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The Patient and State Stability Fund: What happens now?

Kathleen E. Ely, FSA, MAAA
Thomas D. Murawski, FSA, MAAA
Paul R. Houchens, FSA, MAAA

Milliman

The future of the Patient Protection and Affordable Care Act (ACA) is still in question. Conversations continue about its repeal and replacement even though a potential replacement, the American Health Care Act of 2017 (AHCA), was scuttled at the end of March. Several aspects of the ACA have been under consideration for change: Medicaid reforms, taxes, premium credits, subsidies, and the individual and employer mandates. Another feature under consideration is the Patient and State Stability Fund (PSSF), a grant program to states intended to stabilize individual and small group state insurance markets and to lower patient costs. This paper discusses elements of the PSSF as they were originally proposed by the AHCA on March 6, 2017, and outlines important considerations for different stakeholders.

Patient and State Stability Fund overview

The PSSF would have appropriated a total of $100 billion to states over the period 2018 through 2026. The funds under this program could be used in a number of ways,[1] including:

- Providing financial assistance to high-risk individuals who do not have access to health insurance coverage offered through an employer
- Providing incentives to appropriate entities to enter into arrangements with states to help stabilize premiums for health insurance coverage in the individual market
- Reducing the cost for providing health insurance coverage in the individual market and small group market to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost)
- Promoting participation in the individual market and small group market and increasing health insurance options available in those markets
- Promoting access to preventive, dental, and vision services, and to prevention, treatment, or recovery support services for individuals with mental or substance use disorders
- Providing payments, directly or indirectly, to healthcare providers for the provision of such healthcare services as defined by the Centers for Medicare and Medicaid Services (CMS)
- Providing assistance to reduce the out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage

As Republicans have tried to reach consensus on the content of the AHCA, several modifications have been proposed and added to the legislative language of the bill, some of which would impact the PSSF. One proposal split mental health and substance abuse (MHSA) services from the promotion of access to preventive and other services usage, expanded this to include early identification of children and young adults with serious mental illness, added maternity coverage and newborn care as an allowed usage, and allocated a total of $15 billion starting in 2020 for both the MHSA and maternity/newborn usage categories, to be allocated consistent with the other 2020 allocations.[2] A further amendment proposed to create a federal invisible risk sharing pool, funded with $15 billion as well as any unused funds from states electing the default reinsurance pool.[3] It is unclear if this funding will be sufficient to sustain this program.[4]

Additionally, the CBO released an additional report addressing the initial round of changes to the AHCA. While the underlying health coverage and premium cost impacts are not affected, the overall budget savings are reduced to $150 billion over the 10 year window.[5] This estimate does not include the impact of the amendments discussed above.

1 See Section 2202 of the full Energy and Commerce bill at https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/AmericanHealthCareAct.pdf.

2 https://rules.house.gov/sites/republicans.rules.house.gov/files/115/policymngr-amdt.pdf

3 http://amendments-rules.house.gov/amendments/hirisk0246171129382938.pdf

4 Milliman analyzed funding requirements for variations on a preliminary version of this proposal, with estimates running from $3.3 to $17.0 billion. https://thefga.org/wp-content/uploads/2017/04/The-Federal-Invisible-High-Risk-Pool.pdf

5 https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf

If a state does not apply for funding or has an application that is denied, the funds that would have been allocated to that state would be used for a reinsurance program in that state. For 2018 and 2019, the reinsurance program would pay 75% of claims for individual policies and between $50,000 and $350,000 to the insurers in the market. CMS may establish different parameters for this program in 2020 and later.

In 2018 and 2019, $15 billion would be available each year to distribute to all states and the District of Columbia. Allocation in those years was to be primarily based on a state's total incurred claims[6] relative to other states (85% of total), and on the state's relative uninsured and insurer participation rates (15% of total). A state would be eligible for additional funding to the extent the decrease in its uninsured rate for individuals falling below the federal poverty level (FPL) was less than the decrease in the national average from 2013 to 2015 or the state had fewer than three insurers participating in its insurance marketplace in 2017. This funding is distributed proportionally to the number of uninsured below the federal poverty level in qualifying states, relative to the uninsured count for all qualifying states. For example, if a qualifying state had 500,000 uninsured, relative to 5 million in all qualifying states, it would receive 10% of the additional funding.

