MILLIMAN WHITE PAPER

# “A” is for affordable

## Impacts of President Biden’s proposed (and some passed) ACA subsidy changes

Fritz Busch, FSA, MAAA
Jason Karcher, FSA, MAAA
Josh Fink, FSA, CERA, MAAA
Barbara Collier, FSA, MAAA
Jason Sciborski, FSA, MAAA

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With Joe Biden’s inauguration as president and the U.S. Supreme Court generally expected to uphold the major provisions of the Patient Protection and Affordable Care Act (ACA),[1] health insurance carriers are starting to re-evaluate their investments and strategies related to participation in ACA individual markets. One critical consideration that will affect these strategies is the impact of premium subsidies on the overall health of the market.

The ACA market is heavily subsidized and has proven to be dependent on advance premium tax credits (APTCs)—or premium subsidies—to improve affordability of coverage and support overall market viability.[2] As a result, changes to the structure and level of subsidies can have a significant impact on enrollment, health status of the risk pool, and what members spend for coverage in premiums and out-of-pocket costs. As a candidate, President Biden proposed a number of changes that would enhance and extend subsidies, which, at face value, appear to be favorable to overall enrollment, member spending, and market viability. As of the time of this article, some of these proposals have been made law as a part of the American Rescue Plan Act of 2021.[3]

In this whitepaper, we explore the pending changes to the amount and structure of subsidies on the individual exchanges as currently contemplated under the Biden administration’s American Rescue Plan. These changes will improve the affordability of silver-level coverage for all subsidized exchange enrollees, regardless of income. Moreover, for the more than 4 million exchange enrollees under 200% of the federal poverty level (FPL)—nearly half of all enrollees—the subsidy improvements will provide either zero-premium or near-zero-premium benchmark silver coverage and will increase the purchasing power of consumers to select a non-benchmark plan. The extension of subsidies past the current 400% FPL limit will also bring new subsidies to nearly 3 million Americans. Finally, we discuss the potential impact of changing the benchmark subsidy plan to a gold-level coverage, which is not currently under consideration but was promoted by President Biden during his campaign.[4]

[1] Howe, A. (November 10, 2020). Argument analysis: ACA seems likely to survive, but on what ground? SCOTUSblog. Retrieved March 7, 2021, from https://www.scotusblog.com/2020/11/argument-analysis-aca-seems-likely-to-survive-but-on-what-ground/

[2] Through the first half of 2020, 86% of exchange enrollees received premium tax credits. See https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Effectuated-Enrollment-First-Half-2020.pdf

[3] See Section 9661 of H.R. 1319, the American Rescue Plan Act of 2021. Full text may be seen at https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf.

[4] Biden Harris. Health Care. Retrieved March 7, 2021, from https://www.joebiden.com/healthcare

# The Biden healthcare platform: An overview

While as vice-president, Biden's early focus in the Obama administration was on economic recovery rather than President Obama's signature healthcare reform efforts, Biden quickly became one of the ACA's biggest cheerleaders and has continued to vigorously defend its reforms.[5] As such, once elected president, Biden's choice to shape his administration's health policy objectives around improvements to and expansion of the ACA surprised few observers and stood in contrast to the focus of many other Democratic Party leaders on variations of Medicare for All.[6] For example, President Biden's signature public option proposal is a revival of one of the last provisions to be cut from the original ACA and is reminiscent of his 2008 campaign platform, which called for expanding the State Children's Health Insurance Program (SCHIP) and the Federal Employees Health Benefit Program.[7] His supplemental proposal to lower the Medicare eligibility age to 60 harkens back to his 2008 promotion of a Medicare buy-in,[8] and expansion of the ACA's premium subsidies has been a Democratic policy priority since the first years of the ACA's marketplaces.[9]

While the overall cost of healthcare is one of America's great economic concerns,[10] consumers in the ACA's individual market are primarily focused on the portion of costs they pay out of pocket (i.e., premiums and cost-sharing). As of this writing, economic disruption driven by the ongoing coronavirus pandemic has contributed to the demand for and political feasibility of enhancements to premium subsidies, with respect to both who is eligible for and the amount of subsidies provided. As we discuss further below, increasing subsidies for those with household incomes below 400% FPL and then extending subsidies beyond the current 400% limit is likely to increase enrollment on exchanges. Please note that this could vary greatly by state depending on factors like the income distribution within the state, the premium levels of the current exchange market, the availability of alternative coverages and other factors.

The Biden administration's two proposed changes to the subsidy structure, and a third potential change,[11] can be summarized as follows:

- Reducing the maximum premium any ACA enrollee pays as a percentage of income up to 8.5% of household income (currently 9.83%)[12]
- Extending subsidies to households with incomes above 400% FPL
- Indexing the premium subsidies to a gold plan instead of a silver plan (referred to as the "gold standard" in this paper)

We examine each one of these changes in more detail below. Given the potentially significant effects on member spending, we discuss in the remainder of this paper how the proposed subsidy changes and a gold standard will impact the premiums and out-of-pocket spending further.

