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# 2019 Shaping Up as a Watershed Year for New York's Individual Market as Federal Challenges and Uncertainty Continue

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**PETER NEWELL**
Director, Health Insurance Project, United Hospital Fund

**MANDY MILLER**
MPH Candidate 2019, Dartmouth College

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**Anthony Shih, MD, MPH**
**President**

**Deborah Halper**
**Vice President, Education and Program Initiatives**

**Chad Shearer**
**Vice President for Policy; Director, Medicaid Institute**

**United Hospital Fund**
**1411 Broadway, 12th Floor**
**New York, NY 10018**
**(212) 494-0700**
**www.uhfnyc.org**

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Except for the "zeroing out" of the Affordable Care Act (ACA) individual mandate penalty at the end of 2017,[1] legislative efforts by Congress and President Trump to repeal and replace the landmark law outright have stalled for now. Instead, the Trump administration turned in 2018 to regulatory levers and litigation strategy to advance its policy goals of reducing federal health care spending and deregulating the private market, lowering premiums for some enrollees by limiting covered benefits and rolling back pre-existing condition protections for consumers. New York State has successfully defended its ACA markets for the most part, because of laws and regulations it already has on the books, and because of its own aggressive legal strategy. One potentially disruptive federal decision[2]—the suspension of payments to health plans under the Centers for Medicare & Medicaid Services (CMS) risk adjustment (RA) program—was reversed three weeks after it was announced.[3] In New York, that reversal unlocked the transfer of about $151 million to individual market plans with higher-risk enrollees.[4]

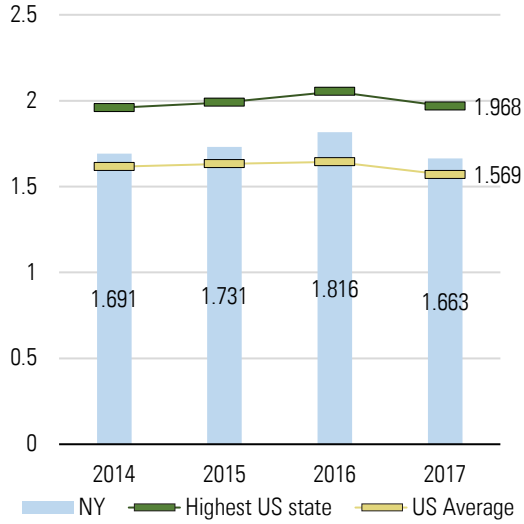
With the ACA's sixth open enrollment period set to begin in New York on November 1, 2018—and important midterm congressional elections to follow a week later that could change the dynamics for U.S. health policy once again—this analysis examines the state of New York's individual health care insurance market. For this update to last year's HealthWatch report on the individual market,[5] we analyzed claims and enrollment data for 2017 compiled by CMS to administer the RA program, and compared them to the cost of coverage and the relative health or sickness of risk pools in other states. We supplemented the RA data with more recent enrollment data, as well as health plans' rate filings for calendar year 2019.

In 2017, New York mostly maintained its ranking among states in terms of its risk profile and affordability—not very good, but not the worst—but more recent market trends suggest the need for policymakers to consider additional steps to keep New York's individual market on track, particularly for those purchasers who do not receive advance premium tax credits (APTCs). The report concludes with a discussion of some actions other states are taking or considering to stabilize their own markets.

## NEW YORK'S INDIVIDUAL MARKET IS STILL SICKER THAN MOST OTHERS

At first blush, 2017 risk profiles for all states and New York (Figure 1) suggest markets that are getting healthier. With higher risk scores representing a sicker risk pool and lower risk scores a healthier one, U.S. average risk scores fell from 1.644 in 2016 to 1.569 in 2017; New York followed this trend, dropping from 1.816 to 1.663. But CMS attributes the 2017 decrease in risk scores to the more accurate data it obtained from health plans on overall enrollment by "metal level"—platinum, gold, silver, and bronze coverage—that is used in the formula to calculate risk scores. In the more useful indicator of how New York's risk profile compared to those of other states, New York did not show much improvement. Overall, 37 states had lower risk scores than

**Figure 1. Individual Market Risk Scores in US and New York, 2014-17**



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New York's in 2017, compared to 40 states in 2016, and New York's score is still well above the U.S. average (1.569). Colorado's risk score (1.186) made its individual market the healthiest in the nation in 2017.

