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Trump Administration’s New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families Key Provision Also Weakens, Rather Than Strengthens, Marketplace Stability

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The Trump Administration’s new proposed rule on health care would raise premiums, out-of-pocket costs, or both for millions of moderate-income families. If finalized as proposed, the rule would reduce the amount of health care that marketplace plans have to cover. That would allow individual-market insurers to offer plans with higher deductibles and other out-of-pocket costs than they can now sell through the marketplaces.¹ It would also have the hidden impact of reducing the Affordable Care Act’s (ACA) premium tax credits, which help moderate-income marketplace consumers afford health care. As a result, the rule would force millions of families to choose between higher premiums and worse coverage.

As explained in more detail below, the proposed rule would result in reduced premium tax credit amounts because it would lower the standards for “silver” plan coverage. Under the ACA, the premium tax credits that consumers receive to help pay for marketplace plans are calculated based on the local cost of a silver plan. By allowing less generous silver plans, the rule would reduce the value of premium tax credits for many of the more than 9 million consumers who receive them — an effect the rule itself acknowledges.² This means that for people who wanted to maintain the same coverage they have today, tax credits would cover less of the cost.

The Administration argues that allowing less generous health plans, with higher deductibles and out-of-pocket costs but lower premiums, will give consumers more choices, draw more people into the marketplace, and, in this way, stabilize the market. But, in fact, this provision of the rule will do just the opposite. Due to the impact on premium tax credits, it will mainly serve to make marketplace coverage more expensive for marketplace consumers. Together with other provisions

¹ The proposed rule would also allow lower-value plans in the Affordable Care Act-compliant, off-marketplace individual market.

² The rule notes that this provision “would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government.”

of the rule, that will almost certainly result in lower enrollment and a weaker risk pool which, in turn, will weaken market stability. Moreover, the rule does nothing to dispel the main source of uncertainty and instability currently affecting the marketplace: the looming threat that congressional Republicans will repeal the ACA, without enacting a comprehensive replacement.

What the Proposed Rule Would Do

The proposed rule allows individual-market insurers to offer plans with higher deductibles and out-of-pocket costs, but lower premiums, than they're now allowed to offer. That's because it allows plans with lower "actuarial value." Actuarial value is the share of a typical consumer's medical costs that the plan covers, as opposed to what the consumer pays directly through deductibles, copays, and coinsurance. For example, in a silver plan with an actuarial value of 70 percent, the plan picks up 70 percent of a typical consumer's costs for covered benefits, while the consumer would expect to pay 30 percent of costs out of pocket.

To help consumers understand and compare plans, marketplace health plans are tiered by actuarial value: 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum).³ Current rules allow insurers to still meet their actuarial value standards if they deviate by a "*de minimis*" 2 percentage points from these standard values.⁴ The proposed rule would allow plans with actuarial values as much as 4 percentage points below the standard values. That would allow bronze plans with higher deductibles than any current marketplace plans.⁵ It also would allow silver plans with actuarial values as low as 66 percent. By allowing for such *silver* plans, the rule would reduce the size of premium tax credits for millions of families, as explained in the next section.

How the Proposed Rule Would Reduce Premium Tax Credits

Under the ACA, the premium tax credits that consumers receive to help pay for marketplace plans are calculated based on the local cost of a silver plan. By letting insurers offer less generous silver plans, the rule would reduce premium tax credits for many of the more than 9 million consumers who receive them — and that's true whether a consumer buys a silver plan or any other kind of plan.⁶

Specifically, premium tax credits adjust dollar-for-dollar based on the premium for the second-lowest-cost silver plan where a consumer lives, known as the "benchmark" plan. All else being equal, a plan with a lower actuarial value will have lower premiums than one with a higher value. In particular, a plan that covers 66 percent of a typical consumer's medical costs will have a lower premium than an otherwise identical plan that covers 68 percent of costs. Allowing plans with lower actuarial values to qualify as silver plans can thus result in lower benchmark plan premiums and, in turn, lower premium tax credits. While low-income families would be largely protected by other

³ These rules also apply in the ACA-compliant small group market and off-marketplace individual market.

⁴ Starting in 2018, certain bronze plans may have actuarial values of up to 65 percent, but still not below 58 percent.

⁵ Catastrophic plans with lower actuarial values can be sold through the marketplace, but are only available to a small subset of consumers and do not qualify for premium tax credits.

