MILLIMAN RESEARCH REPORT

The impact of short-term limited-duration policy expansion on patients and the ACA individual market

An analysis of the STLD policy expansion and other regulatory actions on patient spending, premiums, and enrollment in the ACA individual market

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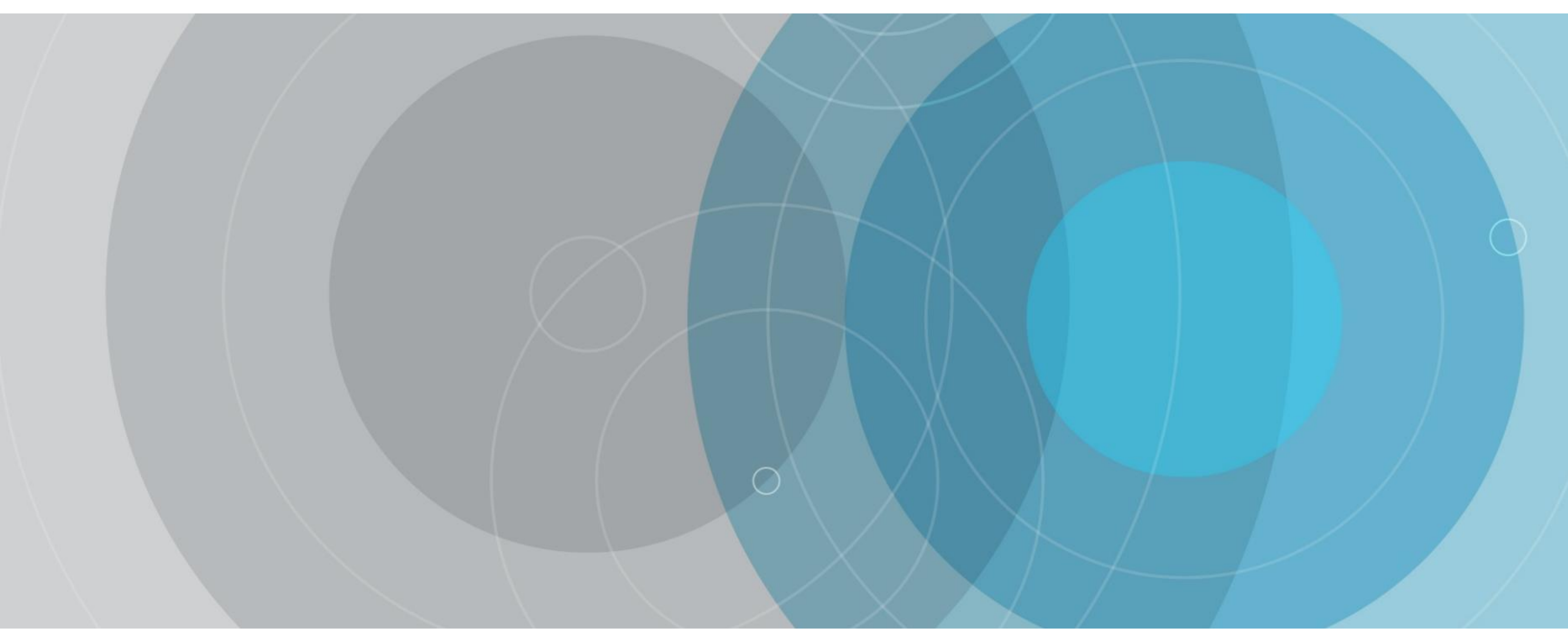

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Executive Summary

The enactment of the Patient Protection and Affordable Care Act (ACA) in 2010 prompted major changes to access of health insurance in the United States, including the creation of federal- and state-based marketplaces for health insurance.[1] As a result, coverage offered today under the ACA rules must be issued and priced without regard to a person's preexisting health conditions, cover a minimum set of "essential health benefits" (EHBs), protect against catastrophically high health expenses, and meet a number of other requirements.[1] Along with the creation of marketplaces, the law introduced an individual mandate penalty to encourage enrollment in comprehensive health coverage and to diversify the health status of the risk pool.[1]

Since 2017, the U.S. Congress and the executive branch have altered the regulations governing the ACA-compliant markets and related products and services.[2] The Tax Cuts and Jobs Act of 2017 reduced the individual mandate penalty to $0 as of January 2019,[3] effectively eliminating the mandate and removing one of the ACA's mechanisms for protecting the marketplaces against anti-selection. Additionally, a final federal rule issued in August 2018 allowed the extension of short-term limited-duration (STLD) policies – which do not qualify as minimum essential health insurance coverage (MEC) as defined by the ACA – to increase plan duration from three months to 12 months, with further renewal options allowable for a total coverage period of up to three years.[4] Together, these regulations have increased the availability of non-ACA-compliant options for those seeking health insurance. Healthcare experts and actuaries expect these options may increase costs in the ACA-compliant individual marketplace as healthier individuals transition to other such coverage options, including STLD policies.[5–7]

STLD policies may be an option for individuals who find ACA products too expensive or offering unwanted coverage, but an individual opting to enroll in an STLD plan may be exposed to additional risk. While STLD policies might offer premiums that more affordable than the unsubsidized premiums for ACA-compliant policies, STLD policies are not subject to the ACA's consumer protections, including minimum benefit standards, the prohibition against denying coverage for pre-existing medical conditions, guaranteed renewability, and a requirement that the insurer expend a minimum amount of premium dollars on medical care.

We analyzed the potential impact of these and other recent regulatory actions on individuals enrolled in the ACA-compliant marketplace. Our study used a large administrative medical and pharmacy claims database and relied on publicly available rate filing materials for 2020. We modeled out-of-pocket expenses for individuals in hypothetical STLD coverage who are newly diagnosed with one of five medical conditions or acute events representing a wide range of associated healthcare spending levels: lymphoma, diabetes, lung cancer, heart attack, and hospitalization as a result of mental health or substance use disorder (MH/SUD). In addition, we quantified the impact of expanded availability of STLD policies on ACA individual market premiums and enrollment, along with other regulatory actions, based on insurers' expectations that the risk pool would worsen.

Our study found that:

- STLD policies may be an option for healthier consumers seeking health coverage due to lower premiums. However, these plans offer less benefit coverage and insurance protection than ACA-compliant policies:
  - Typical STLD policies do not cover two of the ACA's EHBs: prescription drugs and mental health benefits.
  - STLD policy maximum coverage limits (which are not permitted in ACA-compliant plans) and other policy features can lead to significant out-of-pocket expenses for patients and consumers.
- An individual who chooses to purchase an STLD policy assumes additional risk and may spend substantially more for treatment of a condition newly diagnosed while enrolled in an STLD policy compared to an ACA-compliant policy. For example, a newly diagnosed lymphoma patient enrolled in an STLD policy in 2017 could pay $16,800 more in out-of-pocket expenses, including premium and member cost sharing, within six months following diagnosis than a lymphoma patient enrolled in an unsubsidized ACA-compliant policy.
  - Because STLD policies are not guaranteed renewable, those newly diagnosed with a condition while enrolled in an STLD policy may be left uninsured until the next ACA market open or special enrollment period and exposed to providers' billed charges, which are generally much higher than the amounts negotiated by insurers. We

found that a patient who is denied STLD renewal three months following a diagnosis of lymphoma could be responsible for nearly $40,000 more in out-of-pocket expenses in the six-month period following diagnosis than if the same patient had been covered under an ACA-compliant individual policy for the same period.

- Based on our research of ACA individual market rate filing materials for 2020, the impact of regulatory actions is expected to increase unsubsidized ACA individual market premiums by approximately 4% in 2020 among states with full expansion of STLD policies. Few carriers distinguished the impact of the STLD plan expansion from the individual mandate repeal or other regulatory actions. Most carriers that explicitly adjusted ACA-compliant premiums for the impact of the STLD plan expansion attributed a premium increase between 0.5% and 2% in 2020. This finding was similar to the 2019 figures reported by a Kaiser Family Foundation study.[8]
- We estimate that 6% of members in the ACA-compliant individual market will migrate to non-minimum essential coverage, which includes individuals who choose to forgo coverage and those who enroll in STLD policies, by 2021 due to selection dynamics created by the STLD plan expansion and mandate repeal.

This report was commissioned by The Leukemia & Lymphoma Society. The findings reflect the research of the authors; Milliman does not endorse any product or organization. If this report is reproduced, it should be reproduced in its entirety, as pieces taken out of context can be misleading. Two of the coauthors, Dane Hansen and Gabriela Dieguez, are members of the American Academy of Actuaries and meet its qualification standards for this work. The authors thank Emily DeAngelis and Eric Yonda for their research assistance.

Introduction

The objective of this report is to provide insights into the impact of the expansion of STLD policies and other recent regulatory actions on the ACA-compliant individual marketplace. Through research of approved rate filings in the ACA individual market for 2020, as well as analysis of medical and pharmacy claims data for enrollees in the ACA individual market, we:

1. Analyzed typical STLD policy plan designs offered by short-term insurers (shown in Figure 2), and compared patient out-of-pocket expenses under ACA-compliant policies and popular STLD coverage scenarios for individuals who are newly diagnosed with a medical condition or experience an acute event.
2. Summarized the carrier-assumed impact of regulatory actions on 2020 ACA individual market premiums and differences among states with and without restrictions in the STLD market.
3. Estimated the impact of regulatory changes, such as the repeal of the individual mandate penalty and the expanded availability of STLD policies as a result of the 2018 regulation, on the 2020 individual market enrollment, average medical costs, and premiums.