[5] There are many examples of his longstanding defense of the ACA, including this article from 2014: https://www.politico.com/story/2014/01/joe-biden-obamacare-defense-102513 (retrieved March 7, 2021)

[6] Goodnough, A. & Gabriel, T. (June 23, 2019). "Medicare for All" vs. "Public Option": The 2020 field is split, our survey shows. New York Times. Retrieved March 7, 2021, from https://www.nytimes.com/2019/06/23/us/politics/2020-democrats-medicare-for-all-public-option.html

[7] Carey, M.A. (October 23, 2007). Biden unveils health care plan. Commonwealth Fund. Retrieved March 7, 2021, from https://www.commonwealthfund.org/publications/newsletter-article/biden-unveils-health-care-plan

[8] Ibid

[9] There are many examples of a variety of subsidy improvements, including the Affordable Health Insurance for the Middle Class Act, whose full text may be seen at https://www.congress.gov/113/bills/s2908/BILLS-113s2908is.pdf

[10] Commons, J. (September 19, 2018). Healthcare spending at https://www.healthleadersmedia.com/finance/healthcare-spending-20-gdp-thats-economy-wwide-problem

[11] Changing the subsidy benchmark plan to a gold level plan is discussed on the Biden Harris website at https://joebiden.com/healthcare/

[12] This value has been indexed each year for growth in premiums in excess of income since 2014, and on average grows 0.1%-0.2% each year, though there is wide variation in each direction.

## Reducing the maximum premium limit to 8.5% of income

For 2021, the highest amount of premium required to be paid for the silver benchmark plan on the ACA exchanges is 9.83% of income for those qualifying for premium subsidies.[13] The 9.83% out-of-pocket premium limitation is applicable for enrollees with incomes between 300% FPL and 400% FPL (between $38,280 and $51,040 for a single adult in 2021).[14] Enrollees with lower income levels as a percentage of FPL have lower out-of-pocket premium limits. As indicated in the legislative language of the American Rescue Plan Act of 2021 (ARP),[15] under President Biden's healthcare proposal, out-of-pocket premium maximums at all levels of income would drop, resulting in the increased subsidies as shown in Figure 1.[16]

For the 300 to 400% FPL corridor, there is a larger annual impact to premium subsidies of $1,466 for those with incomes of 300% FPL because the premium limit is moving from 9.83% to 6%, whereas there is a smaller annual impact to premium subsidies (and thus net member premiums) of $679 because the premium limit is only moving from 9.83% to 8.5% for those with incomes of 400% FPL. Similarly, the large $2,993 premium subsidy increase in the over-400% FPL group happens for those with incomes just above 400% FPL, which we discuss in more detail in the next section below.

**FIGURE 1: BENCHMARK PREMIUM LIMITS BY INCOME LEVEL, CURRENT LAW AND UNDER ARP**

| | | Premium Limits as % of Income | | |
|---|---|---|---|---|
| **FPL Corridor** | **Associated Income Level (continental US)** | **Current - 2021** | **Under ARP** | **Annual Increase to Premium Subsidies** |
| Under 100% | Under $12,760 | Ineligible | Ineligible | N/A |
| 100 to 133% | $12,760 to $16,971 | 2.07% | 0% | $264 to $351 |
| 133 to 150% | $16,971 to $ 19,140 | 3.10% to 4.14% | 0% | $526 to $792 |
| 150 to 200% | $19,140 to $25,520 | 4.14% to 6.52% | 0% to 2% | $792 to $1,154 |
| 200 to 250% | $25,520 to $31,900 | 6.52% to 8.33% | 2% to 4% | $1,154 to $1,381 |
| 250 to 300% | $31,900 to $38,280 | 8.33% to 9.83% | 4% to 6% | $1,381 to $1,466 |
| 300 to 400% | $38,280 to $51,040 | 9.83% | 6% to 8.5% | $679 to $1,466 |
| Over 400% | Over $51,040 | Ineligible | 8.5%* | $0 to $2,993 |

*The extension of subsidies past 400% FPL is discussed in the next section. We introduce it here for convenience.

Figure 2 illustrates the incremental effects this change would have on an individual with a pre-subsidy $611 monthly benchmark silver plan premium. The blue section of the graph represents the additional premium subsidies an individual would receive under the ARP.

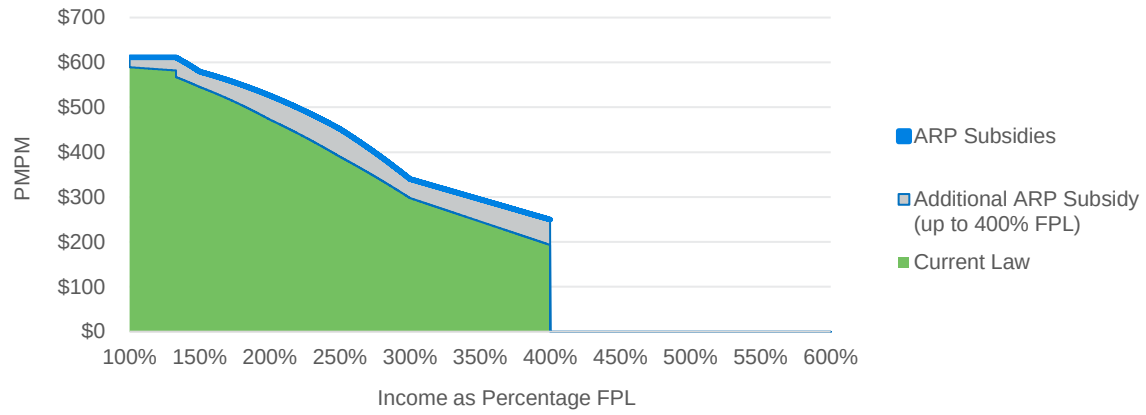
[13] The IRS published required contribution percentages for 2021 in this revenue procedure 2020-36. Retrieved March 7, 2021 from https://www.irs.gov/pub/irs-drop/rp-20-36.pdf

