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Allison K. Hoffman

University of Pennsylvania Law School

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Cost-Sharing Reductions, Technocrat Tinkering, and Market-Based Health Policy

Allison K. Hoffman
Professor of Law
Penn Law School
3501 Sansom St.
Philadelphia, PA 19104
ph: 937-271-4346

*email: ahoffman@law.upenn.edu (preferred method of communication)

Bio: Allison K. Hoffman is a professor of law at the University of Pennsylvania Law School and a Senior Fellow at the Leonard Davis Institute of Health Economics. She graduated summa cum laude from Dartmouth College and from Yale Law School, where she was Submissions Editor for the Yale Journal of Health Policy, Law, and Ethics. Prior to her appointment at Penn Law School, she was a professor of law for seven years at the UCLA School of Law and a fellow at Harvard’s Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics.

Abstract: The Trump Administration has exposed both the durability and vulnerability of the Patient Protection and Affordable Care Act’s insurance reforms. One of the Administration’s first strikes at “Obamacare” was to discontinue federal government payment of cost-sharing reductions, which insurers pay to low-income enrollees on the exchanges to reduce their out-of-pocket share of medical spending. The states struck back with a clever solution that could hold insurers and enrollees harmless. This Article examines this strategy and why, while impressive, it reaffirms larger problems with the ACA’s market-based approach to health reform and the need for new pathways forward.

The past year and a half has been tumultuous for health law and policy, and also offers insight into ways forward for health reform. The Affordable Care Act (ACA) emerged as more dynamic and durable than many people, including Congressional Republicans, anticipated. Even as the repeal of the individual mandate and Independent Payment Advisory Board and executive orders chip away at its finer points, the basic integrity of its core remains. The past year also illuminated how well regulators now understand this law's mechanics in a way that enables real-time adjustment—at the state and local levels—to federal attempts to debilitate the law. Finally, and less optimistically, this constant tinkering shines a light on a major flaw of the law: its complexity, especially with the creation of the exchanges as a new marketplace to sell private insurance directly to individuals and families.

The Trump Administration threatens to undermine “Obamacare” from day one usually referred to the exchanges (although, its sights have expanded beyond, to Medicaid, contraceptive care, and nondiscrimination under section 1557, among other areas). One of the first places the Administration struck at the exchanges was elimination of cost-sharing reduction (CSR) payments to insurers.

The CSRs were designed to make it easier for low-income people to be able to afford medical care, not just health insurance. The ACA reduced out-of-pocket expenses—deductibles, coinsurance, or copayments that someone pays when she uses medical care—for anyone earning between 100 and 250 percent of the federal poverty level (\$250% is just over \$30,000 for an individual or \$60,000 for a family of four in 2018¹). The ACA required insurers to pay these CSRs, which the federal government would (in theory) reimburse. In 2017, an estimated 57 percent of exchange enrollees were receiving CSRs (nearly 6M people), including 77% of enrollees in Alabama and 75% in Florida.²

The controversy over CSRs began when Congress did not include funding for the CSRs in the 2014 budget (the ACA language is ambiguous on permanent appropriation). The Obama Administration made the payments, nevertheless, and the United States House of Representatives, then under John Boehner's leadership, sued the Administration for overreaching its authority when paying CSRs without Congressional appropriation.³ In 2016, the district court in Washington D.C., in a controversial decision, ruled in favor of the House of Representatives.⁴

When the Trump Administration took office in January 2017, the appeal of the district court decision to the D.C. Circuit Court had been stayed until early 2017, in light of the election, since if a future President chose not to make the payments, the case would be moot.

What happened next is the interesting part of the story for larger themes of health law and reform. As the Trump Administration settled in, the states were collecting bids from insurers for their 2018 premiums on exchange plans—an annual process that was well worn by 2017. In the summer of 2017, many states anticipated the vulnerability of the CSRs and planned accordingly, some by asking for bids that assumed no federal payment of CSRs and others by requesting one set of bids that assumed payment and a second set of shadow bids assumed no payment.

Within two weeks after the Trump Administration's October 12 announcement that it would not pay CSRs, nearly every state had a contingency plan in place. To understand the contingency plans requires consideration of the other ACA subsidies for exchange plans: premium subsidies for anyone earning 100-400 percent of the federal poverty. These subsidies are set so that as premiums increase, the federal government picks up a larger share of their cost, holding subscribers harmless from such increases. For example, someone earning 150 percent of the federal poverty level (\$17,820 for an

individual) must spend no more than about 4% of income (about \$700 annually, or just under \$60 monthly) on her health insurance premiums for the benchmark plan, and the federal government pays the rest.⁵ The benchmark plan is the second lowest cost silver-level plan.⁶ If that plan's annual premium is \$3000, she will receive a premium subsidy of \$2300. If the premium increases to \$4000, her premium subsidy from the federal government goes up to \$3300—she pays the same \$700 either way. Also, of note, an individual may use her subsidy to buy any plan. She is not bound to buy the benchmark plan.

Insurers selling plans on the exchanges, working in close conjunction with state regulators, capitalized on the structure of the premium subsidies to make up for lost federal payment of CSRs. What they did was “load” the total amount insurers estimated they would pay to enrollees for CSRs into the premium cost. If an insurer anticipated it would owe a total of \$100,000 in CSRs in 2018, it increased its premium prices to collect an additional \$100,000 in premiums. Even without separate payment of CSRs from the federal government, insurers would come out even, or perhaps ahead.

