COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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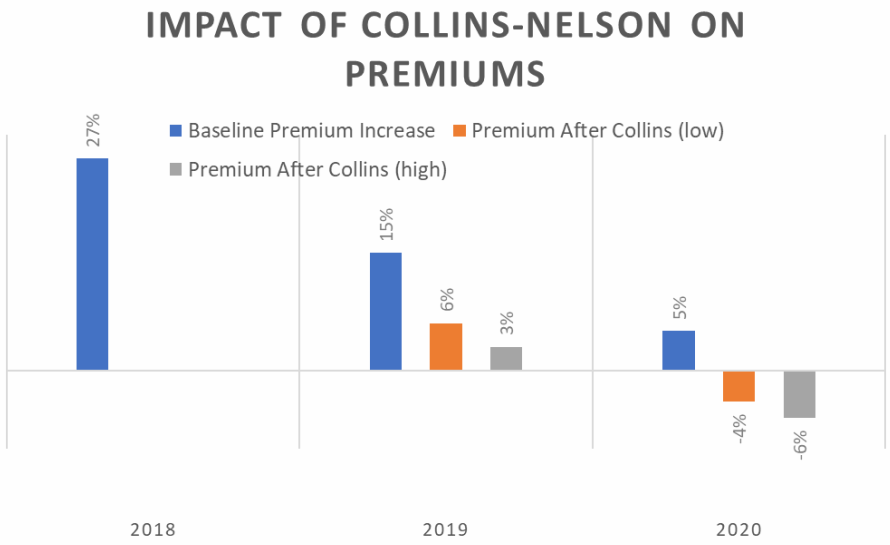
Analysis of the Collins-Nelson Proposal

CAHC's preliminary modeling shows legislation could reverse premium increases under individual mandate repeal, shrink costs for consumers



Throughout 2017, CAHC has argued that federally funded reinsurance could help stabilize individual health insurance markets if the Affordable Care Act's (ACA's) individual mandate was repealed.

The Republican tax cut bill, expected to be signed into law before the end of the year, zeroes out the tax penalties for individuals who fail to get health insurance. The Congressional Budget Office (CBO) assumes that this would have a similar practical impact as repealing the individual mandate outright: individual market coverage would decline, particularly among younger and healthier people, and premiums would thereby be driven up as the market's risk pool skewed more toward older and sicker enrollees.

CBO estimates that eliminating the mandate penalties would increase individual market premiums by 10 percent, and would reduce individual market enrollment by 3 million in 2019 and 4 million in 2020.[1]

However, news reports indicate a vote on legislation introduced by Senators Susan Collins (R-ME) and Bill Nelson (D-FL) may occur during debate on "must-pass" legislation to fund the government, by the end of this year. If enacted, the modified Collins-Nelsons bill would add $10.5 billion in new federal funding to support state-based reinsurance programs under the ACA's section 1332 waiver program. The funding would include $500 million to the states to prepare and submit applications for 1332 waivers, and up to $5 billion in "seed" funding for state-run reinsurance programs in both 2019 and 2020.

[1] Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 8, 2017), available at https://www.cbo.gov/publication/53300

The new Collins-Nelson proposal would allow states to tap not only into the original $10.5 billion fund to establish and run reinsurance programs, but also to share in the resulting savings in reduced federal premium subsidies. Under the 1332 waiver approach, state-run programs that create federal savings, such as by reducing premiums and thereby reducing the federal government's spending on subsidies, are eligible to access those funds by "passing-through" the federal savings to states who must then use them on health programs.

This could allow states to leverage the new federal funding into much larger reinsurance funding pools than the $5 billion seed funding. For example, the actuarial firm Oliver Wyman estimates that the Collins-Nelson proposal would leverage as much as an additional $10 billion per year in federal subsidy savings to create reinsurance pools of $15 billion per year.[2] CAHC estimates that magnitude of reinsurance funding would likely be large enough to completely offset the 10 percent premium increases expected due to the loss of the individual mandate in most states.

Basics of the Collins-Nelson Proposal and Prospects

In conjunction with the Collins-Nelson proposal, the Senate is considering a bill by Senators Alexander (R-TN) and Murray (D-WA) to reinstate federal reimbursement to health plans required by the ACA to reduce copayments and deductibles for low-income enrollees, the so-called Cost Sharing Reduction (CSR) subsidies. The Alexander-Murray bill would also streamline state applications for section 1332 waivers.

The Collins-Nelson proposal would be integrated into the Alexander-Murray bill's 1332 waiver streamlining approach. It would:

1. Create a $500 million fund to assist states in developing and implementing 1332 waivers that include a reinsurance component to reduce premiums.
2. Create a $10 billion, two-year federal fund that states could tap to provide reinsurance under their 1332 waiver. States could tap up to $5 billion for 2019 reinsurance waiver programs, and another $5 billion for 2020 reinsurance waiver programs.
3. Provide fast-track approval processes for states that adopt invisible high-risk pools, copy other state's approved reinsurance waiver approaches, or implement a state-based version of the transitional federal reinsurance (Section 1341 of the ACA) program.

The Collins-Nelson funding approach would allow states to leverage federal savings from reduced federal premium subsidies into additional reinsurance funding. Under 1332 waivers, when states modify the ACA in ways that reduce federal liabilities for premium subsidies, states get the federal savings returned to them as a "pass-through."

