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# Silver State Health Insurance Exchange

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## AGENDA ITEM

☐ **For Possible Action**

☒ **Information Only**

**Date:** April 13, 2017

**Item Number:** VI

**Title:** Affordable Care Act status report

## PURPOSE

The purpose of this report is to provide information to the Board and public regarding the status of the Exchange's implementation of a state based health insurance exchange and other operational matters of the Exchange.

## CONTENTS

PURPOSE ........ 1
CONTENTS ........ 1
GENERAL COMMENTS ........ 1

## GENERAL COMMENTS

The past two months have been some of the Affordable Care Act's (ACA) most contentious months in its seven year history. The Republican leadership in the House of Representatives introduced a bill titled the American Health Care Act (AHCA) on March 6, 2017, which would have effectively repealed the ACA. The AHCA has thus far failed to gather necessary votes to pass, however the bill continues to evolve and could have long and short term impacts on the Silver State Health Insurance Exchange (Exchange), Medicaid, and the individual market in general.

Several items in the AHCA would impact the Exchange and consumers, specifically the continuous coverage "incentive" and the elimination of the "individual shared responsibility payment"; the elimination of Cost Sharing Reductions (CSRs); and changes to the structure of tax credits could have dramatic implications for the 89,061 Nevadans who access Qualified Health Plans (QHPs) through the Exchange. Any combination of these changes, if adopted, would have a significant impact on accessibility and costs for Nevada's consumers.

The AHCA proposes a continuous coverage "incentive" in place of the ACA individual coverage requirement. Through various enrollment options in 2018 and 2019, Nevadans would face a 30% surcharge on premiums if they have not had continuous coverage over the prior 12 months (with no breaks of 63 or more continuous days) under the AHCA proposal. These surcharges would be collected directly by insurance carriers.

Nevada consumers who maintain continuous coverage will maintain the ability to purchase a QHP regardless of pre-existing conditions. Consumers who fail to obtain and/or maintain coverage would not be guaranteed access to coverage at rates that do not reflect their health status. Following the initial enrollment period, and depending on state policy, insurance carriers would be able to deny coverage, include specific health-related exclusions or waiting periods, and/or charge higher premiums to Nevadans who had failed to purchase and maintain coverage.

Research conducted by the RAND Corporation indicates that consumers who lack literacy in the basic concepts of personal finance and health insurance were more likely to remain uninsured after the rollout of the ACA. If educational and informational barriers to buying insurance are a significant deterrent for healthy young adults, then a continuous coverage requirement as proposed in this legislation could fail to attract the healthiest consumers, which is the proposal's stated purpose. Without a healthy risk mix, carriers on the Exchange will likely increase premiums, which will be felt by all Exchange consumers.

Provisions in the AHCA related to the elimination of CSRs would have been effective December 31, 2019. This provision, which offers sliding-scale discounts that lower the amount consumers pay for deductibles, copayments, and coinsurance, will impact both Nevada's consumers and the Insurance carriers who sell QHPs on the Exchange. Under the ACA, insurance carriers participating on the Exchange must provide CSRs to eligible enrollees and the federal government reimburses them for these costs. If these payments cease, insurance companies will face millions of dollars in liability, and could be faced with the decision to either increase consumer premiums or exit the Exchange market all together.

In 2016 Nevada consumers received an estimated $35,600,000 in CSR assistance, which assisted in the coverage of an estimated 51,125 Nevadans. Many of these consumers have serious chronic illnesses requiring costly services and prescription drugs. If the CSRs are eliminated, these consumers will see higher premium costs and deductibles, which will likely put access to affordable health insurance out of their reach financially. Those with the lowest incomes will likely be affected the most by the repeal of this assistance. American Indian/Alaska Natives will also be impacted as they can access Exchange coverage with no cost sharing under the ACA.