Many states implemented this plan enabling enrollees to be held harmless as well. A group of insurance experts (David Anderson, Charles Gaba, Louise Norris, and Andrew Spring) charted out the different ways states loaded premiums.⁷ Six states loaded the CSRs into all plans sold on the exchange, so that each subscriber would pay a little more. A more sophisticated strategy, which over 40 states did in whole or part, was to load them onto only the silver-level plan premiums. Since the premium subsidies are calculated based on the price of the second lowest cost silver plan, by loading the total anticipated shortfall onto silver plans, it drove up their premiums and maximized the increase in premium subsidies. Insurers thus recouped most of the CSR shortfall from a different federal government pocket, premium subsidies. The language in the ACAs funding for for premium subsidies is unambiguous. It is a permanent appropriation that the Administration must pay.

What does this workaround mean for enrollees?

Most people buying insurance on the exchanges will be the same or better off. 84 percent of exchange enrollees receive premium subsidies.⁸ Their subsidy will increase in 2018 in step with the increase in the benchmark plan premium. People in silver-load states who buy a silver-level plan will be held harmless, since the subsidy increase will cover the increase in their premium. Yet, they could be better off if they take the higher premium subsidy to buy a better plan, at no additional cost to them. In many states, gold-level plans, which compensate a higher share of medical care costs than silver-level plans, will now be cheaper than the loaded silver ones. Alternately, for someone who buys a bronze-level plan, the increased subsidy will cover more, perhaps all, of her premium.

The only category of people worse off are those who buy exchange plans without subsidies. In the 40 silver-load states, unsubsidized silver-plan buyers will pay more (bronze and gold plan buyers will be unaffected). Half of these states have worked around this problem by loading the increase onto only *on*-exchange plans, so that people with unsubsidized silver plans can switch to a similar plan off the exchange and avoid paying more, a strategy the experts above call the “silver switcharoo.”

The bottom line is that the lion's share of consumers can be as well or better off, if they navigate the new landscape. This, however, is a *big* if, as discussed below, as it demands more knowledge and health insurance fluency than most people have.

What does it mean for insurers?

Insurers face instability in 2018 as the new plan sorts out. Some have already dropped out of the exchanges in response in part to policy uncertainty.⁹ But this new, no-CSR equilibrium is better for them. It makes uncertainty around CSR appropriations moot. In the short run, they may enjoy a windfall. They can sue the Department of Health and Human Services (DHHS) in the Court of Federal Claims for payment of CSRs owed them. If successful, an insurer could recover for CSRs owed in 2018 and also have received higher premiums intended to make up for unpaid CSRs. Ironically, President Trump lambasted the CSRs as a gift to bloated insurers, but his failure to pay them might be the true gift—one from the federal fisc.

What does it mean for the federal government?

The CBO estimated increased spending of almost \$200B over 10 years if the CSRs are not paid.¹⁰

What does it mean for the future of health policy and reform?

This CSR scuttle shows states' adaptability to the Trump Administration's efforts to undermine the ACA. States managed in short order to find a solution where nearly all insured and all insurers could be held harmless from a strong blow. What is tragic is that, with all of its brilliance, this adaptation consumed massive regulatory energy and, in the end, consumers will struggle to navigate it successfully.

The CSR scuttle offers yet another example of the shortcomings of the modern era of market-driven health policy solutions, which I describe in more detail in a forthcoming Article. They are malleable, time-intensive, and indecipherable. The ACA was offered as a political compromise—a market-based approach—but the price of that compromise continues to be paid.

First, health care markets require constant technocratic tinkering to work. As noted above, six million people get CSRs¹¹—2 percent of the U.S. population.¹² 2017 Total marketplace enrollment 2017 was 10M¹³-- just 3 percent of the population. This drama that has consumed the attention of the White House, Congress, the DHHS, state regulators, the Courts, the media, and many academics is happening at the very margins of health insurance coverage. It distracts from efforts with greater potential impact.

Furthermore, markets that require tinkering are vulnerable to sabotage. The Trump Administration has shown that it can identify and will pull levers to destabilize the exchanges. Its latest efforts threaten to undermine risk pooling, by allowing more bare-bones plans on the exchanges, either through Association Health Plans or as "short-term" plans, which the Administration redefined as up to 364 days. If younger, healthier people choose these plans, premiums for more comprehensive plans may increase for others (of course, if those others receive premium subsidies, increases might not matter). This tinkering could slowly erode the quality and affordability of ACA coverage. The average American is unlikely to take notice of "routine" regulatory tinkering, which, in turn, dampens the kind of collective resistance that helped squelch Congress's bolder repeal and replace attempts.

Second, the past year also shows the vulnerability of policies that requires market participants' cooperation to work well. None of this latest round of turmoil—from CSRs to Association Health Plans to short-term plans – fundamentally sinks the exchanges, unless the insurers decide to sink them.

Third, the idea that consumers can make good choices in health care markets, even if regulators work excruciatingly hard to create such options, is naive. This truth is magnified as exchanges become increasingly complex.

Reams of studies show that people lack sufficient numeracy, health literacy, and financial literacy skills to make good health care decisions.¹⁵ People especially lack health *insurance* literacy. They do not understand the technical terms that describe their health insurance policy, how much it costs, and what benefits are covered.¹⁶ In a survey of insured adults, only 14 percent correctly answered four simple multiple choice questions to elicit basic understanding of cost-sharing features, such as a deductible.¹⁷ Most people do not understand whether they are in a plan where they can see any doctor or in a managed care plan that restricts whom they can see.¹⁸

Even the most astute consumers have difficulty navigating the exchanges, often choosing plans that are not cost-minimizing or in line with their own stated preferences.¹⁴ In 2018, the savviest of consumers will struggle to understand the sharp premium increases for some or all plans and to take advantage of the chess moves, like the silver switcharoo, that enable them to be as well or better off.

The CSR scuffle reaffirms why market-based health policies are time consuming to keep afloat, vulnerable to sabotage, and difficult for people to navigate. This past year makes it perfectly clear that we can and should do better going forward.

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