[14] Income limits used for determining required contributions are the HHS federal poverty guidelines published in January of the prior year. For 2021, incomes are measured against the 2020 federal poverty guidelines, which can be found here: https://www.federalregister.gov/documents/2020/01/17/2020-00858/annual-update-of-the-hhs-poverty-guidelines

[15] Full text of the legislation may be viewed at https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf. Note that the table on p.180 will only apply for 2021 and 2022, and will not be updated for inflation.

[16] We have illustrated premium subsidies for a benchmark plan with a national average benchmark premium for an individual age 50. Subsidy changes will be higher or lower depending on age, family size, and actual benchmark premium level.

**FIGURE 2: CY 2021 PREMIUM SUBSIDY ILLUSTRATION, SINGLE, 50 YEAR OLD, $611 MONTHLY BENCHMARK PREMIUM**




As shown in Figure 2, there is marginal improvement to the actual subsidy amount as well as the subsidy cliff at 400% FPL. Figure 3 shows the net (after subsidy) consumer premiums before and after the subsidy change proposed in ARP for enrollees of up to 400% FPL.

**FIGURE 3: CONSUMER NET PREMIUMS: CURRENT LAW AND AFTER ARP PASSAGE (AGE 50, NATIONAL AVERGE BENCHMARK SILVER)**

**Subsidy Eligibility by FPL Level – Current and ARP**
**Single Household, Age 50, National Average Benchmark Premium**

| % FPL | Pre-ARP Net Premium | ARP Consumer Premium | $ Change | % Change |
|---|---|---|---|---|
| 133% | $29.27 | $0.00 | -$29.27 | -100% |
| 150% | $66.03 | $0.00 | -$66.03 | -100% |
| 200% | $138.66 | $42.53 | -$96.13 | -69% |
| 250% | $221.44 | $106.33 | -$115.11 | -52% |
| 300% | $313.58 | $191.40 | -$122.18 | -39% |
| 400% | $418.10 | $361.53 | -$56.57 | -14% |

While the actual *dollar* difference in premiums is relatively small, Figure 3 illustrates the material *percentage* decrease at most income levels as well as the zero-premium opportunities for enrollees with incomes up to 150% FPL. These reductions in net premiums may create a strong incentive to enroll for eligible consumers at lower income levels currently not enrolled. According to the Centers for Medicare and Medicaid Services (CMS) open enrollment data, over half of the exchange enrollees have incomes less than 200% FPL, which means that almost 5 million[17] consumers will now see zero or very low (less than $50) monthly premiums under ARP.

In addition, with larger subsidies, consumers will likely have greater access to zero-premium *non-benchmark plans* at the gold, silver, and bronze levels. Figure 4 illustrates the estimated percentage of 27 year olds and 50 year olds across the country who will have access to at least one zero-premium coverage option under current subsidy levels and under the subsidies proposed in the ARP.

[17] State-level open enrollment eligibility and plan selection data for the 2020 open enrollment period is published by CMS in a public use file. Retrieved March 7, 2021 from https://www.cms.gov/files/zip/2020-oep-state-level-public-use-file.zip

As illustrated in Figure 4, because subsidies are richer under the ARP, the number of subsidized enrollees with access to zero-premium coverage offerings increases across all metallic levels. For example, based on the 2019 distribution of membership[18] by rating area and assuming age-50 enrollees are distributed identically to the aggregate marketplace population, 13.7% of age-50 enrollees across the country with incomes at 200% FPL currently have access to at least one zero-premium bronze plan. This increases to 85.4% under the ARP.

**FIGURE 4: ESTIMATED PERCENTAGE OF MEMBERSHIP ACROSS RATING AREAS WITH ACCESS TO ZERO NET PREMIUM 2021 ACA EXCHANGE PLANS**

| | | Age 27 | | Age 50 | |
|---|---|---|---|---|---|
| **Metal Level** | **Income as % FPL** | **Current** | **ARP** | **Current** | **ARP** |
| Bronze | 100% | 100% | 100% | 97% | 100% |
| | 150% | 79% | 100% | 97% | 100% |
| | 200% | 14% | 97% | 64% | 100% |
| | 250% | 1% | 32% | 14% | 85% |
| | 300% | 0% | 2% | 2% | 24% |
| | 400% | 0% | 0% | <1% | 1% |
| Silver | 100% | 11% | 100% | 25% | 100% |
| | 150% | 2% | 100% | 6% | 100% |
| | 200% | 0% | 6% | 2% | 10% |
| | 250% | 0% | <1% | 0% | 3% |
| | 300% | 0% | 0% | 0% | 0% |
| | 400% | 0% | 0% | 0% | 0% |
| Gold | 100% | 7% | 29% | 18% | 29% |
| | 150% | 1% | 29% | 4% | 29% |
| | 200% | 0% | 3% | 1% | 7% |
| | 250% | 0% | <1% | 0% | 2% |
| | 300% | 0% | 0% | 0% | <1% |
| | 400% | 0% | 0% | 0% | 0% |

Note: The frequency of zero premium plans for a family of 4 consisting of two adults age 30 and two children age 0 to 14, is similar to a single adult age 50.