Beginning in 2020, the fund would appropriate $10 billion annually. From 2020 to 2026, allocations were to be determined based on cost, risk, the low-income insured population, and issuer participation. The exact methodology was not proposed and was to be developed through consultation with key stakeholders, including consumers, insurers, state regulators, and others.

States would have been required to apply for 2018 funding within 45 days of passage of the bill and in subsequent years by March 31 of the year before funding is requested. However, once an application is approved for a given year, it would automatically be approved for each year through 2026 with respect to the use of funds described in the initial application. This would suggest that states wouldn't need to reapply for funds every year. Similar to Medicaid funding, states are required to make matching funds available each year beginning in 2020. As illustrated in the chart in Figure 1, the schedule of the required matching will vary based on whether a state has developed its own program for using the funds or is using the default CMS reinsurance program. By 2026, states would be required to contribute 50% of federal funds allocated to their PSSFs, creating aggregate national PSSF funding of $15 billion (assuming all states participated).

State-level estimates of the federal allocation and state-required funding for 2018 through 2026 are provided in the appendix[7] of this report. Allocations for 2019 through 2026 assume state funding proportional to 2018.[8] It should be stressed that actual allocations may vary significantly based on the insurance markets included in the definition of a state's incurred claims calculation as well as the source of the uninsured estimate. For example, if the definition of incurred claims is limited to the individual market, California's estimated 2018 allotment is approximately $1.7 billion. However, if fully insured small group and large group adjusted incurred claims are included, California's allotment increases to $2.4 billion. *The estimates contained in the appendix reflect the sum of incurred claims in the individual and fully insured group markets.*[9] Stakeholders should understand the sensitivity of incurred claim definitions and other allocation methodologies as proposed legislation evolves.

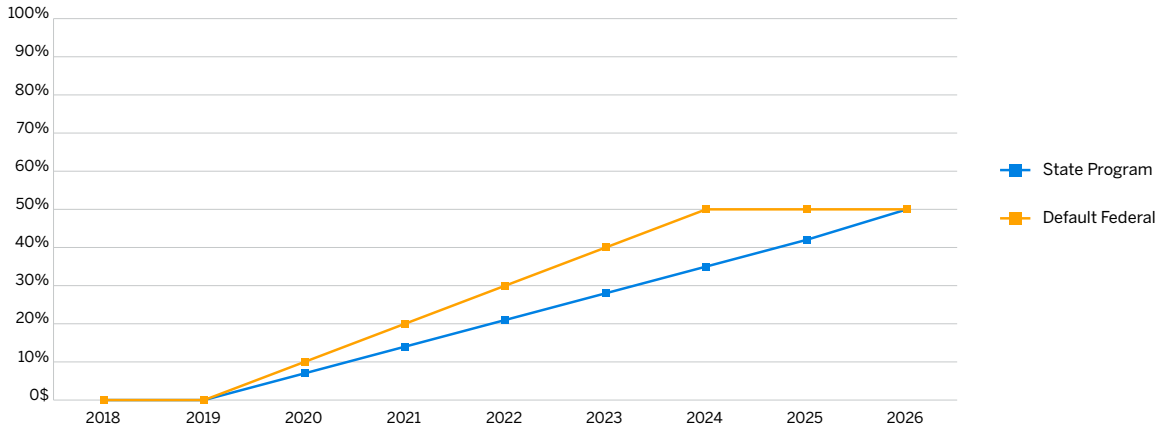
6 The text of the bill does not specify which market(s) should be included in the incurred claim totals.

7 To view the appendix, see: http://www.milliman.com/PSSF_state_estimates/

8 Allocations for 2019 are proposed to be updated by 2016 data. Guidelines are provided for funding allocation in 2020 through 2026, but the specifics of the allocation methodology is uncertain.

