverage, which the Departments recognize in the preamble, and permitting further extension of such coverage options will only serve to increase the adverse selection impact on the individual market. Additionally, as soon as there is a reapplication process for extended coverage beyond a year, STLDI plans will become QHP alternatives—again moving beyond their defined purpose of serving consumers needing to fill temporary gaps in coverage. Put simply, there should not be a reapplication process for STLDI coverage, much less a streamlined process.

ACAP objects to the Departments' proposal to change the language surrounding “extensions that may be elected by the policyholder with or without the issuer’s consent” to simply “without



the issuer's consent.” Specifically, ACAP objects to any renewals of STLDI coverage, much less a streamlined renewal process.

IMPACT

In response to the Departments' request for feedback on their take-up and premium estimates, ACAP asked an actuarial firm to model the impact of the proposed regulation. Please see Appendix A for the full report, produced by the Wakely Consulting Group.

Wakely states that “the difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools and risk segmentation....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.”

Wakely provide three alternate estimates of the impact of the proposed regulation on the ACA-compliant market, all of which are at least four times higher than the Departments' stated estimate of 100,000—200,000 enrollees who will drop ACA-compliant coverage. First, Wakely notes that the Departments' estimate does not include plans purchased “off-Exchange.” When the Departments' own estimates are applied to the off-Exchange market, Wakely found that the entire ACA-compliant individual market would actually decrease between 400,000—790,000 enrollees, resulting in a premium increase of 0.7 to 1.4% in 2019 alone.

Wakely then proceeds to use the experience of “transitional” plans to guide an estimate of the likelihood consumers will take up an ACA-compliant coverage alternative. Wakely notes that STLDI plans are not even as generous as transitional plans and so reduces the number of people enrolled by half to create a proxy for the potential STLDI market. In this case, Wakely estimates that 826,000 consumers are expected to leave the ACA-compliant market to purchase STLDI coverage.

And finally, Wakely estimates a longer-term impact, over the next 4 to 5 years, once issuers have had a chance to fully re-build underwriting capabilities and roll out STLDI products. Wakely used claims and metal level data to estimate which consumers are most likely to drop ACA-compliant coverage for STLDI. Their analysis found that 1.07 to 1.95 million enrollees are likely to switch coverage, which would also result in a 2.2 to 6.6 percent increase in premiums in the ACA-compliant market.



It is also worth noting that all of the estimates discussed above are *after* the impact of the zeroing of the individual mandate penalty is factored in. Yet we know that many of the consumers most likely to drop coverage after elimination of the mandate penalty are in fact the same consumers who are most likely to take up STLDI coverage as an “alternative” policy. Wakely also provides an estimate looking at the combined impact of the mandate penalty repeal and the STLDI proposal to show the overarching impact of those moving to STLDI coverage. Ultimately, Wakely found that with the combined impact of the repeal of the mandate and the STLDI proposal, when looking at all three scenarios modeled, 20.9 to 26.3 percent of the total individual market are likely to switch to STLDI coverage—resulting in total ACA-compliant market premium increases of 10.8 to 12.8 percent.

ACAP rejects the Departments’ estimates of the impact of the proposed rule and instead wishes to submit for the record a full actuarial analysis produced by the Wakely Consulting Group, which is included as Appendix A herein.

DISCLOSURE

The Departments also solicit feedback on proposed changes to the disclosure statement required in all contract and application materials. We urge the Departments, first and foremost, to also require a disclosure statement to be included in marketing materials, so that consumers are aware that such plans are not ACA-compliant. Put simply, consumers deserve to know whether or not their health coverage is comprehensive and meaningful.

Unfortunately, we know that health literacy is low throughout America, and as such, it is important to ensure that consumers are easily able to determine what they are purchasing. We appreciate the Departments’ recognition of this and their plan to continue a disclosure statement in contract and application materials. We believe a similar, shortened disclosure statement should be extended to marketing materials. Furthermore, we urge the Departments to make clear in the disclosure statement not just that STLDI coverage “is not required to comply” with the ACA requirements, but that it “does not comply.” We believe a greater due-diligence is due to consumers than to simply tell them to read and understand their policy, especially as full policy documents for these plans may not accessible to consumers until after they have enrolled in said plan.

ACAP appreciates the Departments’ proposal to require a continued disclosure statement on all contract and application materials. We urge the Departments to also require a disclosure statement on marketing materials and to change the wording of the proposed disclosure statement to make it clear that STLDI coverage does not comply with the federally-mandated ACA requirements.



EFFECTIVE DATE

Finally, ACAP wishes to respond to the proposed effective date. For multiple reasons, we object to the Departments' proposal to permit the sale of STLDI coverage within 60 days of finalizing the rule. First, given the destabilizing effect STLDI coverage will have on the ACA-compliant market, we believe it would be detrimental to QHP issuers whose rates will have long-since been set for that policy year—and will not have factored in the impact of the rule.

Additionally, as the Departments recognize, states also have the authority to regulate STLDI. However, given the infrequency with which some state legislatures meet, we believe it is important to give states adequate time to respond to the changes and that the proposal should not go into effect prior to 2020.

ACAP urges the Departments not to institute an effective date for the proposal prior to January 1, 2020.

Conclusion

The proposed regulation is certain to introduce a new level of instability to the individual market due to adverse selection, increased enrollee churn, and rising premium costs. According to research by Wakely, we also know that it is unsubsidized enrollees in need of comprehensive coverage who will be most harmed—not helped—by this proposal. While this proposal is ostensibly about improving access to coverage choices, for the unsubsidized consumers most in need of access to affordable coverage, this proposal will only serve to put comprehensive coverage out of reach. We urge the Departments not to finalize the proposed regulation.

ACAP thanks the IRS, EBSA, and CMS for their willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfoster@communityplans.net).

Sincerely,

/s/

Margaret A. Murray
Chief Executive Office

Exhibit B



Association for Community Affiliated Plans

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

Prepared by:
Wakely Consulting Group

Michael Cohen, PhD
Consultant, Policy Analytics

Michelle Anderson, ASA, MAAA
Consulting Actuary

Ross Winkelman, FSA, MAA
Principal



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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 departments², a comparison to ACA transitional enrollment³, 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

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 grandmothers 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%.



³The 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.

⁴See 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 benefits⁵ (e.g., prescription drug

⁴ <https://www.irs.gov/pub/newsroom/commissionerletteracafigingseason.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 Ratio⁹ (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

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 pools¹² 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

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

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

²⁰ <https://www.healthaffairs.org/doi/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 2015²⁷ 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.

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-

³³https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_ce_a_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

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

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.

⁴⁰The 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.

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).