While Figure 4 is a national composite view, there will be state and even rating area variability among zero-premium plans. In addition to the metallic level, income, and age shown above, the number of zero-premium plans will also vary by the cost-sharing reduction (CSR) load in the benchmark plan (higher load means higher subsidies and thus more zero-premium plans) and the general level of healthcare costs in a geography.

Based on 2020 effectuated enrollment figures from CMS,[19] currently subsidized individuals represent more than 86% of exchange enrollees in the individual market across the United States (around 9 million individuals). Moreover, the currently uninsured population with qualifying incomes below 400% FPL may find reduced premiums affordable enough with the increased subsides to now enroll. Based on data published by the Congressional Budget Office (CBO) in September 2020, up to 5 million of the approximately 31.5 million people uninsured in 2021 may be able to obtain a lower out-of-pocket premium rate if this change takes effect, all else equal.[20] Based on its initial analysis of

[18] We use 2019 distributions by area due to limitations in CMS open enrollment data. The Risk Adjustment Report data has data for all exchanges, both state-based and those operating on the federal healthcare.gov platform.

[19] CMS. Average Monthly Total Premium and Average Monthly APTC Methodology. Retrieved March 7, 2021, from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2016-2020-Effectuated-Enrollment-Tables.xlsx (Excel download).

[20] CBO (September 29, 2020). Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030—Data Underlying Figures, Figure 6. Retrieved March 7, 2021, from https://www.cbo.gov/system/files/2020-09/56571-Data-Underlying-Figures.xlsx (Excel download).

the House Ways and Means proposal, almost 2 million people would enroll in new coverage.[21] However, President Biden has pledged to increase funding for advertising, which could serve to increase awareness and take-up of marketplace coverage.[22]

## Extending premium subsidies past 400% FPL

President Biden's healthcare proposals under ARP also seek to extend subsidies past the 400% FPL mark, with no new limit being proposed. At a minimum, this would eliminate what has been called the "subsidy cliff." This effect is the loss of subsidies when an individual or family makes one additional dollar of income above the current 400% FPL limit, thereby becoming ineligible for premium subsidies, as previously shown in Figure 2 above. This is illustrated in more detail in Figure 5, using the previously discussed income limit of 8.5% on consumer out-of-pocket premiums.

**FIGURE 5: ILLUSTRATION OF PREMIUM SUBSIDY CLIFF**

| | | 400% FPL | 400% FPL +$1 | Change |
|---|---|---|---|---|
| **(A)** | Annual Income | $51,040 | $51,041 | $1.00 |
| **(B)** | Income Cap | 8.50% | NA | |
| **(C) = (A) x (B)** | Annual Net Premium Limit | $4,338 | NA | |
| | | | | |
| **(D) = $611 x 12** | Annual Gross Premium | $7,332 | $7,332 | $0.00 |
| **(E) = (D) - (C)** | Subsidy | $2,994 | $0 | -$2,994 |
| | As % of Income | | | -5.86% |

Note: Totals may not match due to rounding.

As Figure 5 shows, the loss of subsidies is substantial for a 50 year old enrolling in a national average benchmark plan after income passes 400% FPL by $1, amounting to about 6% of an enrollee's income, leaving the person materially worse off financially. Depending on the region, the loss of subsidies can exceed 20% of income.[23] Thus, eliminating the cliff entirely by not imposing a new but higher income limit will allow enrollees in the highest income brackets to increase their income and be more likely to retain coverage without incurring a net financial penalty for the increased income. Figure 6 shows how extending subsidies would eliminate this cliff and create a smoother slope to premium subsidies. Note that for illustration purposes, the graph in Figure 6 only displays subsidies through incomes 600% FPL, but subsidies would exist for incomes even beyond this level.