## PREMIUMS CONTINUE TO RISE

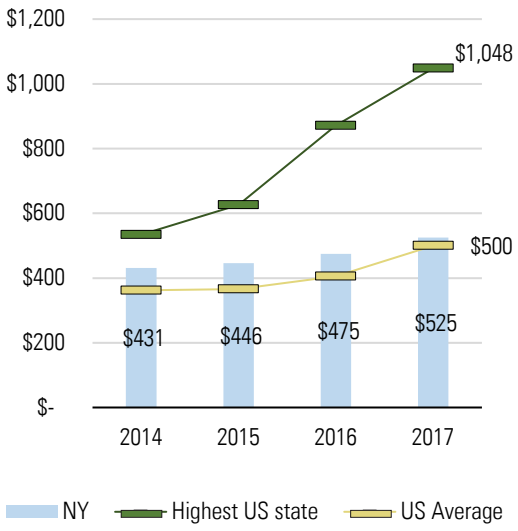
Average individual market premiums in the U.S. rose for the fourth straight year, and the 2016–17 increase (from $405 to $500 per month, or 24%) was much larger than previous years' increases (Figure 2). While the rate of premium increase was lower in New York (11%) than the national average, 31 states had lower average premiums than New York ($525 per month), with Utah the most affordable at $337 per month. In 2016, 43 states had lower premiums than New York, making the 2017 result a modest improvement for New York, but 2018 saw a weighted average increase of 14.5%.[6] Projecting that healthier enrollees would drop coverage without the mandate penalty in 2019, leaving a sicker risk pool, health plans collectively sought an average rate increase of 24% in 2019.[7] With Governor Andrew Cuomo urging regulators to scrutinize the rate increases carefully,[8] DFS reduced the jump to an average of 8.6%.[9] In response, New York health plans warned about politicizing the rate review process, and possibly destabilizing the market, cautioning that 2020 rates could be higher to compensate,[10] but many factors go into each health plan's rates.

Much of the drop in 2019 New York weighted average premiums from 24% to 8.6% can be attributed to the DFS reduction in rates proposed by Fidelis Care, the largest health plan in the individual market, which was seeking the highest increase (26%). For some upstate health plans, rates were lower because DFS instructed health plans to assume no reduction in their RA amounts, which was permitted under a past DFS regulation.[11] The temporary suspension of the ACA premium tax nationally for 2019,[12] which health plans pass on to consumers, also helped temper needed rate increases. Overall, New York's 8.6% increase was lower than Connecticut (12.3%), slightly higher than New Jersey (5.8%), about the same as California and Florida (8.7% and 8.8%), and much lower than Maryland (30.2%).[13]

## ENROLLMENT DIPS, ESPECIALLY OFF-MARKETPLACE

In addition to the claims data CMS collects for the RA program, enrollment both on and off the marketplace is also tallied in the form of "billable member months." New York's total individual enrollment dropped 6% from 2016 to 2017, the equivalent of about 20,000 covered lives. In a companion report[14] released with the risk-adjustment

**Figure 2. Average Monthly Individual Premiums in US and New York, 2014-17**




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, 2016, and 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/

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data, CMS reported a 10% decline in 2017 individual enrollment nationally compared to 2016, driven by a decrease in enrollment by individuals purchasing coverage without advance premium tax credits (non-APTCs). This category declined by 20%, compared to a 3% drop in coverage by individuals with APTCs. The decline in non-APTC coverage in New York (12%) was smaller than that in all but five states, but six states reported higher non-APTC enrollment in 2017. Since the New York State of Health marketplace (NYSOH) reported steady enrollment for marketplace coverage without APTCs,[15] it is likely that decreases in off-marketplace coverage are responsible for the drop. According to DFS data, off-marketplace enrollment dropped by 24,000 between 2016 and 2017, and by another 33,000 from 2017 to 2018.[16] The decline in off-marketplace enrollment is cause for concern, both because the risk pool is contracting overall, and because there is some evidence that off-marketplace enrollees are, on average, healthier than on-marketplace enrollees.[17]

