



As 2018 Open Enrollment Begins, Trump Administration Adds New Challenges for New York’s Individual Market

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New York officials and health plans gearing up for the fifth open enrollment period under the Affordable Care Act (ACA) this November continue to be buffeted by a series of contrary developments in Washington. The failure of the U.S. Senate’s Graham-Cassidy “repeal-and-replace” legislation¹ in September seemed to presage a more orderly sign-up period, but two separate actions taken by the Trump administration on October 12 roiled the waters again. First, a new executive order threatened to undermine key ACA provisions and consumer protections;² and later the same day, the Trump administration announced a halt to an estimated \$7 billion in cost-sharing reduction (CSR) payments owed to health plans.³ Barely a week later, two U.S. Senators announced a bipartisan agreement on re-establishing CSR payments to stabilize ACA markets,⁴ but its future is uncertain. In this HealthWatch report, we assess New York’s individual market at this juncture, and offer some preliminary analysis of the impact of these recent Trump administration actions.

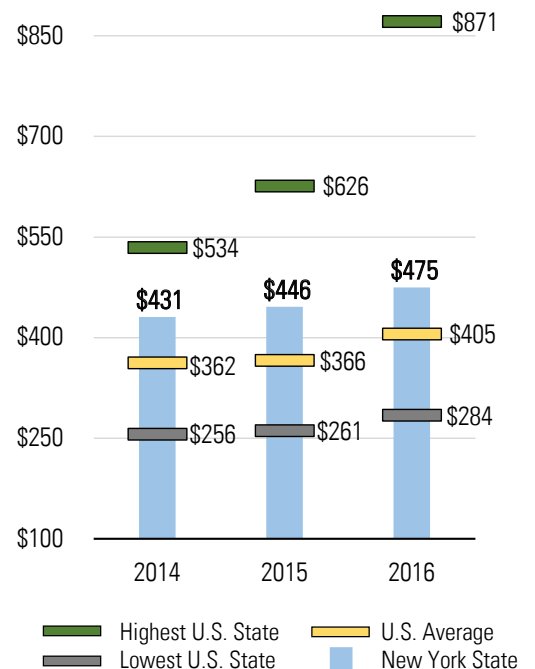
No Implosion. Far from “imploding,” New York’s individual market is still vastly improved since the ACA took effect in 2014, with 12 insurers offering Qualified Health Plans for 2018 through the New York State of Health Marketplace, and another 15 offering Essential Plan (EP) coverage under New York’s Basic Health Program (BHP).⁵ New York officials reported individual enrollment on and off the Exchange of about 375,000 as of January 2017, and another 665,000 EP enrollees.⁶ But there are some warning signs for the affordability of coverage and the stability of the individual market risk pool.

Based on federal risk adjustment data, average premiums in New York’s individual market rose steadily between 2014 and 2016 (Figure

1), and the New York Department of Financial Services granted, on average, 17 percent increases for individual market health plans for 2017 and 14 percent increases for 2018.⁷ In 2016, New York’s average premiums (\$475 per month) were well above the national average (\$405); 43 states had lower average premiums, with Utah the lowest at \$284.⁸

Part of the reason for the steady premium increases is likely the worsening of the individual market risk pool. Federal regulators administering the premium stabilization programs collect claims data and assign states a value based on the relative health or sickness of their individual enrollees. New York’s risk pool has been getting “sicker” each year (Figure 2); 40 states had “healthier” risk pools in 2016, with Colorado earning the lowest risk score of 1.262, about 45 percent

Figure 1. Individual Market Average Premiums, 2014 to 2016

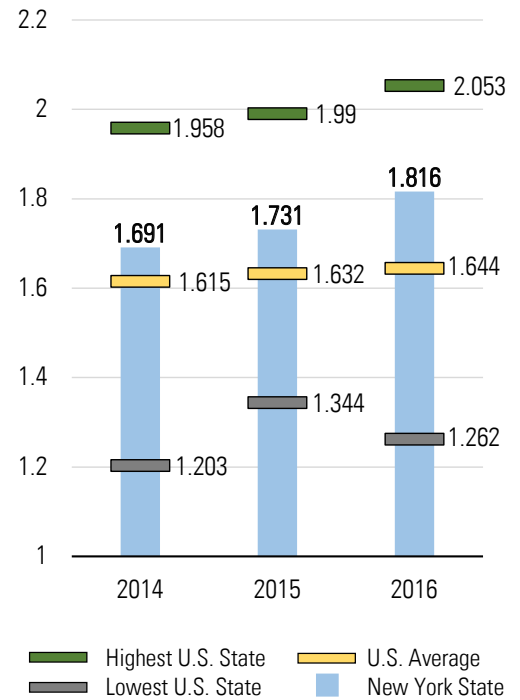


“healthier” than New York’s (1.816), which was also higher than the national average (1.644). Some of the increase in New York’s risk score between 2015 and 2016 might be due to the rollout of the BHP in 2016, which drew lower-income enrollees into the much more affordable EP pool.