We researched publicly available rate filing materials approved for plan year 2020 in the ACA-compliant individual marketplace to determine the average premium impact of regulatory changes including, but not limited to, STLD policy expansion and the repeal of the individual mandate penalty. Our research, along with claims data for a subset of members enrolled in an ACA-compliant policy in 2017, informed our estimates of the future impact of regulatory actions on enrollment and premium.

In addition, we performed a claims-based analysis of the impact of STLD policies on patient out-of-pocket expenses for individuals with one of five select diagnosed conditions or acute events: lymphoma, diabetes, lung cancer, heart attack, and mental health or substance use disorder (MH/SUD) hospitalization. We chose these five categories because they illustrate a mix of acute and chronic conditions as well as a range of associated healthcare spending. This analysis is informed by research on the typical STLD policy plan design, constructed from existing STLD policies currently offered in the market.

Background

The enactment of the ACA in 2010 prompted major changes to access of health insurance in the United States. Coverage offered today under the ACA rules must be issued and priced without regard to a person's preexisting conditions and must cover a minimum set of essential benefits, among other requirements.[1] Along with the creation of these marketplaces, the law introduced an individual mandate penalty to encourage enrollment in comprehensive health coverage and to diversify the health status of the risk pool.[1]

Since 2017, Congress and the executive branch have altered the regulations governing the ACA-compliant markets and related products. Access to various forms of loosely-regulated insurance has expanded. For example, a final federal rule issued in August 2018 allowed the extension of STLD policies to increase plan duration from three months to twelve months, with further renewal options allowable for a total coverage period of up to three years.[4] Additionally, the Tax Cuts and Jobs Act of 2017 reduced the individual mandate penalty to $0 as of January 2019, effectively eliminating the mandate and removing one of the ACA's mechanisms for protecting the marketplaces against anti-selection.[3]

EXPANSION OF LOOSELY REGULATED INSURANCE

Historically, short-term limited-duration (STLD) insurance has been purchased to fill a temporary gap in coverage.[9] People who does not qualify for a special enrollment period under the ACA may consider enrolling in an STLD plan when in-between jobs or health insurance coverage.[10] With fewer regulatory restrictions, STLD policies can offer leaner benefits and lower premiums than coverage available in the ACA marketplace.

STLD plans do not comply with ACA provisions and do not meet the definition of MEC under the ACA.[9] STLD policy carriers can charge higher premiums based on health status and deny coverage for preexisting conditions.[9] STLD plans can impose annual or lifetime limits, opt to not cover essential health benefits, such as mental health or prescription drugs, rescind coverage and deny payment following a diagnosis in certain circumstances, and tend to impose higher patient cost-sharing levels than ACA-compliant plans. Recent research also shows that STLD plans spend less on medical care, as a percentage of premium, than ACA-compliant policies. An analysis of 2018 National Association of Insurance Commissioners (NAIC) data found that the top five STLD policy carriers spent 39.2% of premium on medical claims on average.[11] By comparison, ACA-compliant individual policies require at least 80% of premiums collected to go toward medical care.[1]

As STLD policies are not considered MEC under the ACA, STLD policyholders were subject to the individual mandate penalty prior to its repeal.[9] A final rule issued in October 2016 by several federal agencies, including the Internal Revenue Service (IRS), Employee Benefits Security Administration (EBSA), and the Department of Health and Human Services (HHS), limited STLD policy durations to three-month terms without renewal.[12] This limitation was imposed due to concerns that STLD policies were no longer utilized solely for filling short-term gaps in major medical coverage, but rather as a replacement for such.[12] Limiting the sale of STLD plans also helped to encourage consumers to participate in the ACA's single risk pool, ensuring that risk was reasonably spread and premiums remained stable.[12]

In October 2017, an executive order directed federal agencies to expand the availability and accessibility of non-ACA-compliant health insurance, such as STLD plans.[13] On August 3, 2018, the Departments of Treasury, Labor, and Health and Human Services issued a final rule to expand access to STLD plans.[4] Effective October 2, 2018, this ruling expanded the maximum duration of short-term plans from three months to up to 364 days.[4] Additionally, under this ruling, consumers are allowed to renew coverage for up to 36 months.[4] The Centers for Medicare and Medicaid Services (CMS) estimates that enrollment in the STLD plans will reach 1.9 million by 2022, with a majority of these individuals assumed to be enrollees who were previously covered in the ACA marketplace.[6]

Since the federal expansion of STLD policies, several states have passed legislation to restrict or limit the sale of STLD policies. As of January 2020, 12 states have passed legislation to either ban the sale of STLD policies or have implemented significant barriers to entry such that no STLD carriers have entered the market.[10] An additional 13

states and the District of Columbia have restricted the initial term of STLD policies to less than 360 days.[10] The remaining 25 states have taken no action against the expansion and availability of STLD policies or continue to allow the sale of STLD policies with an initial term of at least 360 days, with or without the option to renew.[10]

The October 2017 executive order also directed federal agencies to expand access to other non-ACA-compliant policies such as association health plans (AHPs).[13] AHPs are group health plans that employer groups and associations offer for their members.[14] The ACA had increased regulatory oversight of AHPs by specifying that AHPs enrolling individuals or small groups were generally subject to the ACA's individual and small group market rules.[15] However, there was a limited exception to this rule: an AHP covering small employers could be considered a single large-group plan for regulatory purposes if the employees shared a common trade, business, or profession and effectively operated as one employer controlling the association.[15] This set of rules governing AHP formation and regulation is commonly referred to as "Pathway 1" in the current regulatory guidelines.[15]

The Department of Labor (DOL) ruled in June 2018 to greatly expand the instances in which an aggregation of small groups could be considered a large group, creating "Pathway 2" AHPs.[16] Under these new regulations, an AHP could be considered a single large group plan if the association served at least one substantial business purpose other than offering health coverage, its membership was in the same business or geographic area (which could span several states), and the employer members controlled the AHP and health plan.[15] In March 2019, a federal judge found major provisions of the Department of Labor's new regulations to be unlawful.[17] The Department of Justice has repealed this ruling and, for the interim, "Pathway 2" AHPs can no longer be formed, but "Pathway 1" AHPs can proceed to form and operate unaltered.[15]

REPEAL OF THE INDIVIDUAL MANDATE PENALTY

The ACA, passed in 2010, requires that individual major medical health insurance policies in the United States offer comprehensive coverage to all individuals at premiums that do not vary based on health status, regardless of preexisting conditions.[1] Implemented in 2014, some of the ACA's major provisions include prohibiting insurers from denying coverage to individuals due to preexisting conditions, abolishing annual and lifetime coverage caps on benefits, allowing states to expand Medicaid eligibility, and introducing "essential health benefits" (EHBs) to ensure that all health plans cover a core set of basic services.[1] As a result of the ACA's new regulations and expansion of Medicaid, the U.S. uninsured population decreased roughly in half between 2010 and 2016 from 46.5 million to 26.7 million, respectively.[18]

The ACA also included a provision known as the individual mandate, which required every individual to have MEC or to pay a penalty.[1] The purpose of the mandate was not only to decrease uninsured rates among the public, but also to help protect against anti-selection in the markets, which occurs when healthier individuals choose to remain uninsured and, as a result, the remaining market participants are disproportionately sicker than the general population.[19] As a sicker population uses more benefits, this ultimately results in higher premiums.[19]

Along with other key regulations of the ACA, the individual mandate was implemented beginning in 2014.[1] In December 2017, Congress passed the Tax Cuts and Jobs Act of 2017, which eliminated the payment penalty portion of the mandate, effective January 1, 2019.[3] This increased the likelihood that healthier individuals would forgo health insurance or seek out alternative non-ACA-compliant coverage options.[19] The Congressional Budget Office (CBO) estimated that roughly an additional 7 million people will choose to go uninsured by 2021 as a result of the repeal of the individual mandate penalty.[20]

Following the repeal of the federal individual mandate penalty, several states have instated their own individual mandate penalties. California, New Jersey, Rhode Island, and the District of Columbia have all recently adopted individual mandate penalties similar to those that were in place under the ACA.[21] Massachusetts had a penalty in place predating the ACA, and Vermont has implemented a state mandate for 2020, but no penalties have been established yet.[21,22]