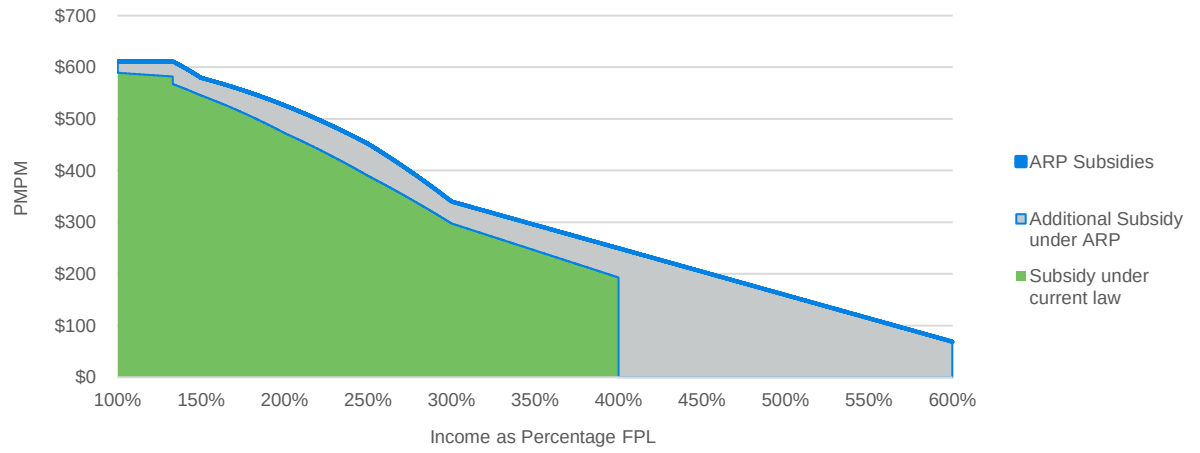
Subsidies grow across the income spectrum, but the greatest dollar increases in subsidies can occur for those just above 400% FPL, though this does depend entirely upon premium cost. Again, looking at this from the point of view of net premiums for the second-lowest-cost silver plan (SLCSP), we can see the clear impact of the subsidy cliff and the more uniform increase in net health premium costs around the 400% FPL marker—a significant difference with our $611 national average SLCSP for an individual age 50.

[21] CBO estimates about 1 million new enrollees under 400% FPL and about 0.7 million enrollees over 400% FPL would enroll. See page 13 of. https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

[22] Andrews, M. (February 16, 2021). The ACA Marketplace Is Open Again for Insurance Sign-Ups. Here's What You Need to Know. Retrieved March 7, 2021 from https://khn.org/news/article/the-aca-marketplace-is-opening-again-for-insurance-sign-ups-heres-what-you-need-to-know/.

[23] With a benchmark premium of $1,231 per month, a 50-year-old in Monroe County, Florida whose income increased from $51,040 to $51,041 would lose out on a $10,437 subsidy—about 20.4% of income.

**FIGURE 6: 2021 PREMIUM TAX CREDIT, HOUSEHOLD SIZE 1**




Approximately 3 million individuals are uninsured in households with incomes above 400% FPL and have no access to subsidized employer sponsored coverage.[24] As with current subsidies, these new subsidies will benefit those with the highest costs, including those in higher-cost areas and older individuals who experience higher premiums under the ACA's age rating curve. But many of these 3 million will not benefit (or will not perceive sufficient benefit) from new subsidies and still choose not to enroll. Therefore, actual new enrollment is likely to be far less. For example, for those with incomes materially higher than 400% FPL, the tax credit may not be a large enough incentive (which at some point becomes zero) to purchase coverage. Uninsured who are younger or in lower-cost areas may also find the new subsidy too small to motivate them to seek out coverage. In a few cases, the gross premiums (i.e., pre-subsidy) for the second-lowest-cost silver plan may be below 8.5% of 400% FPL, in which case this change will not create any new premium credits. Because of these situations, the CBO projects that roughly only around 700,000 will take coverage with the additional subsidies available.[25]

### ACA SUBSIDY BASICS

Under the ACA, qualified individuals making less than 400% FPL are eligible for subsides, such that they pay no more than a fixed percentage of the income for silver-level coverage. Silver-level coverage is generally considered a medium level of benefit richness, covering about 70% of medical and prescription drug expenses. If an enrollee wants richer coverage, such as that offered by a gold plan (which covers about 80% of healthcare expenses), they can buy up and pay the difference in price between the silver and the gold plans.

Subsidy amounts are calculated using the "benchmark silver plan" for each county in a state. The benchmark silver plan is the second-lowest-priced plan offered in that county. As an example, assume that the benchmark silver plan in County A costs $500 and a person's annual income is 200% FPL or $25,520 in 2021. According to federal guidelines, this person will not pay more than 6.52% of income for coverage, meaning they will pay not more than (.0652 x 25,520) / 12 or about $138 monthly for coverage. Therefore, they will receive an advance premium credit of $500 to $138 or $362. Under the ARP, this member would not pay more than 4% of income, or about $84 per month, and would receive a premium credit of $416 for the same plan.

Under the gold standard (discussed in this paper), this enrollee would receive gold-level coverage for the same $138 (or $84 under the ARP's subsidies). This would decrease out-of-pocket medical expenses for services covered under the policy by about a third on average (from about 30% of plan costs to about 20% of plan costs).

[24] CBO, Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030—Data Underlying Figures, op cit.

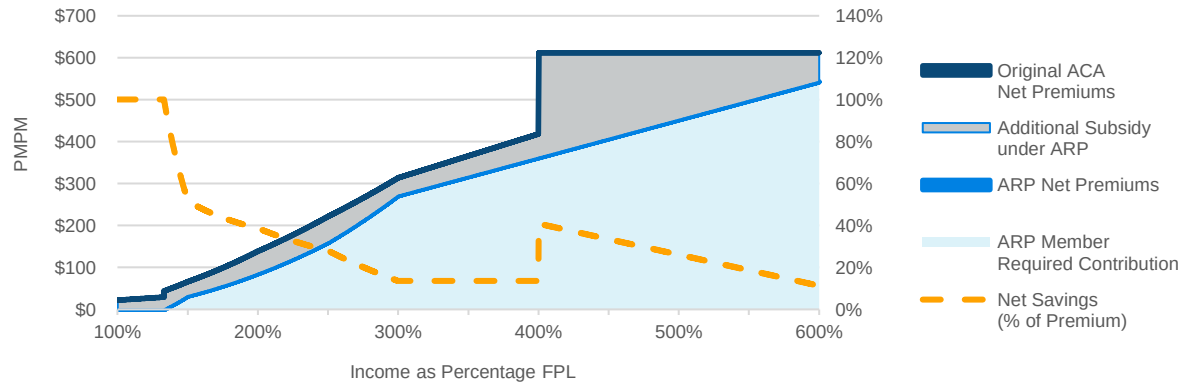
[25] CBO (February 17, 2021). At a Glance: Reconciliation Recommendations of the House Committee on Ways and Means, page 13. Retrieved March 7, 2021, from https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