## LOOKING AHEAD

New York's individual market is sicker and more expensive than those of most other states, two measures that often go hand in hand. The market is contracting—from a base already made smaller by the enrollment of lower-income APTC-eligible individuals into the much more affordable Essential Plan, New York's ACA Basic Health Program (BHP) plan, whose enrollees are pooled separately. And, because of the repeal of the individual mandate penalty, sicker individuals are more likely to retain coverage, and healthier individuals are more likely to drop it in 2019. One health plan's rate increase application called this trend "selective lapsation," and projected a 20% increase in morbidity (the incidence of sickness) from 2017 to 2019.[18] Steady premium increases—although the average for 2019 is much smaller than expected—are driving the market towards a bifurcated state, as APTCs shield eligible families from increases, while unsubsidized families face increasingly burdensome premiums. This dynamic is particularly acute at the ACA's "cliff": up to 400% of the federal poverty level (FPL), premiums are capped at 9.56% of family income, but families with household income above that receive no support at all. Figure 3 displays premium increases for two similarly situated families of four from Manhattan purchasing the lowest-cost bronze plan (the lowest premium of the four metal tiers) in 2017 and 2018. The after-subsidy cost of a bronze plan for the APTC eligible family (up to $98,400 in household income) increased by only $1 monthly from 2017 to 2018, for an annual cost of $6,180. But for the same family with an income of $99,000 annually, slightly above the 400% FPL threshold, premiums rose by $139, to $1,190 per month, or $14,280 annually, about 15% of the family's household income, not counting extensive out-of-pocket costs.

**Figure 3. Family Premiums for Lowest-Cost Bronze Plan in Manhattan, 2017 and 2018**

| | APTC Subsidy | | Monthly Premium | | Annual Premium | |
|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2017 | 2018 | 2017 | 2018 |
| 400% FPL | $517 | $671 | $514 | $515 | $6,168 | $6,180 |
| >400% FPL | $0 | $0 | $1,046 | $1,190 | $12,552 | $14,280 |

Source: UHF analysis of NYSOH premium rates for 2017 and 2018. NYSOH Search for Plans. https://nystateofhealth.ny.gov/individual/searchAnonymousPlan/search

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Faced with similar or even worse trends, many states are trying to address these problems in their individual markets. Following is a summary of three possibilities being implemented or considered elsewhere that New York can consider: a reinsurance program, adopting a state individual mandate for coverage, or providing additional subsidies.

## REINSURANCE

New York once operated its own reinsurance or "stop-loss" programs for the individual market[19] and the HealthyNY program. And from 2014 to 2017, an ACA reinsurance program helped offset needed premium increases by reimbursing health plans for a portion of claims from high-cost enrollees, with funding raised from a national assessment on fully insured and self-funded coverage. In 2014, New York health plans received about $288 million in payments from the federal program, which helped lower premiums by 10%, and when it expired without replacement in 2017, premiums increased.[20] Lower premiums help retain existing enrollment and generate new enrollment, and CMS has been very supportive of state reinsurance programs. CMS invites applications through the Section 1332 Waivers for State Innovation program,[21] and it provides support for states by passing through a portion of federal savings that result from lower premiums, thus lowering federal subsidy amounts.

Three states have implemented reinsurance programs thus far (Alaska, Minnesota, and Oregon), and four others (Maine, New Jersey, Maryland, and Wisconsin) are implementing programs for 2019.[22] For its $325 million reinsurance program for 2019, New Jersey expects to provide about one-third of the total and is counting on federal pass-through funding for most of the rest; the state's application estimates a $70 per member per month premium decrease in 2019, about 15%, and increased enrollment of 10,000 over the current level of 322,000.[23] Total funding for the Maryland program is estimated at $462 million for 2019, with a 2.75% state assessment on health plans expected to raise $365 million of the total, and federal pass-through funding providing the rest, with a projected premium decrease of 30%, and an increase of 5.8% in enrollment.[24] Maryland officials believe that the assessment on insurers will be offset by the suspension of ACA premium tax for 2019, which Congress may extend for another two years.[25] The $133 million Maine program, a hybrid reinsurance and "invisible high-risk pool" program, is funded through assessment on fully-insured and self-funded plan sponsors, along with federal pass-through funding.

The experience in Minnesota, the only other state with a Basic Health Program, is instructive for New York. In preparing legislation and negotiating its Section 1332 waiver for a reinsurance program, state leaders believed that federal pass-through funding would be provided for both the BHP and the individual market, since the reinsurance program would reduce federal expenses in both market segments. CMS's decision to provide only individual market funds came as a bitter surprise to state officials and will result in the loss of about $277 million in BHP funding over two years.[26]

The availability of federal funding and the ability to make an immediate positive impact on premiums in year one are two reasons why many states are implementing reinsurance programs. But the impact on premiums in succeeding years is not as visible (rates go up less instead of going down), and such programs may not be the most cost-effective approach in terms of new enrollment. An actuarial analysis of the Maine

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plan[27] estimated a coverage gain of roughly 1,000 enrollees, a cost of about $55,000 per uninsured person.