⁶ Data on consumers currently receiving premium tax credits are as of early 2016: Centers for Medicare and Medicaid Services, "March 31, 2016 Effectuated Enrollment Snapshot," June 30, 2016, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html>.

provisions of the ACA, moderate-income families would be left with the choice of paying higher premiums or opting for worse coverage.⁷

Consider an example: Under the ACA, a family of four with \$65,000 of income is expected to contribute \$5,664 per year to buy the benchmark plan. Suppose the current benchmark plan has an actuarial value of 68 percent and a premium of \$13,080 per year — the national average benchmark premium for a family of four. The family’s premium tax credit will equal the difference between the gross premium of \$13,080 and the \$5,664 that the family is expected to pay: or \$7,416. If, however, the benchmark plan’s actuarial value falls to 66 percent and its premium falls commensurately, the premium tax credit will fall by \$327.⁸

At first blush, the family might be indifferent between these two outcomes because both its premium tax credit and its benchmark premium fell. But in fact, as illustrated by Table 1, the family would now face a worse set of choices.

- It could pay the same amount in premiums as before, but buy a plan with a lower actuarial value, meaning some combination of higher deductibles, higher copays, and higher coinsurance. In the illustrative example in the table, the deductible for a benchmark plan increases by \$550 *per person* under the new rules.
- Or, the family could choose to buy a plan with the same cost sharing as it had before, but it now would have to pay more in premiums. The 68 percent actuarial value plan that previously cost the family \$5,664 in premiums will now cost \$5,991, a premium increase of \$327 per year.

To be sure, the proposed rule does not require all silver plans to reduce their actuarial values to 66 percent. Just like today, insurers presumably would offer silver plans with a range of actuarial values within the allowed corridor. But because premium tax credits are based on the *second-lowest-cost* silver plan on offer, they will generally be based on silver plans that adopt the actuarial values at or near the bottom of the allowable range: 68 percent today, 66 percent under the rule. That’s especially likely to be the case in more competitive markets.

As a result, while a stated goal of the rule is to expand consumer choice, it actually would leave many moderate-income consumers with worse choices and less affordable coverage.

⁷ It appears that the proposed rule partially protects consumers who qualify for cost-sharing reductions — those with incomes below 250 percent of the federal poverty level — from increases in costs. When these families purchase silver plans, insurers are required to provide them with cost-sharing reduction “variant” coverage with higher actuarial values, for which the insurers are reimbursed by the federal government. The proposed rule does not appear to modify actuarial value requirements for these variant plans. However, the rule would still reduce premium tax credits for these families, increasing their net premiums if they choose to purchase plans in a metal tier other than silver (and in some cases if they choose to purchase a silver plan other than the local benchmark). Meanwhile, families with incomes above 250 percent of the federal poverty level qualify only for premium tax credits, not cost-sharing reductions.

⁸ This calculation assumes that 85 percent of the plan’s premium covers medical costs, while 15 percent covers administrative costs and profits. Thus, the reduction in actuarial value from 68 percent to 66 percent lowers the premium by \$327. Here’s the arithmetic: $85\% \times \$13,080 \times (1 - 66/68)$.

TABLE 1

How the Proposed Rule Could Affect Coverage Affordability

Illustrative Example: Family of Four with Income of \$65,000*

	Annual Gross Premium	Premium Tax Credit	Net Premium	Per-person Deductible	Change for Family
Current Rules					
68% actuarial value silver plan (benchmark)	\$13,080	\$7,416	\$5,664	\$1,900	N/A
Proposed Rule					
66% actuarial value silver plan (new benchmark)	\$12,753	\$7,089	\$5,664	\$2,450	Deductible ↑ \$550/person
68% actuarial value silver plan (old benchmark)	\$13,080	\$7,089	\$5,991	\$1,900	Premium ↑ \$327/year

* The illustrative example assumes an initial premium equal to the national average benchmark premium for a family of four with one 40-year-old adult, one 38-year-old adult, and two children. It assumes that 85 percent of the plan's premium covers medical costs, while 15 percent covers administrative costs and profits. Deductible values are calculated using the Centers for Medicare and Medicaid Services 2017 actuarial value calculator assuming a plan with a deductible that applies to all services, a 30 percent coinsurance rate above the deductible, and a \$7,200 out-of-pocket maximum.