While changes to affordability in the ACA individual market are important because it is the market of last resort,[26] this market covers only about 10% of those with private coverage.[27] But improvements in subsidies beyond the 400% FPL mark could also affect the much larger employer-sponsored insurance market, although that impact is less straightforward due to the more complex trade-offs employers face. However, with the advent of the Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) under the 21st Century Cures Act in 2015 and then by the creation of Individual Coverage Health Reimbursement Arrangements (ICHRAs) through regulation in 2019,[28] there are now tax-preferred vehicles to facilitate employers providing coverage in the individual market. Improved subsidies under 400% FPL, new subsidies above 400% FPL, and the elimination of the subsidy cliff could provide additional incentives for employers to explore individual coverage in lieu of traditional group coverage. The appeal of this is dependent on, among other things, the relationship between premiums in the small group and individual markets; in many states, small group premiums are noticeably lower for similar plans, which could limit the appeal of a QSEHRA to employees and employers.

## Indexing premium subsidies to gold instead of silver premiums

A significant proposal in President Biden's election platform (but not as yet proposed in Congress) is to change the indexing of subsidies from the second-lowest-cost silver plan to the second-lowest-cost gold plan, which we refer to as the "gold standard" in this paper. This would mean that, all else equal, a subsidized individual who has currently selected the benchmark silver plan and is receiving a subsidy based on either the current or proposed percentages of income described in Figure 7, could receive gold level coverage for no additional cost.[29] Coverage under a gold plan would be richer, reducing the individual's annual out-of-pocket expense on average by a third (for persons not qualifying for a CSR plan),[30] while leaving the net premium (after federal subsidy) the same.

**FIGURE 7: 2021 SECOND-LOWEST-COST SILVER NET PREMIUM UNDER CURRENT LAW AND AFTER ARP CHANGES**




### OPTIONS FOR CSR PLANS

One of the unknowns related to implementation of the gold standard is how cost-sharing reduction (CSR) plans would operate. Currently, an eligible enrollee making less than 250% FPL qualifies for a silver plan that has reduced member cost-sharing requirements compared to a standard silver plan, with an average member responsible for approximately 27%, 13%, or 6% of medical expenses (compared to about 30% for the standard silver plan), depending on the enrollee's income level. Tying these richer CSR variations to the benchmark metallic level ensures that eligible individuals can find plans with premiums that are affordable according to the federal standard.

[26] Individuals generally enrolled in individual market coverage only when they do not have access to other coverage.

[27] CBO (September 29, 2020). Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030, page 22. Retrieved March 7, 2021, from https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf,

[28] QSEHRAs are only available to small employers, but can integrate with premium subsidies. ICHRAs are available to all employers, but do not integrate with premium subsidies.

[29] Increased subsidies would generally increase the number of zero-premium plans, but otherwise do not materially affect the results of our analysis.

[30] The average out-of-pocket expense under a silver plan is 30% and under a gold plan its 20%.

Under the gold standard, the benchmark plan would be a gold-level plan, which might imply that CSR plans would also be based on the gold benchmark plan to maintain guaranteed affordability. However, due to the complexities of federal laws and regulations related to CSR subsidies, which are beyond the scope of this paper, it is not a foregone conclusion that CSR plans would be tied to a gold benchmark. The situation is further complicated by the current absence of federal funding for cost-sharing subsidies, which has resulted in most issuers increasing premiums to silver plans to cover the additional cost—a practice known as silver loading (see the What Is CSR Loading? sidebar).[31]

This leads to three alternatives for CSRs under a gold standard, relative to the current silver benchmark, silver CSR status quo:

1. **Gold standard, silver CSRs:** Subsidies are indexed to the second-lowest-cost gold plan, but CSR plans remain tied to silver plans, and "silver loading" remains.

   One anticipated side effect of this arrangement is the likely shift of non-CSR silver members to gold plans under the gold standard. This movement away from silver will decrease the membership volume upon which a load could be applied. Moreover, most remaining enrollees in silver plans would have 87% and 94% CSR plans, whereas the current distribution includes some members at the 73% level. These combined dynamics serve to increase the silver load to an estimated 29%.[32] This is illustrated in Figure 8.

2. **Gold standard, gold CSRs**: CSR plans shift to gold plans, and "gold loading" occurs.