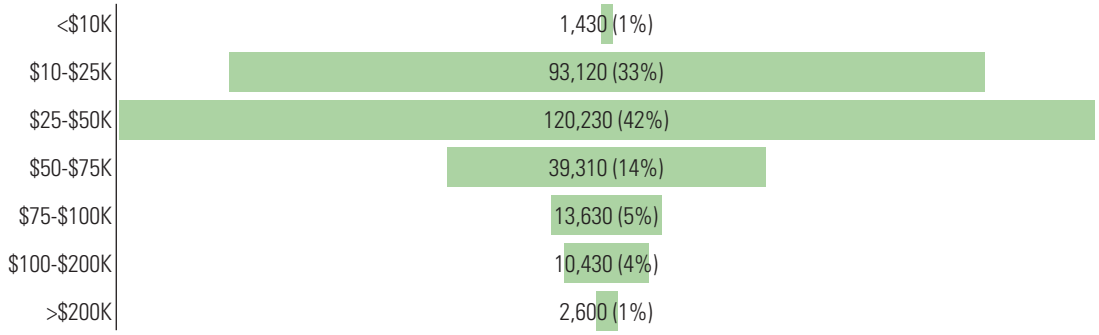
## STATE INDIVIDUAL MANDATE PENALTY

New Jersey[28] and the District of Columbia[29] moved quickly to enact coverage mandates in 2018, effectively continuing the ACA penalty without interruption, and enrollees are expected to benefit from lower rates as they renew or purchase coverage in the upcoming open enrollment period. Since the existing federal mandate (with a $0 penalty) is intact, state laws can simply reference the federal standards for who is subject to the penalty, the type of coverage that qualifies, and the amount of the tax penalty, or devise their own. For the years 2016 and beyond, the ACA called for a penalty of the greater of $695 or 2.5% of income, capped at the national average annual cost of a bronze plan. New Jersey adopted the ACA standard, and the District of Columbia will set its penalty annually. The Massachusetts mandate, with its more generous affordability standard tied to an additional state subsidy, was the model for the ACA and could now serve as a model for states as well.[30] Vermont also enacted a state coverage mandate in 2018, but it created an advisory group to report back in 2019 on how the mandate should be structured and enforced for the 2020 benefit year.[31]

With a state personal income tax and successful state marketplace already in place, New York has the necessary prerequisites for adopting a state mandate. According to Internal Revenue Service data for 2016,[32] the most recent year available, New Yorkers made an estimated 280,750 filings in 2016 with ACA "health care individual responsibility payments," for a total of $201.6 million. Figure 4 shows the distribution of penalty payments among different categories of adjusted gross income (AGI). Households in the $10,000–$25,000, and $25,000–$50,000 AGI categories accounted for over 75% of total filings; for an individual, $25,000 is just slightly more income than is allowed for Essential Plan eligibility, and $50,000 is just beyond the upper income limit for APTCs.

Compared to the 2015 tax year,[33] 2016 filings with penalty payments decreased in number by about 30% (from 405,610), with the biggest decreases in the $10,000–$25,000 (39%) and $25,000–$50,000 (29%) AGI categories. At

**Figure 4. New York Returns with Individual Responsibility Payments by AGI, 2016**




Source: SOI Tax Stats Historic Table 2. Internal Revenue Service. https://www.irs.gov/statistics/soi-tax-stats-historic-table-2
Note: Total number of filings with individual responsibility payments in 2016 was 280,750, and total amount of payments was $201.6 million.

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the same time, the total amount of penalties collected increased from $186 million in 2015 to $201.6 million in 2016, about 8%. One factor in the decrease in penalties and the increase in the amount collected might be the increase in the penalty amount from 2015 to 2016;[34] fewer individuals were willing to pay the higher amount, and those that did paid more. The full implementation of the Essential Plan for households earning less than 200% FPL in 2016 also probably led to fewer penalties paid by lower-income taxpayers.

A national state-by-state study[35] estimated that if New York had a mandate in place in 2019, the uninsured rate would dip by 10.2%, as 142,000 individuals gained coverage (including 93,000 individual market enrollees), and individual premiums would drop by about 10%, as an estimated 284,000 "tax units" would be subject to the penalty, at a cost of $271 million.

