Next on the Affordable Care Act: Funding for Cost-Sharing Protections and Marketplace Stability Programs[1]

March 27, 2017

The House of Representatives, on March 24, 2017, withdrew budget reconciliation legislation (House bill) that would have made substantial changes to the Affordable Care Act (ACA). The House Speaker indicated that the ACA will remain in place "for the foreseeable future." With the legislative efforts to make broad changes to the ACA halted (at least temporarily), Congress might turn its focus to specific provisions of the law in need of attention. **Two items are of particular importance: (1) creating explicit authority for funding cost-sharing reductions (CSRs) in order to maintain these protections from out-of-pocket costs when accessing health care services; and (2) re-establishing funding for Marketplace stability programs in order to reduce premiums for health insurance offered through a Marketplace**.

Priority #1: Explicit Authority for Funding CSRs

Under the ACA, AI/ANs who meet the definition of Indian and enroll in coverage through a Marketplace qualify for comprehensive CSRs, meaning they pay no deductibles, co-insurance, or copayments when receiving essential health benefits (EHBs).[2] Other Marketplace enrollees who have an income that does not exceed 250% of the federal poverty level (FPL) qualify for general CSRs, provided that they enroll in a silver-level plan. The federal government makes advance CSR payments to qualified health plan (QHP) issuers to compensate them for the CSR amounts that they provide to eligible Marketplace enrollees.

In an ongoing lawsuit, House Republicans have challenged whether the federal government has the legal authority to fund CSR payments to QHP issuers. Regardless of the outcome of the lawsuit, issuers will have to continue provide the CSRs, but without the payments, the health plans likely would have to charge significantly higher premiums or exit the Marketplace. **Communicating to members of Congress the value of the CSRs to AI/AN enrollees in the Marketplace—and the need for continued funding of health plans for these protections—might bolster efforts to (continue to) authorize federal payments to Marketplace health plans for cost-sharing protections.**

Background on Lawsuit on CSR funding

Members of the House of Representatives initially filed the lawsuit in 2014, seeking to end the CSR payments on constitutional grounds. The lawsuit, *House v. Burwell*, argued that Congress authorized

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (*i.e.*, member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Under sections 1402(d)(1) and (2) of the ACA, Indians can enroll in either a zero or limited cost-sharing plan, depending on their income level, and receive comprehensive cost-sharing protections (*e.g.*, no deductibles, coinsurance, or copayments).

but never appropriated funding for the CSR payments and that the Obama administration improperly funded the payments without congressional approval. In May 2016, a U.S. District Court ruled in favor of the House members but allowed the CSR payments to continue pending the resolution of an appeal.

After the presidential election, House members in November 2016 filed a motion to hold in abeyance all briefings in the appeal of the lawsuit. A three-judge panel of the U.S. Court of Appeals for the District of Columbia Circuit in December 2016 granted the motion and ordered the parties to file motions governing further proceedings in the appeal by February 21, 2017. On that date, House members and the Trump administration filed a joint motion to hold the case in abeyance to "allow time for a resolution that would obviate the need for judicial determination of this appeal, including potential legislative action." With the recent failure of the House bill and the pending lawsuit, the funding of the CSRs remains uncertain.

Priority #2: Funding for Marketplace Stability Programs

The ACA established the Reinsurance and Risk Corridors programs to help foster competition among health insurance issuers, as well as promote insurance market stability, during the first three years of Marketplace operations beginning in 2014. The overall goal was to compensate Marketplace health plans for high-cost individuals in order to minimize the need for issuers to increase health insurance premiums for plans offered through a Marketplace. A subsequent Congress cut the funding available for these programs, retroactively reducing the amount of funds available to Marketplace plans and resulting in the bankruptcy of several "co-op" health plans and the exit of issuers in several Marketplaces. Although the ACA's premium tax credits (PTCs) limit the premiums paid by Marketplace enrollees who qualify for them, Marketplace enrollees not eligible for PTCs are subject to the full plan premiums.

Reinsurance Program

The Reinsurance program, which ended in 2016, provided payments to health plans that enrolled higher-cost individuals.[3,4] The program required all issuers and self-insured plans to contribute funds, with individual market plans subject to ACA insurance market reforms, both inside and outside the Marketplace, eligible for payment. Under the program, a health plan qualified for payment if an enrollee had costs that exceeded a certain threshold. The program served to protect against premium increases in the individual market by offsetting the costs of higher-cost enrollees.

Risk Corridors Program

The Risk Corridors program, which applied to qualified health plans (QHPs) offered in the Marketplace, limited losses and gains for issuers beyond an allowable range. Under the program, which ended in 2016, HHS collected funds from QHPs with lower-than-expected claims and made payments to plans with higher-than-expected claims.[5] Through the program, the ACA sought to discourage issuers from

[3] See 45 CFR 153.210-253.270.

[4] States have the option to operate their own Reinsurance program or allow HHS to administer one for the state; states operating their own program had the option to continue the program beyond 2016. See 45 CFR 153.210.

[5] QHPs with actual claims less than 97% of target amounts pay into the program, and those with claims greater than 103% of target amounts receive funds. See 45 CFR 153.510.

hiking their premiums because of uncertainty about the population that would enroll in QHPs (*i.e.*, concerns about a disproportionate share of higher-cost enrollees).

Congressional Actions Post-Enactment of the ACA

In 2014 and 2015, Congress imposed a budget neutrality requirement on the risk corridors program, limiting payments to the amount of contributions from QHP issuers. As a result, HHS reduced risk corridor payments by at least $8.5 for those two years, including $5.8 million for 2015 alone.[6] This shortfall has played a key role in the decisions of many issuers to increase their premiums significantly or, in some cases, to scale back or end their Marketplace operations.

In the recently withdrawn House bill, Congress would have re-established a Reinsurance program, with $10 million to $15 billion in funding available annually, as part of a new "Patient and State Stability Fund." According to the Congressional Budget Office (CBO), the program would have reduced premiums in the non-group insurance market and played an important part in stabilizing the market under the legislation.[7] Reestablishment of such a Reinsurance/Risk Corridor program is an important element to stabilizing and reducing health insurance premiums in the Marketplace.

Support of Reinsurance and Risk Corridor programs by Tribes and Tribal organizations might increase the likelihood of Congress taking legislative action to re-establish funding for these programs, thereby helping ensure that AI/ANs can continue to secure affordable health insurance through the Marketplace in 2018 and future years.

NOTE: Status of Employer Mandate

The ACA requires all employers that have more than 50 full-time employees (applicable large employers, or ALEs) to offer minimum essential health insurance coverage to their full-time (FT) employees and dependents or make shared responsibility payments to the federal government (aka the "employer mandate"). In addition, the ACA includes reporting requirements for ALEs.

The employer mandate took effect, in part, in 2015. To date, however, neither the Obama administration nor the Trump administration has issued invoices to employers requesting potentially owed shared responsibility payments. The recently withdrawn House bill would have eliminated any penalty for ALEs that do not offer minimum essential coverage retroactive to January 1, 2016, but the legislation would have retained the ACA reporting requirements. Tribes and Tribal health organizations might wish to renew an effort—which was unsuccessful during the last administration and Congress—to secure an administrative or legislative exemption from the shared responsibility payments for at least Tribal member employees.

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[6] CCIIO, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year* (Washington, DC: Nov. 18, 2016). See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf.

[7] CBO, *Congressional Budget Office Cost Estimate: American Health Care Act, Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017* (Washington, DC: Mar. 13, 2017). See https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.