   If CSR plans shift to gold plans, then the 73% silver variant could be eliminated, because the standard gold plan would be richer. In addition, if CSR plans are aligned with the gold benchmark plan, we estimate the CSR load to premiums would be materially reduced from about 23% (the current nationwide average silver load) to about 10% (the anticipated nationwide gold load)[33] due to a smaller actuarial value (AV) difference between the CSR 87% and CSR 94% plans and the standard gold plan. This is illustrated in Figure 9.

3. **Gold standard, funded CSRs[34]:** Federal funding for CSRs is restored and the location of CSR plans is less important to premium levels, because no CSR loading would exist.

**FIGURE 8: ESTIMATE OF CSR LOADS TO SILVER BENCHMARK (CURRENT LAW) AND UNDER A GOLD BENCHMARK WITH SILVER CSR PLANS**

| Silver Plan | Estimated CSR Load by Plan | 2020 Enrollment Distribution | Projected Enrollment Distributions Under Gold Benchmark / Silver CSRs |
|---|---|---|---|
| **Standard** | 0.0% | 15% | 4% |
| **73 CSR** | 4.3% | 12% | 0% |
| **87 CSR** | 24.3% | 26% | 34% |
| **94 CSR** | 34.3% | 47% | 62% |
| **Total** | NA | 100% | 100% |
| **Estimated Composite CSR Load** | | 23.1%[35] | 29.5% |

[31] Three states—Indiana, Mississippi, and West Virginia—currently require issuers to spread these costs over all plans, a practice called broad loading.

[32] Ibid.

[33] Based on Milliman analysis of distribution of enrollment by FPL in the 2020 CMS Open Enrollment report and CSR membership distributions from state exchange data.

[34] Like premium tax credits, CSR funding appears to clear the procedural hurdles of budget reconciliation.

[35] CMS estimated a composite CSR load of 20% in 2018 for FFE states here: https://www.federalregister.gov/documents/2020/02/10/2020-02472/basic-health-program-federal-funding-methodology-for-program-year-2021#p-139. Our estimate is higher for a number of reason but does not materially affect results.

**FIGURE 9: ESTIMATE OF CSR LOADS TO GOLD BENCHMARK WITH GOLD CSR PLANS**

| Gold Plan | Estimated CSR Load Under Gold Standard | Gold Standard Gold CSRs |
|---|---|---|
| Standard Gold | 0% | 34% |
| (No 73 CSR) | | |
| 87 CSR | 9% | 24% |
| 94 CSR | 18% | 43% |
| - | - | 100% |
| **Estimated Composite CSR Load** | | **9.5%** |

### WHAT IS CSR LOADING?

Under the ACA, eligible enrollees with incomes between 100% and 250% FPL can enroll in a silver-level benefit plan (which normally covers approximately 70% of healthcare expenses) with reduced member cost sharing (the plan covers 73%, 87% or 94% of expenses, depending on enrollee income). The ACA was originally designed so that issuers would be reimbursed for this reduced cost-sharing directly by the federal government. In response to a federal court ruling, this funding ceased in October 2017, even as carriers were forced to continue providing these richer benefits. With support from state regulators, issuers responded by increasing rates, whether on all metal plan offerings on the exchange or by increasing premium rates on their silver exchange offerings only (known as silver loading). Carriers can offer separate off-exchange only silver plans without the cost of silver loading to market to members with higher incomes who are not eligible for subsidies.

As the market has evolved, silver loading has been encouraged by regulators, primarily because it results in the largest increase to premium subsidies, and only three states (Indiana, Mississippi, and West Virginia) load CSRs to all plans. Due to silver loading, members who choose the benchmark plan pay roughly the same premium net of subsidies compared to when CSRs were funded directly by the federal government, but the higher subsidies increase affordability for subsidized enrollees' choosing bronze or gold plans.

## MODELING THE CHANGE TO GOLD AS THE BENCHMARK PLAN

To understand the relative changes to subsidies of a switch to the gold standard, we gathered 2021 premium rates from 48 states at the bronze, silver, and gold metallic levels for all rating areas within each state (we excluded Massachusetts and Vermont, because their individual and small group markets are merged, and we also excluded the District of Columbia). We assumed that under the gold standard, the second-lowest-cost gold plan would become the benchmark plan. We did not attempt to estimate future premium rates or rate increases, but rather modeled relative changes in known 2021 premium rates under the three CSR scenarios described above. However, we did model estimated changes to the CSR loads for both silver and gold plans as detailed in the previous sections.

Under any of the CSR scenarios, subsidized consumers would always be responsible for the same percentage of their incomes for benchmark coverage. An enrollee's premium would not exceed the income percentage described in Figure 1 above. However, if a subsidy-eligible enrollee wants to purchase coverage other than the benchmark plan, premium subsidy generosity will drive an important feature of the subsidized ACA market for this individual: the availability of zero-premium plans. In short, the higher the benchmark premium, the higher the premium subsidies and the more likely it is that the consumer will have a zero-premium coverage option.[36] As we have previously seen in Figure 4 above, the projected distribution of zero-premium plans by age, metallic level, and income is greater under the ARP. However, this still assumes that the benchmark plan is the second-lowest-cost silver and that CSRs continue to be funded with a silver loading.

[36] Zero-premium coverage results when a consumer eligible for subsidies selects a plan that has a lower premium than the benchmark plan—enough so that the plan premium is actually less than their federal premium subsidy.