The Executive Order. The stated policy of the order is to “facilitate the purchase of insurance across State lines” and provide lower-cost, high-quality health care. It focuses on three areas: 1) so-called “association health plans,” in which groups of small employers or individuals are bundled together as a large, fully insured or self-funded group; 2) removing legal barriers to short-term, limited-duration insurance, often with limited benefits and high cost-sharing; and 3) expanding the use of Health Reimbursement Accounts (HRAs) by employers so employees can use the funds to offset the cost of individual market premiums. Many questions have arisen regarding the open-ended order, mainly because it directs key agencies to issue regulations without specifying what will be in them. The overriding concern for all states is the extent to which *state* insurance regulation and consumer protections can be overridden by federal regulations. Certainly state and national regulators, consumer groups, and legal experts have sounded the alarm about the threat to the stability of state insurance markets.⁹

Given the current risk profile of New York’s individual market, adding a mechanism that siphons off younger, healthier individuals would be of great concern. At present, however, the order seems to pose more risk for New York’s small group market than for its individual market, as it is focused on fostering group association plans, rather than authorizing individuals with no professional

Figure 2. Individual Market Risk Scores, 2014 to 2016



Source for Figures 1 and 2: Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. Summary Reports on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for Benefit Years 2014, 2015, and 2016. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/>

connection to join unregulated or lightly regulated association plans. With regard to temporary insurance with limited benefits, existing statutory¹⁰ and regulatory provisions¹¹ in place in New York prohibit short-term plans. Finally, the impact of expanded use of HRAs, already authorized for individual coverage in the 21st Century Cures Act,¹² is uncertain. On the one hand, it could make coverage more affordable for individuals who are not eligible for subsidies, but at the same time, it might sap enrollment from the small group market, the subject of an upcoming HealthWatch brief.

Cost-Sharing Reductions. New York’s individual market faces less immediate

disruption from the cutoff of CSR payments than other states. The loss of the payments was factored into New York health plan rate filings for 2018, and though plans may reconsider participation in the market in the future, they are obligated to provide the reduced-cost-sharing coverage to eligible individuals for 2018. Most importantly, as noted in an earlier publication,¹³ enrollment in plans with CSR coverage is smaller in New York because of the availability of the Essential Plan.

Of course, the elimination of the CSRs, which provide 25 percent of the annual support for the EP, poses a more serious threat, since it has effectively become a second and more affordable individual market for nearly 700,000 lower-income people. But the elimination of CSR payments to insurers is different from an outright statutory repeal of the program. Health plans have discussed legal action, and a coalition of state attorneys general has already won the right to intervene in the lawsuit brought by the U.S. House of Representatives challenging the constitutionality of the payments without explicit appropriation authority; the group is now seeking an injunction to keep the payments flowing.¹⁴ In their response opposing the intervention motion, House attorneys argued that stopping CSR payments “would have no impact on the amount of a state’s BHP subsidy,” surprisingly providing an argument that may help protect the BHP for New York and Minnesota.¹⁵

Reinsurance. Since the expiration of the federal reinsurance program, a handful of states with shaky individual markets have moved to set up their own reinsurance mechanisms.¹⁶ While states must find resources to establish reinsurance programs, Alaska won approval of a program under which federal “pass-through” funding will

reduce its costs, by earmarking a portion of the federal savings generated by lower premiums, and hence, smaller federal premium subsidies. More recently, however, there have been some mixed signals on federal interest in state reinsurance programs: Oklahoma was forced to withdraw its reinsurance application because of a delay in federal approval, but Oregon’s application was approved.¹⁷

Minnesota also won approval of federal support for its reinsurance mechanism. As the only other state with a BHP plan in place, its experience is of particular interest to New York. The BHP funding a state receives is based in part on premiums for the second-lowest-cost silver plan on the Exchange, which will be reduced through a successful reinsurance program. Minnesota’s bid to recoup some of the drop in federal BHP payments that result from this dynamic was denied.¹⁸

Conclusion. Given the individual market’s troubled history in New York, recent trends suggest the need for state policymakers to examine options to bolster the market, such as a reinsurance program, revamping the way risks are pooled, or developing strategies to encourage younger, healthy individuals to purchase coverage. The uncertain future of the U.S. Senate stabilization plan, particularly since a competing proposal¹⁹ was unveiled, and recent actions by the Trump administration, signal that New York may not have a federal partner in its efforts, and that the task of preserving hard-won coverage gains and preserving affordable, comprehensive coverage for individuals without subsidies may get harder. Regulations implementing President Trump’s executive order could take up to six months—an eternity in the repeal-and-replace era.