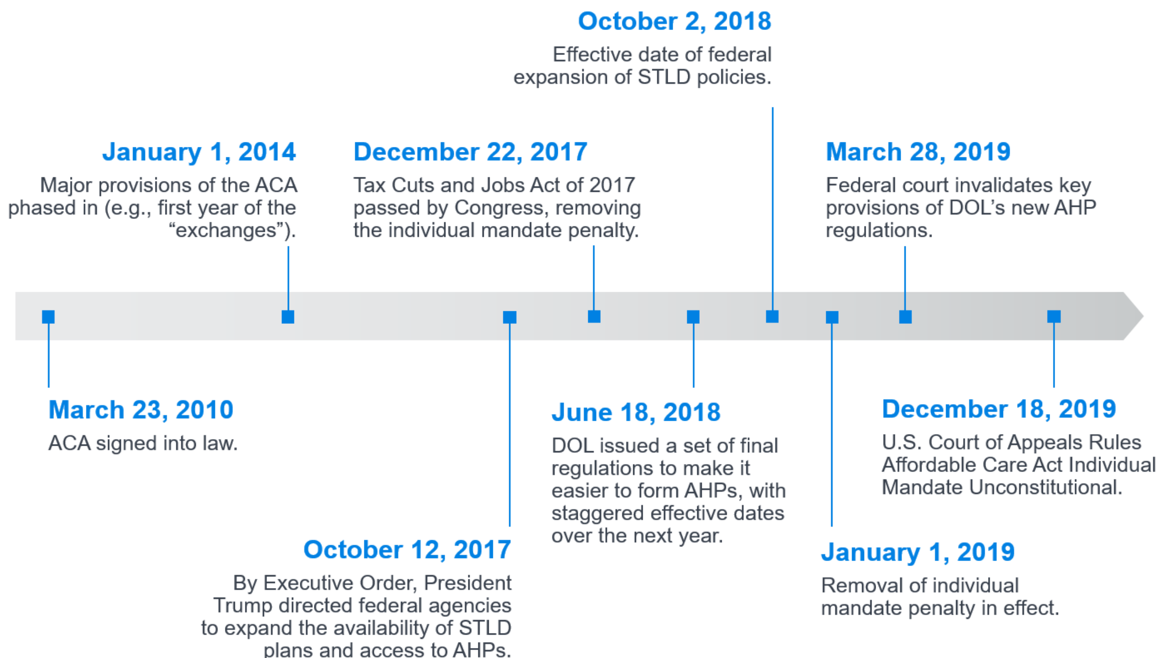
In December 2019, the Fifth U.S. Circuit Court of Appeals ruled the individual mandate of the ACA unconstitutional.[23] The court cited that the individual mandate cannot hold after the tax penalty for not having insurance was reduced to $0.[23] The court, however, did not conclude on whether other ACA provisions are unconstitutional.[23] As such, other

ACA provisions remain intact while the litigation process continues as a federal appeals court ordered a trial judge to reconsider a 2018 ruling to invalidate the ACA without the individual mandate.[23]

CURRENT REGULATORY ENVIRONMENT

Figure 1 illustrates a timeline of the regulatory actions impacting the ACA marketplace. Both the repeal of the individual mandate penalty and the impact of the expansion of STLD policies were effective for January 2019.

FIGURE 1: TIMELINE OF REGULATORY ACTIONS IMPACTING ACA MARKET



The combination of the expansion of loosely regulated insurance, particularly STLD policy expansion, and the repeal of the individual mandate penalty has created uncertainty in the future of the ACA markets. Without the individual mandate penalty, healthier and younger individuals no longer have an immediate and certain financial incentive to remain covered by ACA-compliant health insurance. This, coupled with the increased availability and duration of STLD plans, encourages the healthier population to explore alternative coverage options, like STLD policies, with lower premiums, or to go uninsured. The migration of healthier individuals from the ACA-compliant markets causes deterioration of the ACA market risk pool, which leads to premium increases due to the resulting sicker pool. As the premiums increase, additional disenrollment of healthier members in the ACA-compliant individual market is expected. This cycle may create a "spiral," leading to higher premiums and further disenrollment.

Various studies have estimated the impact that these regulatory changes will have on ACA market enrollment and premiums. In April 2018, one study estimated that the proposed STLD plan regulatory changes and the repeal of the individual mandate penalty would together increase ACA premiums by 10.8% to 12.8% and decrease ACA enrollment by 20.9% to 26.3% in the near term (i.e., over four to five years after implementation), with enrollment decreases of 2.7% to 5.4% attributed to STLD plan expansion.[5] In August 2018, another study estimated these regulatory changes would increase ACA premiums by more than 18% in most states and decrease ACA enrollment by 15.5% by 2019.[7] Furthermore, CMS has estimated that gross premiums in the ACA marketplace would increase by 2022 as a result of STLD expansion.[6] The variation in these estimates indicates the inherent uncertainty in future ACA enrollment and premiums due to regulatory changes.

An October 2018 study reviewed all publicly available rate filings for insurers in the 2019 ACA individual marketplace.[8] The average rate increase carriers attributed to the repeal of the individual mandate penalty and expansion of STLD and AHP plans was approximately 6% for 2019.[8] This represented carriers' best estimate as to how much premiums would need to increase in order to counteract healthier members potentially leaving the ACA marketplace for alternative coverage options.[8]

Results

We analyzed the impact of the expansion of STLD policies and the repeal of the individual mandate penalty on the ACA-compliant individual marketplace, with a focus on premiums, costs, and enrollment, based on publicly available rate filing materials for rating period 2020. These materials represent insurers' expectations of the impact of STLD policy expansion and the mandate penalty repeal on the ACA individual market in 2020.

We also performed a claims-based analysis to compare patient out-of-pocket expenses under ACA-compliant individual coverage and typical STLD policies, using data from individuals with ACA-compliant individual coverage ("ACA individual" population) in 2016 and 2017. Income data was not available in our data source, so cost-sharing subsidies and premium tax credits were not considered. Our analysis focused on individuals with a newly diagnosed disease or an acute event among the following: lymphoma, diabetes, lung cancer, heart attack, and mental health or substance use disorder (MH/SUD) hospitalization.

Throughout our findings, "regulatory actions" are defined as recent legislation, federal rules, or executive orders that impact the healthcare industry, including the repeal of the individual mandate penalty, the expansion of STLD policies, and the availability of AHPs. These regulatory actions do not include the impact of any future changes.

A SURVEY OF SHORT-TERM PLAN DESIGNS

We reviewed the plan designs of 96 STLD policies offered in December 2019 through eHealth in the Atlanta, Georgia market. The Atlanta market was selected for in-depth investigation because it is a large, competitive market with total healthcare benefit costs near the national average, according to Milliman's 2019 Health Cost Guidelines™ (see further description of this data in the Data Sources, Methodology, and Limitations section of this report).

From our review of STLD policies, we constructed two STLD plan designs:

- Typical STLD plan: The typical STLD plan is a hypothetical policy representative of the median benefits or most common characteristics among the STLD policies included in our research. Data on actual enrollment by STLD policy was unavailable, so the typical plan design in Figure 2 does not reflect enrollment-weighted average benefits.
- Popular STLD plan: Among the policies in our research, we chose the Short Term Medical Value Select A plan, offered by UnitedHealthcare, for illustration purposes. UnitedHealthcare is the nation's largest STLD insurer by enrollment.[11]

Key findings on typical STLD plan designs

Figure 2 summarizes the policy features of the typical STLD plan. Our research identified the following key findings:

- Among the policies reviewed in our research, all had durations of either six months or 12 months. Each plan design was offered as either a six-month duration or a 12-month duration.
- Over 25% of the policies included in our research had a deductible greater than the 2019 annual maximum limit for ACA-compliant policies of $7,900, established by the Department of Health and Human Services (HHS). Sixty percent of these policies had a maximum out-of-pocket (MOOP) limit for policyholders greater than $7,900. Over a quarter of these policies had a MOOP over $15,000. The STLD deductible and MOOP values apply for the duration of the policy; in some cases, this was only six months.
- Most of the policies included in our research were coinsurance-based, but detailed cost-sharing information was unavailable.
- The vast majority of STLD policies surveyed (88%) had a maximum coverage limit of $1 million or $2 million. Maximum annual or lifetime benefit coverage limits are prohibited for essential health benefits (EHBs) under ACA-compliant coverage.

- Approximately 33% of the STLD policies included in our research covered prescription drug benefits, and 42% of policies covered mental health benefits. Many carriers define mental health benefits to include services for substance use disorders. Member costs for these excluded services do not contribute toward the member's deductible and MOOP.

FIGURE 2: TYPICAL STLD PLAN DESIGN

POLICY FEATURE	TYPICAL STLD PLAN
Initial duration	6 months
Deductible	$5,000
Member cost sharing	Coinsurance, 20%
Maximum out-of-pocket limit	$10,000
Policy maximum coverage limit	$2,000,000
Prescription drug coverage	Not covered
Mental health service coverage	Not covered
Maternity service coverage	Not covered
Monthly premium (age 27, female, nonsmoker)	Approx. $130

Figure 3 compares a popular STLD policy to a popular ACA-compliant bronze policy. For comparison purposes, we have included the plan design for the Anthem Bronze Pathway X Guided Access HMO 4600 Online Plus ACA-compliant bronze policy, offered by Anthem in 2019 on the individual market in Atlanta, Georgia. This plan was the most popular bronze or catastrophic policy offered in Atlanta for 2019 based on enrollment reported in 2020 Unified Rate Review Templates (URRTs). We limited our comparison to bronze or catastrophic ACA-compliant plans because we assumed unsubsidized individuals, who are more likely to switch to an STLD plan, are likely to choose more affordable, leaner plan designs. Bronze and catastrophic plans are the lower-cost and leanest ACA-compliant policies so they most closely resemble the plan design and cost sharing of an STLD plan.

FIGURE 3: ILLUSTRATIVE PLAN DESIGN COMPARISON

POLICY FEATURE	POPULAR STLD PLAN*	POPULAR ACA PLAN**
Initial duration	6 months	12 months
Deductible	$12,500	$4,600
Member cost sharing	Coinsurance, 30%	Coinsurance, 30%
Maximum out-of-pocket limit	$22,500	$7,900
Policy maximum coverage limit	$2,000,000	N/A
Prescription drug coverage	Not covered	Covered
Mental health service coverage	Not covered	Covered
Maternity service coverage	Not covered	Covered
Monthly premium (age 27, female, nonsmoker)	$77.10	$293.01

* Reflects the plan design for the Short Term Medical Value Select A policy, offered by UnitedHealthcare.
** Reflects the plan design for the Anthem Bronze Pathway X Guided Access HMO 4600 Online Plus ACA-compliant bronze policy, offered by Anthem in 2019.