However, it is not clear exactly how much additional reinsurance would be generated via pass-through funding. We believe that participating states could receive pass-through funding ranging from $3.5 billion

[2] Tammy Tomczyk, FSA, FCA, Kurt Giesa, FSA, MAAA, "How States Could Leverage $5 Billion into More Than $15 Billion to Stabilize the Individual Market," Oliver Wyman Health (December 09, 2017), available at http://health.oliverwyman.com/transform-care/2017/12/how_states_couldlev.html.

to more than $6 billion, depending on the degree to which states poured pass-through funding into additional reinsurance, which would further reduce premiums and federal subsidies.

The table and figure in this document provide an illustration of the federal costs under two assumptions about the total reinsurance funding: a "lower" $8.5 billion total (seed funding plus pass-through) reinsurance funding level, as well as a "higher" total reinsurance funding of more than $11 billion. The lower pass-through funding would support a premium reduction of about 9 percent, roughly sufficient to offset the 10 percent premium increase expected by repealing the individual mandate. Under the assumption of higher pass-through funding, the premium reduction could be 11-12 percent, more than offsetting the likely impact of the individual mandate repeal.

The federal costs of implementing Collins-Nelson would be approximately $10.5 billion over ten years, regardless of the assumption about how the pass-through funding was calculated and used. For this estimate, we use data from CBO's recent updated baseline for ACA-related coverage and costs,[3] as well as new information about 2018 premium increases from HHS.[4]

Will States Use the Reinsurance Funding?

Of course, these estimates at the national level do not take into consideration that results at the state level could be quite varied. Importantly, it is possible that some states would either decline the funding or would not be able to apply for and implement their 1332 waiver in time to use the federal funding. Some states may be concerned that the federal funding under Collins-Nelson is only available for two years, and might be reluctant to start a program that could require state funding to continue after the federal funding ended. In any event, we assume that the total $10.5 billion made available would be spent, possibly by allocating any untapped funding from nonparticipating states to states that chose to participate.

Under the Collins-Nelson proposal, states would have the option of applying for 1332 waivers to use the available reinsurance funding. State's waivers could contain more than just reinsurance provisions, but would have to at least use a reinsurance or invisible high-risk pool to leverage the federal funds.

CAHC believes most states would participate. Unlike Medicaid expansion, where there were deep ideological arguments from state to state on whether to take the federal funding, reinsurance is a very common, nonideological way to mitigate risk in voluntary insurance markets. In fact, CAHC believes it is a near-essential component of making individual health insurance markets work, alongside other incentives to obtain coverage, such as premium subsidies. CAHC has also argued that states and the federal government should consider additional positive incentives for enrollees to maintain continuous coverage, including premium discounts and other inducements to keep enrollees from dropping out of the insurance market once the individual mandate is repealed.

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[3] Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's September 2017 Projections, available at: https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-09-healthinsurance.pdf.

[4] ASPE Research Brief, Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange (October 30, 2017), available at https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

While 1332 waivers are an excellent way to give states flexibility to shape markets and create innovative programs that are sensitive to states' priorities and opportunities, the preferred House approach is laid out in the House-passed *American Health Care Act* (H.R. 1628).

Under the House-passed bill, states would have a wide variety of options to reduce premiums, improve benefits and otherwise encourage participation in the non-group health insurance market. A federal reinsurance program would act as a fallback for states that did not develop plans to use the funds. This would ensure all states had some form of reinsurance mechanism. CBO estimated that most states would "rely on the default program for one or more years, until they had more time to establish their own programs."[5]

While the House-passed approach would guarantee funds to all states, only states using 1332 waivers would be eligible for pass-through savings from reduced federal subsidies.

Illustration of Budget and Premium Impacts, Modified Collins-Nelson Proposal
FY, Billions of Dollars

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2027
Application and Implementation	0.5										0.5
Reinsurance Funding		5.0	5.0								10.0
"Lower" Pass-Through Assumption											
Premium Tax Credits		-3.5	-3.5								-7.0
Pass-Through Funding to States		3.5	3.5								7.0
"Higher" Pass-Through Assumption											
Premium Tax Credits		-6.2	-6.2								-12.5
Pass-Through Funding to States		6.2	6.2								12.5
Total	**0.5**	**5.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**10.5**
Memorandum:											
CBO Baseline Premium Trend (%)	5%	5%	5%								
Risk Pool Deterioration (varies widely by state) (%)	22%	0%	0%								
Individual Mandate Repeal (%)	0%	10%	0								
Premium Increase Before Collins-Nelson	27%	15%	5%								
"Lower" Pass-Through Assumption											
Potential Reinsurance Pool		8.5	8.5								
Potential Impact on Premiums (%)		-9%	-9%								
"Higher" Pass-Through Assumption											
Potential Reinsurance Pool		11.2	11.2								
Potential Impact on Premiums (%)		-12%	-11%								
Net Premium Increase (low, participating states)	**27%**	**6%**	**-4%**								
Net Premium Increase (high, participating states)	**27%**	**3%**	**-6%**								

Prepared by CAHC Chief Economist Jeff Lemieux and CAHC President Joel White.

[5] Congressional Budget Office, H.R. 1628, American Health Care Act of 2017, Cost Estimate (May 24, 2017) available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.