The AHCA proposes to replace Advanced Premium Tax Credits (APTC) with new tax credits effective 2020. The APTC under the ACA takes into account a family's income, local costs of insurance, and age, while the AHCA proposes tax credits based only on age, with a phase out for individuals with annual incomes above $75,000. For Nevadans not eligible for subsidized group coverage or public coverage, the proposed AHCA tax credits could be used to purchase insurance on the individual market or unsubsidized Consolidated Omnibus Budget Reconciliation Act (COBRA). The following outlines the tax credits afforded through the AHCA:

- The new tax credits would be flat amount per year based on age (and not coverage costs or income):
  - Under 30: $2,000
  - Between 30 and 40 years old: $2,500
  - Between 40 and 50 years old: $3,000

  - Between 50 and 60 years old: $3,500
  - Over 60 years old: $4,000

- The new tax credits would be given in advance of QHP purchases and refundable to consumers with the system for advance payments to be established by the U.S. Department of Health and Human Services, integrating as much as possible off the current system. This leaves questions about the future and function of state based marketplaces.
- To the extent the credits exceed the cost of premiums, individuals would only receive that excess if they requested it to be deposited in a Health Savings Account (HSAs).
- The tax credits could not be used to purchase transitional (grandfathered or grandmothered) coverage or plans that include abortion coverage, other than to save the life of the mother or in cases of rape or incest.

Under the ACA, insurance companies are only allowed to charge an older person three times what they would charge a younger person. The AHCA proposes the limit of three times would move to five times, effectively allowing Nevada insurance companies to charge older people 66 percent more than they would be charged under the ACA. The intent of this change is to allow an insurance company to charge younger Nevadans less, which would in theory, encourage younger and healthier people into the risk mix and bring down the costs of health care. The Congressional Budget Office's analysis indicates that the proposed age-rating change will broadly cost young people less to enroll however, it would do so at a higher cost for the older population.

The Exchange estimates that Nevada consumers received $265,500,000 in APTC in plan year 2016. Proposed tax credits under the AHCA are estimated to cost the average 40 year old Nevadan making an annual income of $30,000 an additional $461/year, while a 60 year old making an annual income of $30,000 would pay an additional $6,145/year.

Proposed AHCA tax credits will increase out-of-pocket costs for Nevada's low-income working families and older consumers. In plan year 2016, the Exchange's consumers between the ages of 55 and 64 made up 26 percent of total enrollees. Increased premium burdens from the changes to the tax structure and the age-rating will ensure that fewer low-income and older Nevadans have access to affordable health insurance. Impacts to Nevada's communities as a result of this shift in coverage will likely increase uncompensated care for hospitals.

When Republican House leadership took the AHCA to the floor on March 24, 2017 they were forced to pull the bill before a vote because they did not have the required votes necessary to pass the bill. It was largely thought that the bill was dead after this failed vote, with Paul Ryan saying, "Obamacare is the law of the land for the foreseeable future." However, less than a week later the ACHA had a resurgence with the White House leadership and Congressman Paul Ryan leading discussions with Republican House leadership. The same difficulties that prevented consensus in late March are still very much at play, causing divisions that make it difficult to see how enough votes will be found to support the bill.

The Exchange continues to monitor federal discussions and proposed legislation related to healthcare reform and the potentials impacts to our operations and consumers. Of utmost concern is stability in the marketplace for plan year 2018 and beyond. There are several ways in which the structure of plan year 2018 could be stabilized including funding cost sharing reductions and enforcement of the individual mandate.

Cost sharing reductions are required benefits to be offered by health plans; failing to provide direct, ongoing federal funding would actually increase federal costs by hundreds of millions of dollars and result in dramatically higher premiums for consumers, particularly those who do not receive any financial assistance. The participation of insurance carriers on the Exchange is fragile and will largely be determined by the stability that the current administration offers. The American Health Insurance Plans national industry group has encouraged funding of the CSRs due to the financial burdens that not funding them would place on the carriers and consumers. If the CSRs are not funded the Exchange's carriers may choose not to participate, this could potentially disrupt access to most of Nevada's rural areas where there is currently only one carrier offering QHPs.

The individual mandate is a requirement under the ACA and helps to ensure a healthy pool of consumers which helps to lower premiums for all of the Exchange's consumers. For 2017, insurance carriers set their rates based on their best analysis of the risk pool, which assumed a percentage of healthy consumer participation by individuals wishing to avoid paying the penalty. If the penalty is no longer enforced, it is likely that many healthy consumers will cancel their coverage and a sicker risk pool will remain. This change to the risk pool will create a scenario of higher claims and significant losses for insurance carriers. A less healthy risk pool will raise the costs for participating consumers, and some of the Exchange's insurance carriers may decide to leave the market entirely.

As the federal debate surrounding the ACA continues, the Exchange is working with stakeholders, state agencies, and grantees in order to determine how our collective efforts can add stability to Nevada's individual market. Market stability for plan year 2018 and on-going will be critical in the Exchange's ability to connect consumers to affordable QHPs and to the development of new relationships and projects.