Short-term limited-duration plans offer lower premiums and less benefit coverage and insurance protection than ACA-compliant policies.

The STLD plan market is seen by some as creating additional choices for consumers who are looking for health coverage options. While the average premium for the popular STLD policy is lower than the unsubsidized premium for the popular ACA-compliant bronze policy, the popular STLD policy has several limitations that may increase cost exposure for individuals who choose STLD insurance over ACA coverage:

- The deductible for the popular STLD policy is greater than the deductible for the popular ACA-compliant bronze plan, leading to greater patient out-of-pocket spending before members are subject to cost sharing (i.e., copays and coinsurance).
- Under the ACA, prescription drugs, maternity services, and mental health/substance use disorder services are EHBs, so all ACA-compliant policies are required to cover these benefits. The popular short-term policy does not cover several EHBs, including maternity services and prescription drugs. According to a similar report by the Kaiser Family Foundation, no STLD plans covered maternity services.[9] Additionally, the popular short-term policy excludes the "treatment of mental disorders, or court-ordered treatment for substance abuse." Services resulting from substance use are also excluded.
- All STLD policies in our research included a preexisting condition exclusion provision. This provision may prevent individuals with a medical condition that existed prior to the STLD policy application from obtaining coverage. ACA-compliant policies are guaranteed renewable and preexisting condition exclusions are prohibited.
- All STLD policies in our research included a benefit maximum between $1 million and $5 million, with most policies covering up to a maximum limit of either $1 million or $2 million. The ACA prohibits annual dollar benefit limits on essential health benefits (EHBs). Under an STLD policy with a policy maximum, the covered individual is responsible for covering all charges above the policy maximum. This can lead to significant out-of-pocket expenses for high-cost claimants.

Appendix A also shows a comparison between the popular STLD policy and a popular ACA-compliant silver policy with its cost-sharing reduction (CSR) variations for subsidy-eligible enrollees. Most enrollees with silver policies receive premium and cost-sharing subsidies and thus have less incentive to switch to an STLD policy. However, this comparison is relevant for individuals who may elect to enroll in an STLD policy but are unaware that they are subsidy-eligible or are unaware of the limitations of an STLD policy at enrollment.

THE COST OF NEWLY DIAGNOSED CONDITIONS OR ACUTE EVENTS

With typically lower premiums, STLD policy premiums are often more affordable than ACA premiums for healthier consumers, but these policies may come at a cost. With fewer patient protections than ACA-compliant policies, STLD coverage may lead to higher out-of-pocket costs for patients who are diagnosed with a new condition or experience an acute event. In addition, ACA-compliant policies guarantee renewability, ensuring that coverage is available to individuals who are newly diagnosed with a medical condition. STLD policies are not guaranteed renewable and could deny renewal coverage to these patients. Patients that are denied renewal of their STLD policy may be left with no insurance protection until ACA enrollment becomes available for the following year.

We modeled out-of-pocket costs for new (i.e., “incident”) cases of five select conditions: lymphoma, diabetes, lung cancer, heart attack, and mental health or substance use disorder (MH/SUD) hospitalization. Incident cases are those where a member presents a diagnosis for a condition in 2017, but that diagnosis was not present in 2016.

Of the five selected conditions, incidence of a new diagnosis is higher for diabetes than all other conditions, with an annual incidence of 1.5% among non-CSR enrollees. Incidence of a new diagnosis of lymphoma, a heart attack, lung cancer, or an MH/SUD hospitalization was between 0.05% and 0.25% among non-CSR enrollees in 2017. The prevalence of diabetes was also highest among the selected conditions at 4.8%.

Individuals with a known diagnosis of a costly medical condition are more likely to purchase a richer benefit plan.

Figure 4 provides incidence and prevalence rates for lymphoma. Figure 4 suggests that individuals enrolled in ACA-compliant bronze and catastrophic plans have lower incidence rates of serious conditions than those enrolled in richer benefit plans, likely due to a younger and healthier risk pool. In addition, we observed higher prevalence rates of diagnosis of the five select conditions among individuals enrolled in more comprehensive plan designs. As the benefit richness increases from catastrophic to platinum, the prevalence of lymphoma increases, suggesting that individuals with known diagnoses of costly conditions like lymphoma are more likely to enroll in a plan with a more robust benefit structure and favorable cost sharing. We expect the age and sex mix of the population enrolling in STLD policies may closely resemble a population of individuals enrolled in ACA-compliant bronze or catastrophic policies due to the similarities in plan design (i.e., lower cost and leaner benefit designs than other ACA metallic tiers). Appendix B provides incidence and prevalence rates for each of the five conditions.

FIGURE 4: INCIDENCE OF NEW DIAGNOSES AND PREVALENCE OF DIAGNOSED LYMPHOMA IN 2017 ACA INDIVIDUAL MARKET, BY METALLIC TIER

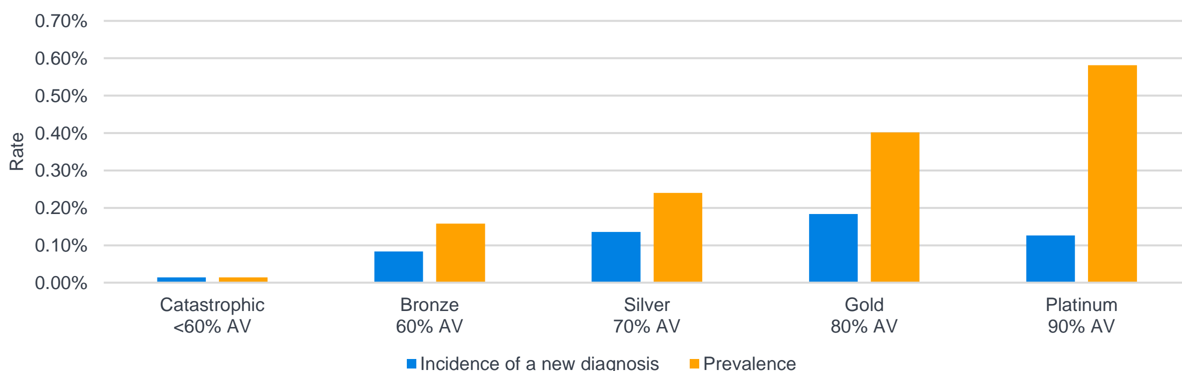
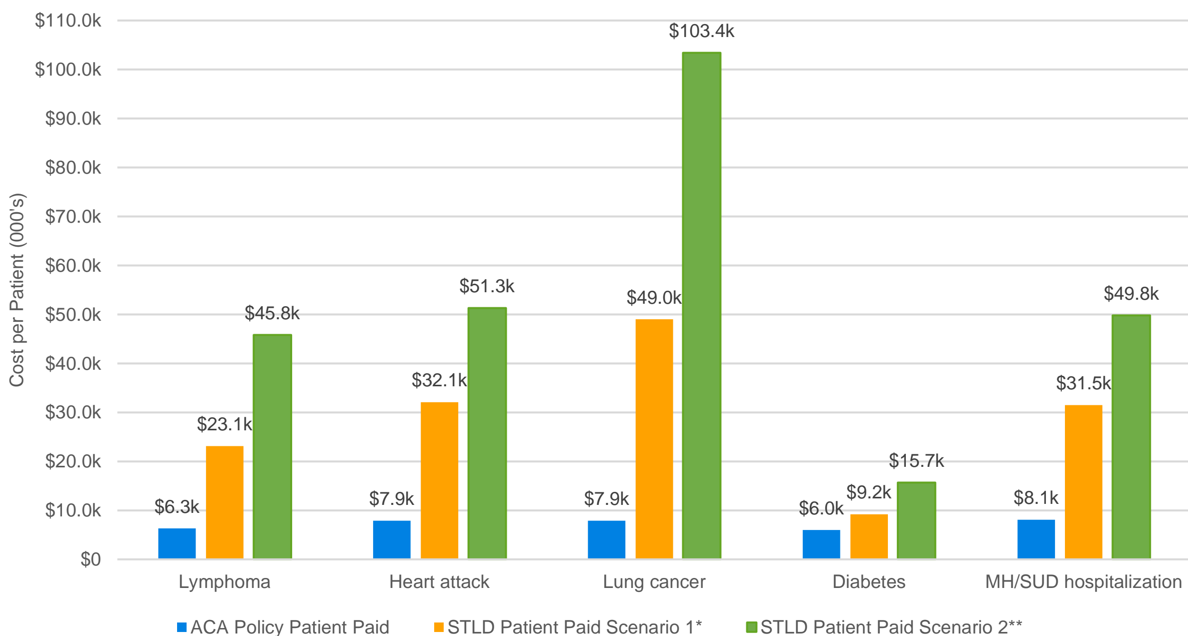


Figure 5 illustrates the cost per patient in the six-month period following the incident diagnosis of one of the five select conditions among individuals enrolled in non-CSR plans in 2017. We define the “cost per patient” to include an estimate of the average monthly premium as well as average member cost-sharing payments. Average monthly unsubsidized premiums for individuals diagnosed with one of these five conditions range from $364 to $681 for an

ACA-compliant policy and $104 to $214 for an STLD policy. The supporting table in Figure 5 breaks down the cost per patient between estimated premium and member cost-sharing payments. This chart and supporting table provide the total cost per patient under an ACA-compliant policy and the assumed cost per patient under two illustrative STLD policy scenarios:

- Scenario 1: Assumes the patient is enrolled in an STLD policy for the full six-month period following diagnosis of a new medical condition.
- Scenario 2: Assumes the patient is enrolled in an STLD policy for three months following diagnosis of a new medical condition and is declined renewal thereafter (i.e., uninsured for the following three-month period).