Notes

- 1 For background information on the legislation, see www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson
- 2 Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States. October 12, 2017. The White House, Office of the Press Secretary. www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition
- 3 Statement of U.S. Health and Human Services Acting Secretary Eric Hargan and Centers for Medicare & Medicaid Services Administrator Seema Verma. October 12, 2017. Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments. www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html
- 4 The Bipartisan Health Care Stabilization Act of 2017, introduced by U.S. Senate Health, Education, Labor & Pensions Committee Chair Lamar Alexander and Ranking Member Patty Murray, includes provisions to: 1) continue CSRs through 2019; 2) authorize all individuals to purchase high-deductible “copper” or catastrophic plans; and 3) increase state flexibility and streamline the process for federal review of Section 1332 State Innovation Waivers. www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20TEXT.pdf and www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20SECTION%20BY%20SECTION.pdf
- 5 New York State of Health. September 28, 2017. “NY State of Health Announces 2018 Insurance Options” (press release). <https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-2018-insurance-options>
- 6 See Figure 1 from Newell P. June 2017. *Rewind: New York State Faces Familiar Issues and Few Challenges in the “Repeal and Replace” Era*, www.uhfny.org/publications/881214
- 7 Figures are weighted averages. New York State Department of Financial Services Press Releases, August 15, 2017, “DFS Announces 2018 Health Insurance Rates in a Continued Robust Market,” www.dfs.ny.gov/about/press/pr1708151.htm; and August 5, 2017, “Department of Financial Services Announces 2017 Health Insurance Rates,” www.dfs.ny.gov/about/press/pr1608051.htm.
- 8 See source for Figures 1 and 2.
- 9 LaMantia J. October 13, 2017. NY Insurance Chief Slams Trump Executive Order. *Crain’s NY Business*. www.crainnewyork.com/article/20171013/HEALTH_CARE/171019946; Statement, Office of the Insurance Commissioner, Washington State. October 12, 2017. Kreidler: Trump’s Order Threatens Health Insurance Markets Nationwide. www.insurance.wa.gov/news/kreidler-trumps-order-threatens-health-insurance-markets-nationwide; Jost T. October 12, 2017. Trump Executive order Expands Opportunities for Healthier People to Exit ACA. HealthAffairs Blog. healthaffairs.org/blog/2017/10/12/trump-executive-order-expands-opportunities-for-healthier-people-to-exit-aca/; and Palanker D, K Lucia, and E Curran. October 11, 2017. New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumer and the Individual Market. *To the Point*. Commonwealth Fund. <http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans>
- 10 See NYS Insurance Law sections 3217, 4304(l), and 4328(b).
- 11 Chapter 11 New York Codes, Rules and Regulations Part 52 (NYS DFS Regulation 62)
- 12 21st Century Cures Act, Title XVIII. Public Law 114-255. <http://scipol.duke.edu/content/21st-century-cures-act-public-law-114-255>
- 13 Newell P. June 2017. *Rewind: New York State Faces Familiar Issues and Few Challenges in the “Repeal and Replace” Era*. United Hospital Fund. www.uhfny.org/publications/881214
- 14 The State of California, et al. v. Donald J. Trump, President of the United States, et al. In the United States District Court for the Northern District of California. Plaintiffs’ Ex parte Motion for a Temporary Restraining Order and Order to Show Cause Why a Preliminary Injunction Should not Issue. Case No. 4:17-cv-05895-KAW. https://oag.ca.gov/system/files/attachments/press_releases/Dkt%2010%20-%20Ex%20Parte%20Motion%20for%20TRO.pdf
- 15 Opposition of the United States House of Representatives to the Motion for Leave to Intervene. July 10, 2017. USCA Case #16-5202. Document #1683289. United States Court of Appeals for the District of Columbia Circuit. United States House of Representatives v. Thomas E. Price, et al. premiumtaxcredits.wikispaces.com/file/view/DCC+House+state+interv+op.pdf
- 16 The Center for Consumer Information & Insurance Oversight. Section 1332: State Innovation Waivers. www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

- 17 Letter from the U.S. Department of Health & Human Services Administrator to Alaska Governor Bill Walker, July 7, 2017. www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter.pdf; Letter from Oklahoma Health and Human Services Secretary Terry Cline to U.S. Treasury Secretary Steven Mnuchin and U.S. Department of Health and Human Services Secretary Thomas Price, September 29, 2017. www.ok.gov/health2/documents/Oklahoma%201332%20Waiver%20Withdrawal%209.29.17.pdf; Letter from the U.S. Department of Health & Human Services Administrator to Jean Straight, Acting Director of Oregon Department of Consumer and Business Services, October 19, 2017. www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-OR.pdf
- 18 Letter from the U.S. Department of Health & Human Services Administrator to Minnesota Governor Mark Dayton, September 22, 2017. www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-MN.pdf
- 19 The proposal by U.S. Representative Kevin Brady and U.S. Senator Orrin Hatch would extend CSR payments for two years, add anti-abortion provisions, and eliminate individual and employer responsibility requirements. <https://www.hatch.senate.gov/public/index.cfm/2017/10/hatch-brady-introduce-healthcare-proposal-combining-funding-with-critical-reforms>