The report acknowledges the political will required to implement a state mandate, but New Jersey, aided by single-party control of the legislature and the governor's mansion, enacted legislation without much blowback; it also shrewdly earmarked the revenue from its mandate for its reinsurance program. In effect, New Jersey penalty payers will be providing a subsidy to help keep rates down for other New Jersey individual market purchasers, taking some of the sting out of continuing the ACA requirement on a state level. Similarly, the DC exchange will invest mandate payments in special outreach and education programs. A study conducted for Maryland went a step further, advocating the creation of a down payment account for penalty payers for future coverage, and potentially auto-enrolling them in $0 premium bronze plans.[36]

## ADDITIONAL PREMIUM SUBSIDIES

A recent survey and analysis of market stability activities in 10 states[37] also suggested a third option for easing pressure on individual markets: providing direct state subsidies to individuals ineligible for ACA subsidies. This could increase enrollment and bolster state risk pools, while also driving down the uninsurance rate and avoiding some of the shortcomings of reinsurance programs—particularly helpful for states offering a BHP, as New York does.

Several different approaches could be taken to provide some relief for those whose needs are not addressed by the ACA, and to improve the risk pool at the same time. One possibility would be to increase subsidies for those currently eligible for cost sharing or premium assistance; the number of New Yorkers with modest incomes paying penalties suggests this investment might be well received by consumers not enrolled in coverage. Another approach would "smooth out" the cliff, by continuing the ACA's income-graduated premium caps beyond 400% FPL, with incremental increases as household income rises. A related approach would "push back" the cliff by continuing the current 9.56% premium cap indefinitely for all income groups or by extending the cap to higher income levels, such as 500 or 600% of FPL. Legislation pending in Minnesota[38] addresses the cliff problem by maintaining the premium cap for all incomes; it also addresses a second ACA flaw, the "family glitch."[39] This legislation would allow families eligible for but unable to afford employer-sponsored family coverage to access marketplace coverage and subsidies when their family contribution—rather than the cost for a single employee—exceeds the ACA affordability limit.

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## CONCLUSION

Uncertainty from federal repeal-and-replace efforts is likely to continue, as are the ongoing litigation and regulatory changes threatening the ACA. Some speculate that if the midterm elections do not change the majority in the U.S. House, a new repeal-and-replace effort could begin, with a blueprint modeled on the Graham-Cassidy legislation already on the shelf.[40] A different outcome could boost the chances of agreement on bipartisan legislation to bolster the ACA, such as the Alexander-Murray legislation[41] that would create a federal reinsurance program, appropriate funding to restart cost-sharing reduction payments, and authorize federal pass-through savings for BHP states undertaking reinsurance programs.

Despite the many challenges and distractions, New York agency officials, policymakers, health plans, and consumers have never lost their focus on implementing the ACA and defending the resulting coverage gains. New York's underlying regulatory framework, in place since before the adoption of the ACA, makes it less vulnerable to some potential threats, and the state's commitment to the ACA is frequently on display. For example, when the federal Department of Justice announced that it would not defend a lawsuit brought by ACA-unfriendly states to eliminate preexisting condition protections and other ACA standards,[42] New York could point to homegrown protections that predate the ACA, and joined attorneys general from other states to defend the law. And when the Trump Administration issued regulations that could have undermined the individual and small group markets by overriding state rating laws for associations and allowing limited benefit coverage without pre-existing condition protections, DFS moved with alacrity to notify insurers and brokers that association health plans had to follow New York regulations, not the lax federal standards.[43] Finally, when the Trump administration abruptly cut off an important funding source for the Essential Plan, New York's attorney general quickly joined Minnesota and sued in federal court to restore the payments, winning an interim settlement[44] and a final order implementing a new BHP payment methodology that will drive an additional $422.3 million to New York for the first three quarters of 2018.[45]

But New York's individual market, while unquestionably more vibrant than before the ACA, is showing some wear and tear. Premium subsidies have made coverage affordable for thousands, but they may be falling short of their second purpose—supporting a broader, healthier risk pool that improves affordability for those without subsidies. And the ACA's individual mandate, a second tool to achieve that goal, expires in January. New York passed on the opportunity to establish a state reinsurance program when the federal one lapsed in 2017, and on the chance to establish an individual mandate when the federal penalty was eliminated for 2019. Reinsurance, a state individual mandate penalty, or additional subsidies are certainly approaches worth consideration, and others have been discussed as well, such as taking steps to lower costs for younger enrollees. No matter what course policymakers take, bringing the same sense of urgency and resolve to the task of stabilizing the individual market that helped meet so many other challenges will be a key ingredient in any success.

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## Notes

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