FIGURE 5: ESTIMATED PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) IN SIX-MONTH PERIOD FOLLOWING DIAGNOSIS OF SELECT CONDITIONS IN 2017, AMONG NON-CSR PATIENTS ENROLLED IN ACA-COMPLIANT INDIVIDUAL MARKET



	ACA POLICY PATIENT PAID			STLD PATIENT PAID SCENARIO 1*			STLD PATIENT PAID SCENARIO 2**		
CONDITION	ESTIMATED PREMIUM	COST SHARING	TOTAL PATIENT COST	ESTIMATED PREMIUM	COST SHARING	TOTAL PATIENT COST	ESTIMATED PREMIUM	COST SHARING	TOTAL PATIENT COST
Lymphoma	$3,500	$2,800	$6,300	$1,000	$22,100	$23,100	$500	$45,300	$45,800
Heart attack	$4,000	$3,900	$7,900	$1,300	$30,800	$32,100	$600	$50,700	$51,300
Lung cancer	$4,000	$3,900	$7,900	$1,200	$47,800	$49,000	$600	$102,800	$103,400
Diabetes	$3,700	$2,300	$6,000	$1,200	$8,000	$9,200	$700	$15,000	$15,700
MH/SUD hospitalization	$2,200	$5,900	$8,100	$600	$30,900	$31,500	$300	$49,500	$49,800

* Assumes the patient is enrolled in an STLD policy for the full six-month period following diagnosis. We assume STLD policies have an average actuarial value (AV) of 50%, consistent with other published studies.[6,24] Because the typical STLD policy does not cover maternity services, mental health services, or prescription drugs, we have assumed that the patient is responsible for the full amount negotiated between the provider and the insurer for these services, or the allowed (discounted) amount.

** Assumes that the patient is covered under an STLD policy for three months following diagnosis of the condition and is declined renewal thereafter. While the patient is covered by the STLD policy, we assume that the policy has an AV of 50% and does not cover maternity services, mental health services, or prescription drugs, for which the patient is responsible for the allowed amounts. After the STLD policy terminates coverage, we have assumed that the patient is uninsured and is responsible for the full amount billed (i.e., undiscounted) by the provider for all services.

Under both illustrative STLD policy scenarios, the estimated patient cost in the six-month period following diagnosis are substantially greater than the actual patient costs for members in our database with ACA-compliant coverage in 2017. For example, in the six-month period following a new diagnosis in 2017, a new lymphoma patient enrolled in an STLD policy could pay $16,800 more out-of-pocket, including premium and cost sharing, than that person would have while enrolled on an ACA-compliant policy (see STLD Scenario 1).

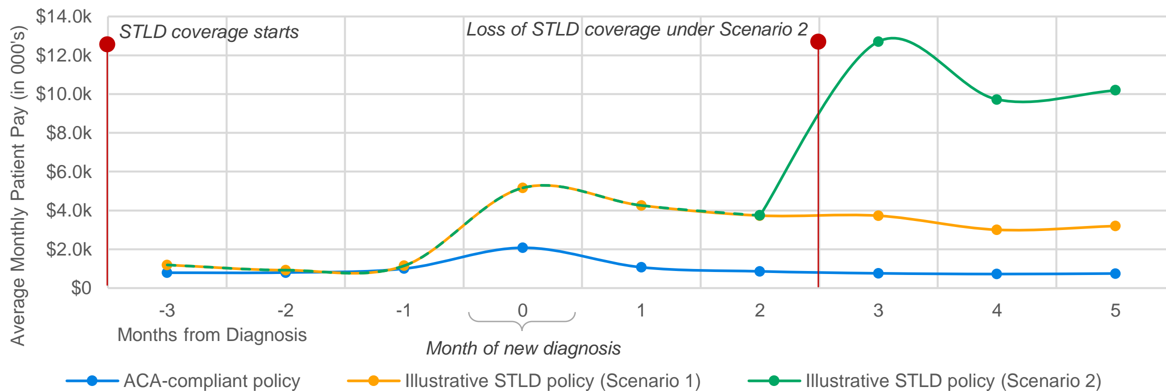
ACA-compliant policies offered substantial insurance and financial protection for individuals with an incident condition in our study. In the six-month period following diagnosis of lymphoma, total patient cost sharing was $2,800, or about 7% of total allowed cost (i.e., the amount negotiated between the provider and the insurer for medical services) for an individual enrolled in an ACA-compliant policy. The average patient cost sharing peaked in the month of diagnosis, reaching $1,510, but fell to approximately $180 per month within six months following the diagnosis. About 13% of the patient's average monthly cost sharing in the six months following diagnosis was on prescription drugs, which are not covered by most STLD policies.

In the six-month period following diagnosis, a newly diagnosed lymphoma patient enrolled in an STLD policy could pay $16,800 more in out-of-pocket expenses than that person would have while enrolled on an ACA-compliant policy.

ACA-compliant policies also offer guaranteed renewal; whereas a typical STLD policy includes preexisting condition exclusion provisions, which may lead to newly diagnosed enrollees without health coverage once their STLD policy duration has ended. Under this scenario, the newly diagnosed individual may be at risk for the undiscounted amount billed by the provider for medical services after expiration of the STLD policy, which is generally much higher than the negotiated amount paid by insurers. We determined that a patient who is denied STLD renewal three months following a new diagnosis of lymphoma and subject to providers' billed charges would be responsible for $39,500 more in the six-month period following diagnosis than the same patient covered under an ACA-compliant individual policy (see STLD Scenario 2). While patients in STLD policies would be at risk of nonrenewal because of new diagnoses, we note that they would be eligible, and are likely to sign up, for ACA-compliant coverage during the annual open enrollment period.

Figure 6 illustrates the monthly out-of-pocket costs (including monthly premiums and member cost sharing) for an incident lymphoma patient enrolled in an ACA-compliant policy as well as two illustrative scenarios of STLD coverage. We indicate the month of diagnosis as "month 0." Figures for patients with an ACA-compliant policy are based on historical data, while figures for STLD policies are estimated. To estimate STLD patient cost sharing, we applied the benefit descriptions commonly observed in STLD policies to the empirical monthly billed charges, allowed amounts, and out-of-pocket expenses of an ACA individual enrollee with a new diagnosis. Charges related to mental health, maternity, and pharmacy services were assumed to be not covered, and out-of-pocket expenses for covered medical services were 50% of allowed amounts. No maximum out-of-pocket limits were applied. The resulting estimates represent what the out-of-pocket costs would have been, had the member been enrolled in an STLD policy instead of an ACA plan. Monthly premium payments for ACA-compliant and STLD policies are estimated based on the 2019 unsubsidized premium of the popular ACA and STLD policies (see Figure 3) for a patient of the average age and sex with a new diagnosis of each of the five conditions.

FIGURE 6: MONTHLY TOTAL PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) PER MONTH IN THOUSANDS FOR ACA-COMPLIANT INDIVIDUAL MARKET NON-CSR ENROLLEES WITH A NEW DIAGNOSIS OF LYMPHOMA IN 2017 (N = 414)



* See Figure 5 for scenario definitions.

For an individual covered by an STLD policy for the six-month period following a new diagnosis of lymphoma (i.e., STLD Scenario 1), the estimated per patient cost in the three months leading up to diagnosis was $700 higher than what would have been covered under an ACA-compliant policy, and was another $16,800 higher in the six-month period following diagnosis. For individuals who are denied STLD policy renewal three months after diagnosis and are uninsured for the following three-month period, estimated patient out-of-pocket expenses were nearly $40,000 higher in the six-month period following the month of diagnosis. Figure 7 summarizes these results for all five conditions.

FIGURE 7: ESTIMATED DIFFERENCE IN PER PATIENT COST UNDER STLD POLICY VERSUS ACA-COMPLIANT POLICY, BEFORE AND AFTER INCIDENT DIAGNOSIS OF SELECT CONDITIONS IN 2017

CONDITION	THREE MONTHS PRIOR TO DIAGNOSIS	SIX MONTHS FOLLOWING DIAGNOSIS	
		STLD SCENARIO 1*	STLD SCENARIO 2*
Lymphoma	$700	$16,800	$39,500
Heart attack	$1,800	$24,100	$43,400
Lung cancer	$2,500	$41,100	$95,500
Diabetes	$0	$3,200	$9,700
MH/SUD hospitalization	$3,100	$23,400	$41,700

* See Figure 5 above for illustrative STLD scenario definitions.