To get a more comprehensive view of this key metric of affordability (i.e., the availability of zero premium plans) under the various gold standard scenarios, we model the anticipated member movements across metallic levels, model the new required CSR loads for each metallic level and each state, and then summarize the likelihood that zero-premium plans exist for each rating area and income level for a given age. Figure 10 displays the results of this analysis.

**FIGURE 10: PERCENTAGE OF AGE 50 MEMBERSHIP LIVING IN REGIONS WITH A ZERO PREMIUM 2021 EXCHANGE PLAN UNDER VARIOUS BENCHMARK AND CSR SCENARIOS**

| | | | Gold Standard Scenarios, ARP Income Limits | | |
|---|---|---|---|---|---|
| **Metal Level** | **Income as % FPL** | **ARP Silver Benchmark, Silver CSR** | **Silver CSR** | **Federal Funded CSR** | **Gold CSR** |
| Bronze | 100% | 100% | 100% | 100% | 100% |
| | 150% | 100% | 100% | 100% | 100% |
| | 200% | 100% | 100% | 100% | 100% |
| | 250% | 85% | 100% | 100% | 100% |
| | 300% | 24% | 68% | 67% | 88% |
| | 400% | 1% | 8% | 7% | 19% |
| Silver | 100% | 100% | 78% | 100% | 100% |
| | 150% | 100% | 78% | 100% | 100% |
| | 200% | 10% | 56% | 100% | 100% |
| | 250% | 3% | 24% | 90% | 96% |
| | 300% | 0% | 6% | 50% | 69% |
| | 400% | 0% | <1% | 5% | 11% |
| Gold | 100% | 29% | 100% | 100% | 100% |
| | 150% | 29% | 100% | 100% | 100% |
| | 200% | 7% | 16% | 16% | 18% |
| | 250% | 2% | 5% | 5% | 7% |
| | 300% | <1% | 1% | 1% | 1% |
| | 400% | 0% | <1% | <1% | <1% |

The following observations can be made based on Figure 10:

- All three of the gold standard scenarios are favorable to the current environment (silver benchmark with silver CSRs), because the gold standard raises premium subsidies overall. The benefit to consumers, as measured by the availability of zero-premium plans, is only a matter of degree between each scenario.
- The gold standard/gold CSRs scenario is the most favorable to consumers (the darkest green) and substantially increases the likelihood of zero-premium plan availability across income levels, geographic areas, metallic levels, and ages. Zero-premium bronze and silver plans would be available for income levels as high as 250% FPL for a majority of members age 50 in the United States. Based on 2021 benefit offerings and insurer pricing practices, there would be a significant number of zero-premium gold plans available for enrollees whose income is near 100% FPL.
- For the gold standard/federal-funded CSRs scenario, the availability of zero-premium plans increases over the current environment and is almost identical to the gold standard/silver CSRs scenario for gold and bronze plans, but is superior for consumers when it comes to silver plans. This is because the federal funding of CSR removes the silver loading under this scenario, making those plans cheaper, and thus more plans become available at no cost.

## Conclusion

The recent trend of more carriers entering the ACA individual market may continue as membership opportunities present themselves if legislation is passed as early as 2021. Carriers will likely have new opportunities to increase their enrollment if membership in the overall individual market swells as a result of the subsidy increases in the ARP, and even more so if a gold standard is adopted. The combined effect of the enhanced subsidies currently being considered and the potential change to a gold-level benchmark plan would significantly improve affordability of benchmark coverage and increase the affordability of a number of other plan choices that are associated with no or very low net consumer premiums. Re-tooling a product portfolio centered on gold as opposed to silver and careful plan design at all metallic levels with prudent pricing will be critical to winning share and remaining profitable as overall market size increases.

Individual market enrollment increases will likely come primarily from the currently uninsured. However, additional enrollees could increasingly come from small and large employers through the use of a tax-preferred health reimbursement arrangement (HRA) such as the Qualified Small Employer HRA (QSEHRA) or the Integrated Coverage HRA (ICHRA). With the subsidy cliff eliminated, employers could see exchanges as more appealing than in the past.

As a Democrat-led Washington, D.C. makes the first steps of its latest foray into healthcare reform, there are many questions remaining about what additional moves might look like, beyond the enhancement of subsidies. To succeed, carriers will need to stay abreast of what will certainly be a fast-paced reform legislative schedule and be ready to model opportunities from a risk and revenue standpoint.

## Caveats and limitations

In preparing this paper, we relied on legislative text H.R. 1319, the American Rescue Plan Act of 2021, as passed by the Senate on March 6, 2021 and approved by the House on March 10, 2021, enrollment information published by CMS, and analyses published by the Congressional Budget Office. Any changes to the legislation or the assumptions underlying these analyses will impact the conclusions found in this article.

We are not attorneys and nothing included in this article should be interpreted as legal advice.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Fritz Busch, Jason Karcher, Josh Fink, Barbara Collier, and Jason Sciborski are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this article.

Milliman



**CONTACT**

Fritz Busch
fritz.busch@milliman.com

Jason Karcher
jason.karcher@milliman.com

Josh Fink
josh.fink@milliman.com

Barbara Collier
barbara.collier@milliman.com

Jason Sciborski
jason.sciborski@milliman.com