9 For further discussion of the medical loss ratio data, please see the 2015 commercial health insurance report.

FIGURE 1: STATE-REQUIRED FUNDING AS A PERCENTAGE OF FEDERAL ALLOCATION



The role of PSSF in the AHCA

The Congressional Budget Office (CBO) released a report[10] on March 13, 2017, that outlined the overall impact of the AHCA to the federal budget and deficits from 2017 through 2026. This report examined the provisions of the AHCA and how the bill would affect the number of individuals enrolled in federally subsidized health insurance through Medicaid, individual coverage, and employer-sponsored policies. The projected impact to enrollment in various programs and markets was considered when developing the overall cost impact of the AHCA. The report states that the AHCA would reduce federal deficits by $337 billion between 2017 and 2026. This savings is largely attributable to the reduction in outlays for Medicaid and to the various subsidies for the individual health insurance market established by the ACA. Specifically, the CBO report estimates that the reduction in Medicaid spending would be $880 billion total from 2017 through 2026. The reduction in spending on premium credits and other subsidies over the same time period is projected to be $673 billion. The cost of the age-based tax credits introduced by the AHCA is projected to be $361 billion, implying a net $312 billion reduction in spending from all changes to the various tax credits and subsidies.

The reforms in the AHCA, as with any change, would cause disruption in the market. The PSSF was intended to provide funds with the purpose of countering this disruption and stabilizing the insurance markets. As shown in Figure 1, the allowable uses of these funds is intentionally broad, and it would be left up to the states to decide how to utilize these resources to meet the needs of their populations.

10 https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf

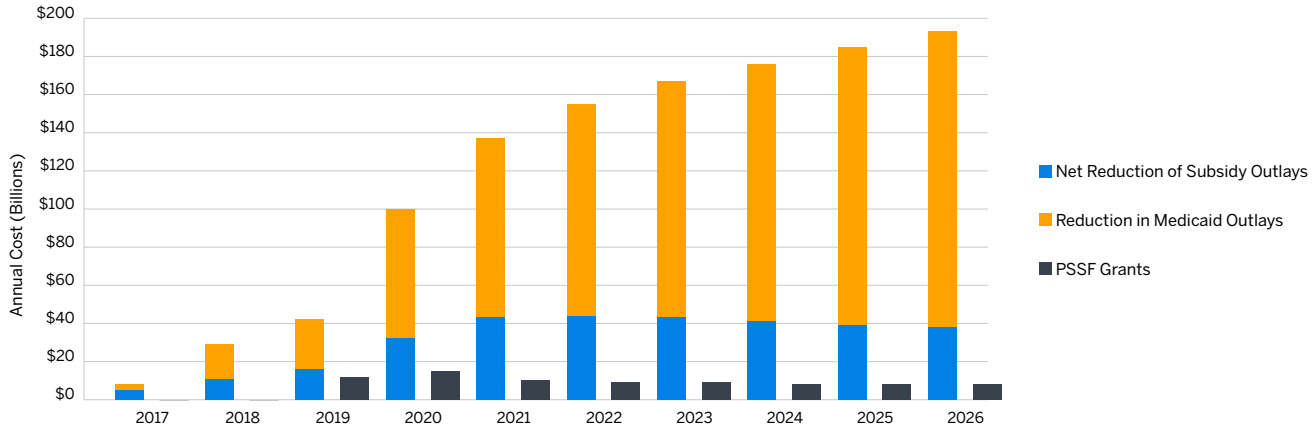
The graph in Figure 2 illustrates the absolute value of total estimated savings from the changes in the AHCA compared to the dollars that would be available from the PSSF to implement new programs. The source of the cost savings include changes to the ACA subsidy programs and federal Medicaid spending. The values in the graph are from the CBO report, which detailed nationwide figures for these categories by fiscal year.

Considerations for uses of the PSSF grants

The estimates from the CBO, as illustrated by Figure 2, suggest that the funding available from the PSSF would be insufficient to fully replace the programs and spending repealed by the AHCA. As such, states would need to recognize and prioritize the needs of their populations when designing programs to utilize the PSSF. It should be noted that the value of the reduction in federal outlays for subsidies and Medicaid will depend on actual enrollment outcomes and other external forces. Specifically, the CBO forecasted a significant drop in enrollment for both Medicaid and the commercial marketplace in the absence of the individual mandate. To the extent enrollment does not decrease by a similar magnitude, the reduction in funding outlays for the Medicaid and ACA subsidies shown would be significantly less. The CBO recognizes in its report that the combined impact of these forces is difficult to predict.