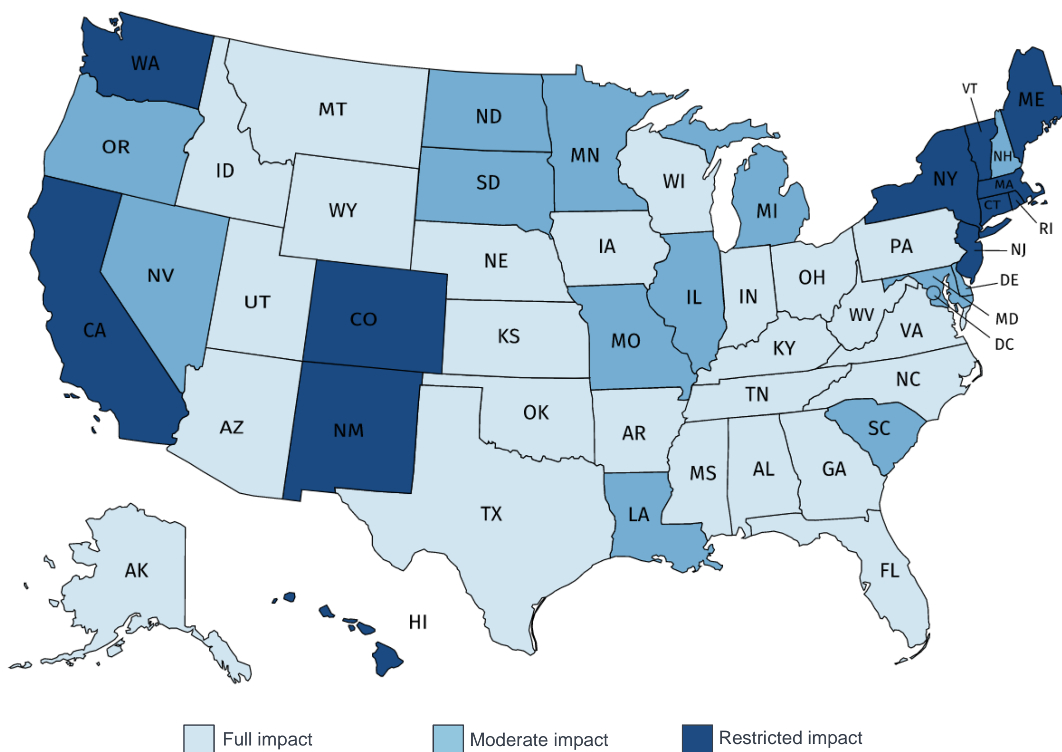
IMPACT ON 2020 PREMIUMS: A CARRIER PERSPECTIVE

We reviewed carriers' rate filing materials in the ACA individual market for plan year 2020 to determine the expected impact to unsubsidized premiums of regulatory actions, including the expansion of STLD policies and the repeal of the individual mandate penalty. We found that carriers offering ACA-compliant individual coverage in states with nonrestricted availability of STLD policies included an adjustment of approximately 4% in their 2020 premiums for the expected increase in population morbidity due to regulatory changes. These actions are anticipated to create alternative options for low-cost, low-risk individuals in the ACA-compliant marketplace, including enrolling in an STLD policy or forgoing insurance altogether, which increase premiums in the ACA individual market.

The results below are summarized by the degree of STLD plan regulation as of the writing of this report. Figure 8 illustrates a map of classification of the degree of STLD plan regulation. Appendix D provides further detail.

- States that have adopted the federal guidelines for STLD policies (364-day plans, with option to renew up to 36 months) or with at least 360-day initial duration (with or without the option to renew) are classified as “full impact” states (25 states).
- States that have limited STLD policies (such as through initial durational limits up to three-month or six-month periods) are classified as “moderate impact” states (13 states, plus the District of Columbia).
- States that have banned the sale of STLD policies or that have significant barriers to entry are classified as “restricted impact” states (12 states).

FIGURE 8: STATES BY CLASSIFICATION OF DEGREE OF STLD REGULATION*



* Classification of the degree of STLD regulation by state is based on research available at healthinsurance.org.[31]*Classification of the degree of STLD regulation by state is based on research available at healthinsurance.org.[25]

There are important differences among states with and without restrictions in the STLD market. Carriers offering individual coverage in states without restrictions on STLD availability assumed an average rate impact approximately 5% greater than states with low-to-moderate restrictions on STLD availability. Figure 9 summarizes the average 2018-2020 rate change and the reported impact on 2020 individual market premiums due to regulatory changes, such as the individual mandate penalty repeal, expansion of STLD policies, and expansion of AHPs.

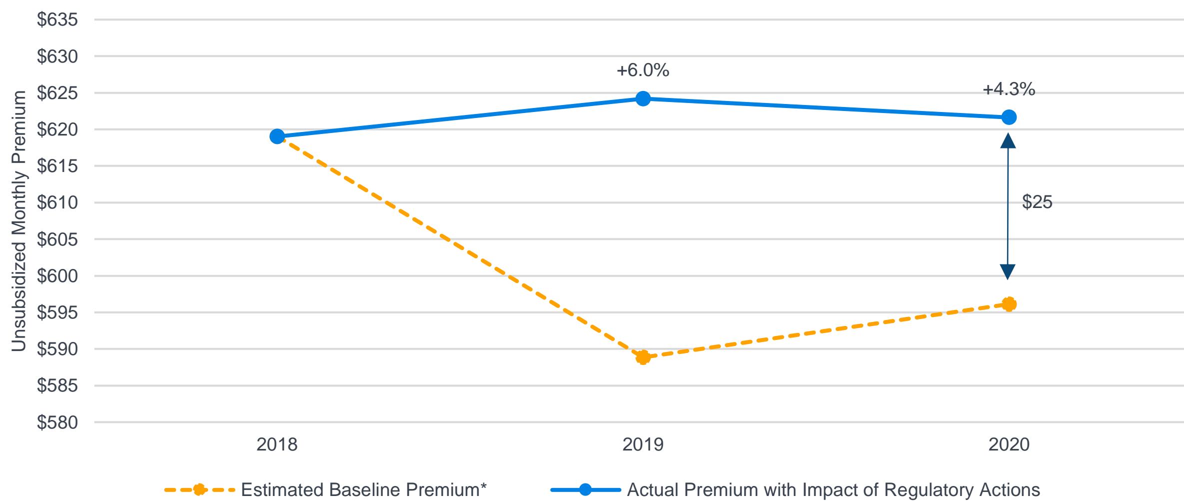
Based on our research of 2020 approved rate filings and URRTs in the ACA individual market, the impact of regulatory actions (which include but are not limited to the repeal of the individual mandate penalty and the expanded availability of STLD policies) is expected to increase population morbidity by approximately 4%. See Appendix E for additional state-level and carrier-level detail.

FIGURE 9: SUMMARY OF IMPACT OF REGULATORY ACTIONS ON 2020 ACA-COMPLIANT INDIVIDUAL MARKET PREMIUMS

DEGREE OF STLD REGULATION	OVERALL 2018-2020 UNSUBSIDIZED RATE CHANGE	2020 RATE IMPACT OF REGULATORY ACTIONS
Full impact	+0.4%	+4.3%
Moderate impact	-2.0%	+3.0%
Restricted impact	+7.5%	-1.2%

In states that have adopted the federal guidelines or substantial portions of the federal guidelines for STLD availability (i.e., "full impact" states with at least 360-day initial policy duration, with or without the option to renew), we found that average monthly unsubsidized premiums in the 2020 ACA individual marketplace are approximately 4.3% greater, or about $25 higher, due to regulatory actions such as the individual mandate penalty repeal and the STLD policy expansion. Figure 10 provides a simple illustration of our research for full impact states.

FIGURE 10: SUMMARY OF IMPACT OF REGULATORY ACTIONS ON 2020 ACA INDIVIDUAL PREMIUMS AMONG STATES WITH FULL IMPACT OF STLD EXPANSION



* Baseline ACA-compliant individual market premiums assume no impact due to regulatory actions, including the elimination of the individual mandate penalty and expansion of STLD policies or AHPs. Reflects the average 2018 premium for renewing policies within the ACA-compliant individual market, calculated from URRT PUFs.
** Informed by Kaiser's rate filing research for 2019[8] and Milliman's rate filing research for 2020 on the carrier-assumed impact of regulatory changes on ACA-compliant individual market premiums.

On average across states with the federal guidelines for STLD policies (i.e., full impact states), approved rate increases have been relatively flat between 2018 and 2020 (0.8% in 2019 and -0.4% in 2020). However, carriers loaded their premiums with adjustments in 2019 and 2020 to account for regulatory changes, including the individual mandate and the expansion of STLD plans, leading to monthly premiums that are $25 higher than a "baseline" premium (assuming no regulatory changes).

In general, the impact of regulatory actions on 2020 premiums is lower than the assumed impact on 2019 premiums from Kaiser Family Foundation research.[8] Using data reported in Kaiser's issue brief on the impact of regulatory changes on 2019 premiums, we determined that the average impact was greater in 2019 than in 2020 for all groupings of states by degree of STLD plan regulation (i.e., full impact, moderate impact, and restricted impact). For example, for states with the full impact of STLD plan expansion, the 2019 rate impact of regulatory actions was 6.0%, versus 4.3% on 2020 premiums, as illustrated in Figure 9 above. In 2018, CMS projected that gross premiums in the ACA-compliant individual marketplace would ultimately increase about 6% by 2022 due to the impact of STLD policy

changes, with roughly 4% of that overall rate increase occurring by 2020.[6] Our research of 2020 rate filings shows that premiums in states with the federal STLD regulations (i.e., full impact) are 4.3% higher due to the expansion of STLD policies, which aligns with CMS's projections for 2020.

This decrease indicates carriers are assuming that the impact due to the repeal of the individual mandate penalty and STLD policy expansion on the morbidity of the individual risk pool is less than what had been originally assumed for 2019 pricing. Although complete claims and enrollment data for calendar year 2019 were not available when carriers were pricing for the 2020 rating period, emerging data may have suggested that 2019 enrollment had not declined significantly from 2018 despite the availability of alternative coverage options. For example, our analysis of CMS Open Enrollment Public Use Files (PUFs) determined that consumer plan selections in the individual market only decreased 2.6% between 2018 and 2019 open enrollment periods.