As proposed legislation evolves, policymakers, insurers, and other stakeholders should have a firm understanding of the changes in federal and state expenditures that are estimated to occur relative to spending under the ACA. Given the unique demographics, individual market premiums, and Medicaid programs in each state, national-level analysis may not account for state-specific characteristics of health insurance markets, consumer behavior, or political climate.

FIGURE 2: THE VALUE OF PSSF GRANTS COMPARED WITH THE REDUCTION IN FEDERAL SPENDING FOR MEDICAID AND FOR PREMIUM AND COST-SHARING SUBSIDIES BY FISCAL YEAR*



*Figures used to generate the graph in Figure 2 were from Table 3 of the CBO report, p. 33, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

Below is a list of additional considerations for stakeholders who may be affected by the PSSF:

- **Value of reinsurance option:** Even if states elect the reinsurance program for 2018, they should continue to evaluate that option against implementing a custom state program, if changing the intended use of the PSSF is allowed. If states elect the reinsurance option, the cost of claims covered by the listed reinsurance parameters will not exactly equal the computed allocation of funds for the state. It is currently unclear how the extra funds would be used if the cost of reinsurance claims is below the state's allocations in 2018 and 2019. Likewise, it is unclear how the reinsurance program would be funded if the cost of reinsurance claims is above the state's allocated PSSF grant. Stakeholders should seek clarification for the use of excess funds and the possibility of unintended liabilities if the grant money is insufficient for the reinsurance program as currently defined.
- **Short application window:** The AHCA states that applications would be automatically approved if not denied within 60 days. It is not presently clear if states have the option to reapply for funds in future years with a different intended purpose. Stakeholders should seek clarification on the overall application process. The short application window may affect states' abilities to create custom programs to fund with the PSSF, especially for 2018. States should examine the potential value of the reinsurance program against the grant money they would receive using the allocation methodology described in the bill. Stakeholders should consider the likelihood of their states implementing custom programs or the default reinsurance option.
- **State-specific impact of AHCA provisions:** The impact estimated by the CBO report represents nationwide average figures. Stakeholders should consider the state-specific impact of AHCA provisions. States would be disproportionately affected by the restructuring of premium tax credits and cost-sharing subsidies based on the distribution of household income and age of individual market participants. Because tax credits are currently a function of the second-lowest-cost silver plan in the market, prevailing premium levels by state would also dictate the impact of the tax credit changes. States would also be affected differently, depending on their current levels of Medicaid funding and participation in Medicaid expansion. Finally, stakeholders should recognize that states would be required to provide matching funds to receive federal funding from the PSSF starting in 2020. This requirement will be a critical consideration, especially for stakeholders in states projected to have severe budget constraints.
- **High-risk pools:** High-risk pools were used as mechanisms to subsidize the cost of care for high-risk individuals in many states before the ACA. These pools were largely discontinued, which is due to the preexisting condition exclusion rule changes and transitional reinsurance programs. The AHCA may permit the PSSF to be used to establish similar mechanisms again. Although the AHCA maintains the single-risk-pool rating rules, stakeholders should consider the potential impact of subsidizing care for high-risk individuals.
- **State-run cost-sharing subsidies**: States could be permitted to establish their own subsidy programs for cost sharing to augment the federal program in 2018 and 2019, and/or replace it starting in 2020. This type of program would not reduce premium levels, but would provide assistance for lower-income individuals in meeting out-of-pocket cost-sharing requirements. Stakeholders should consider the impact of reduced cost sharing on utilization levels for services.