The impact of regulatory actions, including the repeal of the individual mandate penalty and the expanded availability of STLD policies, is expected to increase unsubsidized premiums by approximately 4% in 2020 among states with full expansion of STLD policies.

Our review of carriers' rate filing materials in the ACA individual market for plan year 2020 suggests that the impact of the STLD expansion was hard to measure, and carriers did not distinguish from the impact of the mandate repeal. Most carriers did not distinguish the impact of regulatory actions on 2020 individual market premiums between the effects of the individual mandate penalty repeal, the STLD policy expansion, and other regulatory actions (such as the expansion of AHPs). Among the few carriers that explicitly included a premium adjustment for the expansion of STLD policies, it was generally between 0.5% and 2% in 2020.

On average, the 2020 premium impact of regulatory actions among states that restricted the sale or duration of STLD policies was -1.2% (see Figure 9), indicating that premiums were lower due to regulatory action. This is driven primarily by changes in California, where the individual mandate penalty was reinstated for 2020, resulting in an average decrease to 2020 individual market premiums of approximately 2.6%. California's large individual market enrollment relative to other states results in a weighted average impact among restricted states that is heavily influenced by California's individual mandate reinstatement.[26] Excluding California results in a weighted average rate impact of 0.6% among states with restrictions on STLD policies.

Regulatory actions among other states that have restricted STLD policies have led to low rate impacts:

- Massachusetts: The average assumed impact of regulatory actions among the eight carriers offering coverage in 2020 who publicly quantified a rate impact was 0%. Massachusetts, which implemented a long-standing individual mandate penalty in 2007, also imposes tight regulations on STLD policies.[27,28] No STLD policies are currently available for purchase in Massachusetts.[27,28]
- New Jersey: Among the two carriers that publicly quantified a rate impact, the average adjustment was 0% in New Jersey due to regulatory actions. New Jersey, which also enacted an individual mandate penalty effective in 2019, does not allow STLD policies to be sold.[29,30]
- New York: The average rate adjustment in 2020 among carriers that publicly quantified an impact due to regulatory changes was +1.5%. Because New York does not allow the sale of STLD policies,[31] most carriers attributed the full rate impact to the individual mandate.

- Washington: Carriers assumed an average impact of +0.8% in 2020 due to regulatory actions, ranging from 0% to 5% for the repeal of the individual mandate penalty. Washington limits the duration of STLD policies to three months, with renewals prohibited, and enforces restrictions on the sale of STLD policies and on preexisting condition exclusion provisions.[32]

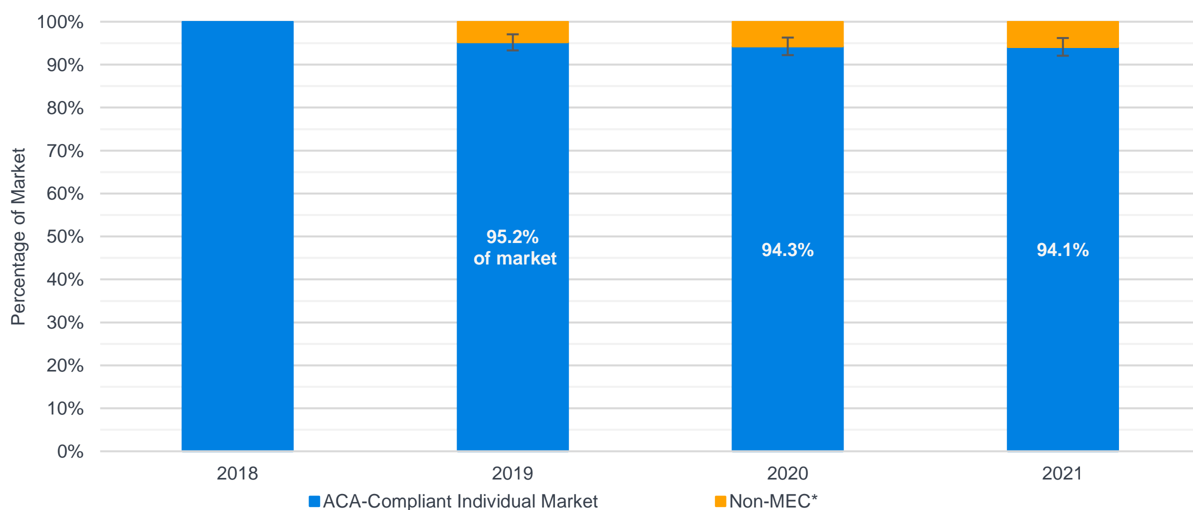
Our research on the 2020 approved individual market rate filings indicated that carriers generally did not consider the degree of availability of STLD policies when setting assumptions; carriers in states with both moderate impact STLD regulations and full impact STLD regulations assumed average premium impacts of approximately 4%. Several multistate carriers (i.e., insurers that offer individual coverage in multiple states) assumed the same premium adjustment in 2020 for each state in which they were filing premiums, regardless of whether the state implemented moderate impact regulations on the sale or duration of STLD policies. Many carriers assumed the same rate impact in their 2019 premiums and 2020 premiums.

PROJECTED IMPACT OF REGULATORY ACTIONS

Using Kaiser's reported findings and our research on the impact of regulatory actions on 2019 and 2020 individual market premiums, we estimated the impact on ACA-compliant individual market enrollment and premiums between 2019 and 2021. If current trends continue, the ACA-compliant individual market may lose up to 6% of members to non-MEC by 2021 among states with full impact STLD regulation. We expect that the impact of these regulatory actions on enrollment will largely subside after 2021.

Figure 11 illustrates the projected impact of regulatory actions, such as the individual mandate penalty repeal and STLD policy expansion, on enrollment among states with the full impact of STLD regulation based on our modeling of 50,000 members with ACA-compliant individual coverage.

FIGURE 11: PROJECTED IMPACT OF REGULATORY ACTIONS ON ENROLLMENT IN ACA-COMPLIANT INDIVIDUAL MARKETS WITH NONRESTRICTED STLD REGULATIONS AND NON-MINIMUM ESSENTIAL COVERAGE, 2018-2021



* Reflects enrollment in non-minimum essential coverage, including STLD policies and individuals without insurance.
Note: Error bands reflect 95% confidence interval.

We assume that low-cost, low-risk individuals are healthy and more likely to switch to a form of non-MEC, which includes individuals who choose to forgo coverage and those who enroll in STLD policies. Based on our modeling of members enrolled in ACA-compliant individual coverage, we anticipate that approximately 6% of the ACA individual

market would have to migrate to non-MEC by 2021 in order for the expected premium increases, as informed by carriers' assumed rate adjustments due to the regulatory actions in 2019 and 2020, to be realized. However, we assume that individuals eligible for a premium or cost-sharing subsidy in the ACA-compliant market are less likely to dis-enroll from ACA-compliant coverage due to the financial advantages that the subsidy provides. Using data released by CMS, we found that 87% of individuals who selected an ACA-compliant policy through healthcare.gov during the 2019 open enrollment period were eligible for either a premium tax credit subsidy or a cost-sharing reduction subsidy. The availability of subsidies in the ACA individual market provides incentives that make staying on ACA-compliant coverage an attractive option for many.

As the risk pool continues to deteriorate, premiums will increase, leading to further adverse selection against the ACA-compliant marketplace. Our research found that, for every 1% increase in premium, historical enrollment in the ACA individual market has decreased by 0.2%. Extrapolating this research to the expected premium impact of regulatory actions would lead to enrollment deterioration of approximately 6% by 2021 in the ACA individual market.

Discussion

STLD policies can offer lower premiums for healthy individuals that must fill a temporary gap in coverage. Often, STLD policy premiums are less expensive than unsubsidized premiums available through ACA-compliant marketplaces. Our analysis of STLD policies found that STLD policies typically have lower premiums but offer less benefit coverage and insurance protection than ACA-compliant policies. Our research found that the typical STLD policy does not cover prescription drugs, mental health services, or maternity services, all of which are required essential health benefits under the ACA. Additionally, of the STLD policies surveyed, the typical STLD policy has a policy maximum coverage limit of $2,000,000. Such policy maximum limits are prohibited under the ACA. All plans in our research included a preexisting condition exclusion provision, which is also banned under the ACA. These STLD plan provisions, coupled with high deductibles and member cost-sharing levels, can lead to significant out-of-pocket patient costs.

The diagnosis of an incident condition or acute event, while rare, may be financially catastrophic for an individual enrolled in an STLD policy. Our research suggests that individuals enrolled in ACA bronze or catastrophic policies, which may resemble the demographic profile of individuals enrolled in STLD policies, have lower incidence rates of costly medical conditions than those enrolled in richer benefit plans. While STLD products often offer lower premiums than ACA coverage, individuals can be exposed to high medical expenses. In the six-month period following a new diagnosis of a costly medical condition in 2017, an individual may spend up to six times more on patient out-of-pocket expenses, including monthly premium payments and member cost sharing, while enrolled in an STLD policy than they would have on an ACA-compliant policy. For certain conditions, such as diabetes, the lack of prescription drug coverage under an STLD policy contributes to roughly 40% of a patient's out-of-pocket spend. For substance use disorder hospitalizations, the potential lack of coverage for mental health services under an STLD policy can raise a patient's out-of-pocket expenses in the six months following diagnosis from roughly $5,900 under an ACA-compliant policy to $30,900.