As discussed in this paper, provisions of the PSSF establish a default CMS reinsurance program for the individual market. The PSSF may also permit the establishment of a separate risk pool for high-risk individuals. The inclusion of a reinsurance program or high-risk pool for the individual health insurance market is not an idea confined to the PSSF. In a March 13, 2017, letter to state governors, the Secretary of Health and Human Services (HHS) encouraged states to submit Section 1332 State Innovation Waiver (1332 waiver) proposals that include "high-risk pool/state-operated reinsurance programs".[11] As indicated in the letter, the State of Alaska has already implemented a state-run reinsurance program for 2017 that "mitigated a projected rate increase significantly" and has now applied for a 1332 waiver to establish the Alaska Reinsurance Program for 2018 and beyond. From the funding perspective HHS indicates, "A state may receive pass-through funding associated with the resulting reductions in federal spending on Marketplace financial assistance consistent with the statute." To the extent a reinsurance program lowered premiums, it would decrease the federal government's cost of providing premium assistance. When evaluating the effects of the PSSF or other similar policy initiatives, stakeholders should consider the interaction between various funding and expenditure items.

11 https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf

- **State-run premium subsidies:** States could use the PSSF to establish their own premium subsidy programs. This type of program would directly reduce premiums for qualifying individuals and could lead to higher enrollment figures. Depending on the structure of the program, funds can be used to subsidize individual market premiums for those who lose Medicaid coverage. States can also wrap around the federal age-based subsidies to augment subsidies by age or vary subsidies according to income, similar to the ACA.
- **Reduced Medicaid enrollment and benefits:** The most significant source of savings from the AHCA is due to major changes to the funding of the existing Medicaid program. The AHCA proposes changes to Medicaid financing, loss of enhanced funding for expansion, and the elimination of the requirement that Medicaid must provide all essential health benefits (EHBs). These reductions may lead to overall declines to population health and an increase in uncompensated care for providers. Stakeholders should consider how reduced Medicaid funding and changes to rules around covered benefits may lead to lower Medicaid enrollment and lower benefit levels for Medicaid enrollees, and how the healthcare needs of this population can be met in this new environment.
- **PSSF grant allocation methodology:** The AHCA outlines the method that would be used to allocate the available funds to the states every year. The bill describes a specific methodology for 2018 and 2019, and it describes how the methodology would be established for 2020 and onward. Stakeholders should understand how funding may change depending on the future interpretation of legislative terms and position themselves to contribute to the conversation when the future method is being formed. As discussed earlier in this report, there is significant uncertainty in allocated funding even with the language currently proposed.
- **Promotion of and payment for preventive care:** The promotion of preventive care along with dental, vision, mental health, and substance abuse benefits were specifically listed in the AHCA as a potential use of the PSSF. It also indicates that paying providers directly for these types of services is permitted. Funding could conceivably be used to pay providers to provide certain populations with preventive services, even if they don't have coverage through Medicaid or an individual policy. This could be used to provide very basic services to those who may lose coverage because of reduced Medicaid funding.
- **Impact to healthcare providers:** As mentioned above, one option is to use funds to pay providers directly. While the impact to hospitals and physicians is uncertain and would depend on the state's use of available funds, it is reasonable to assume that the disruption and reduction in the flow of funds to the states from other provisions of the AHCA could have a destabilizing effect on providers, particularly hospital systems. The PSSF could potentially be used to augment Medicaid fee schedules or value-based payments to offset the reductions in the flow of funds.

The AHCA contained specific changes concerning Medicaid, Medicare, tax credits, and payment of the tax credits. Future proposals will differ from what was released on March 6. In its report, the CBO recognized that the cost impact of the provisions of the AHCA were difficult to predict, and as a result, the estimates included in their March 13 report are uncertain.

The comments and summaries contained in this paper are based on the interpretation of the AHCA by the authors. The authors are not attorneys and, therefore, cannot issue legal interpretations or opinions.

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CONTACT

Kathleen E. Ely
kathie.ely@milliman.com

Thomas D. Murawski
tom.murawski@milliman.com

Paul R. Houchens
paul.houchens@milliman.com

Illustrative Funding Estimates Based on Insurer Reported Individual and Group Adjusted Incurred Claims

For a state-by-state breakdown of funding estimates, see the appendix at:
milliman.com/PSSF_state_estimates