Furthermore, as STLD policies allow medical underwriting, the diagnosis of a high-cost condition can result in loss of coverage after the STLD policy duration has ended. Individuals losing coverage under an STLD policy are not eligible for a special enrollment period in the ACA marketplace and must wait until the next open enrollment period. This can result in periods of no coverage under either an STLD policy or an ACA-compliant policy. During this time, an individual would be responsible for the full undiscounted amount billed by providers for healthcare services, resulting in substantial out-of-pocket expenses. While STLD policies can offer low-premium options for healthy individuals, the potential financial burden can be devastating if diagnosed with a high-cost condition.

The recent expansion of STLD policies and other loosely regulated insurance has implications on the ACA-compliant market. Carrier expectations for the impact of these regulatory actions on premiums in the ACA individual market for 2020 are approximately 4% in states that have not restricted the sale or duration of STLD policies. Many states have implemented regulations on the sale or duration of STLD policies since the federal expansion of such policies in 2018. Less than half of the states that had once adopted the federal guidelines for STLD policies still do. Among the states that have limited the impact of loosely regulated insurance through reinstating an individual mandate or by restricting STLD expansion, carriers have assumed an average premium impact in 2020 due to regulatory actions that is about 5% lower than other states.

Previous studies on recent regulatory actions, including the repeal of the individual mandate penalty and expansion of STLD policies and other loosely regulated insurance, have reported higher premium impacts to the ACA individual marketplace.[5,7,8] The diminished impact of regulatory actions on 2020 premiums suggests that emerging data has indicated that enrollment in the ACA individual market has not declined as significantly as originally expected. Due to the availability of subsidies on the ACA individual market, we expect that ACA individual market enrollment will decline by approximately 6% between 2018 and 2021 in order to result in premium increases that are consistent with carrier expectations for 2020.

The results of our study on the expansion of STLD policies have important implications on both individuals considering purchasing an STLD policy as well as the ACA-compliant individual marketplace as a whole. Patients

electing coverage under an STLD policy should be aware of the financial exposure they could face if diagnosed with a costly medical condition.

Data Sources, Methodology, and Limitations

DATA SOURCES

Milliman's Consolidated Health Cost Guidelines™ Sources Database (CHSD)

The Consolidated Health Cost Guidelines Sources Database (CHSD) contains paid cost, allowed cost, and billed cost, along with utilization, for inpatient, outpatient, professional, and pharmaceutical services for a commercial population, including individual market insurers as well as small and large group employer-sponsored plans. We used CHSD data for 2016 to 2017 for individuals enrolled in ACA-compliant individual policies in our analysis.

Milliman's 65+ Health Cost Guidelines™ (HCGs)

The HCGs provide a flexible but consistent basis for the determination of health claims costs and premium rates for a wide variety of health plans. The HCGs are developed as a result of Milliman's continuing research on healthcare costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as they are used in measuring the experience or evaluating the rates of health plans, and as they are compared to other data sources. We used the HCG-assigned service categories to identify mental health/substance use disorder hospitalizations, as well as maternity-related services.

ACA Individual Market Rate Filings for 2020

We reviewed rate filing materials for all carriers filing for individual market coverage effective January 1, 2020, across all markets. The extent to which filing materials, which included actuarial memoranda, Unified Rate Review Templates (URRTs), and carrier objection responses, were available varied widely by state and carrier. Data was available through the following sources:

- HealthCare.gov Rate Review (ratereview.healthcare.gov)
- URRT Public Use Files (PUFs) for 2020
- State insurance department websites
- System for Electronic Rate and Form Filing (SERFF) filings

METHODOLOGY

Impact of regulatory changes on 2020 ACA-compliant individual market premiums

We reviewed publicly available rate filings for ACA-compliant individual coverage effective in plan year 2020 that were submitted to state regulators to determine the assumed impact to 2020 premiums for all regulatory actions, including the expansion of STLD policies and the repeal of the individual mandate penalty. We have included all carriers filing for individual market coverage effective January 1, 2020, across all states. The extent to which filing materials, which include actuarial memorandums, Unified Rate Review Templates, and carrier objection responses, are available varies widely by state and insurer. Data was available through ratereview.healthcare.gov, URRT Public Use Files (PUFs), state insurance department websites, or SERFF filings.

We excluded insurers where the premium impact due to regulatory changes was not specified in the public rate filings. We assigned these insurers a value of "N/A," indicating that a company either did not mention the regulatory changes at all (e.g., individual mandate, STLD, AHPs, etc.); or the company mentioned an impact but did not quantify the amount; or quantified the rate impact but redacted the amount from public filings. In some cases, we assigned a value of "N/A" when it was clear the insurer requested a rate impact but it was unclear whether the state allowed that load, or if the insurer built in the load elsewhere in its rate calculations. Carriers that did not quantify the premium impact due to regulatory changes were excluded from the averages provided in Figures 9 and 10 above and

Appendix E. A value of "0%" indicates the insurer did publicly quantify the impact and specified that it was 0%. Averages are weighted on aggregate premium as of March 2019 by carrier for renewing plans.

States are divided by degree of regulation on STLD policies based on our research as of January 2020. States that have adopted the federal guidelines for STLD policies (364-day plans, with option to renew up to 36 months) are labeled as "full impact" states. States that have limited STLD policies (such as through durational limits up to three-month or six-month periods) are labeled as "moderate impact" states. States that have banned the sale of STLD policies or that have significant barriers to entry are labeled as "restricted impact" states. Appendix D provides the current degree of STLD regulation by state, along with notes on any state-specific restrictions.

Anti-selection modeling methodology

To simulate the ACA-compliant individual marketplace, we used Milliman's 2017 Consolidated Health Cost Guidelines Sources Database (CHSD) to establish a cohort of 50,000 unique members with ACA-compliant individual coverage (the "Cohort") and their historical allowed costs. The 50,000 members for our simulation were selected such that the distribution by metallic level was consistent with the CMS 2019 Open Enrollment Report. Within each metallic level, the sample selection from CHSD was random.

The anti-selection model (the "Model") randomly selects 5,000 members from the Cohort and models their enrollment patterns over time. This process is repeated 500 times in order to understand the impact of different sample composition and randomness.

To model enrollment patterns, the 5,000 sample members are segmented by historical allowed costs by decile. Members in the first decile had the lowest allowed costs (e.g., below the 10th percentile), and members in the 10th decile had the highest allowed costs (e.g., above the 90th percentile). Probabilities that a member will switch to non-MEC were assigned to each decile, based on analysis of available ACA filings and of the observed relationship between enrollment patterns and premium trends. Members in the 10th decile (i.e., those with the highest allowed costs) were the least likely to switch to non-MEC, while members in the first decile (i.e., those with the lowest allowed costs) are the most likely to switch. We assumed members in richer plans have a much lower probability of switching to non-MEC due to the selection bias that is commonly observed with metallic tier selection. Members enrolled in subsidized plans (cost-sharing reduction plan variants) do not switch regardless of decile because leaving the ACA market would cause them to lose the subsidy.

The samples of 5,000 members were modeled for four periods (2018-2019, 2019-2020, 2020-2021, 2021-2022). Members who migrated to non-MEC had the possibility to switch back to ACA-compliant coverage if their annual allowed costs were high.

We made the following assumptions in our modeling:

- Starting population: All members in the Cohort were enrolled in ACA-compliant individual coverage; there were no members enrolled in non-MEC coverage at beginning of simulation. The membership distribution by metallic tier is consistent with the CMS 2019 Open Enrollment Report.
- Static population: We assumed that the sample of 5,000 members was static throughout the simulation (i.e., no new entrants or deaths among the sample).
- Cost adjustments: In order to model the isolated impact of regulatory changes, we included no morbidity, utilization, or cost trends, and did not model year-to-year changes in allowed costs on an individual basis.
- Switch probability: The probability of switching to non-MEC in each year is informed by the impact of regulatory changes on premiums in 2019 and 2020 (per Kaiser Family Foundation research and Milliman research, respectively), as well as Milliman's research on the relationship between historical premium increases and enrollment in the ACA-compliant individual market.

Members in a gold or platinum ACA plan have a 30% lower likelihood of switching to an STLD plan, due to the presumption of selection bias by metallic level for enrollees.

Members enrolled in an ACA cost-sharing reduction (CSR) plan will not switch to MEC.

Random number generators were used to determine whether individuals switched between ACA-compliant coverage and non-MEC.

In order to determine a range of reasonable results using this model, we employed a Monte Carlo approach, which reruns the model 500 times using a different group of 5,000 sample members and a different set of random numbers for each run. For each state categorization (i.e., full impact, moderate impact, and restricted impact), we generated 500 such iterations of the model.

STLD plan design methodology

We surveyed 96 STLD policies available through eHealth, an online vendor for short-term health insurance. We focused on policies available in Atlanta, Georgia (ZIP Code 30301), an area that is closely representative of national average healthcare costs according to Milliman's Health Cost Guidelines (HCGs). The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually.

For each of the 96 policies include in our research, we collected data on the following plan design features:

- Policy carrier
- Plan name
- Plan duration
- Policy waiting period
- Deductible
- Coinsurance- or copay-based policy
- Global coinsurance value
- Patient out-of-pocket limit
- Policy maximum limit
- Primary care physician (PCP) cost sharing
- Specialty care provider (SCP) cost sharing
- Prescription drugs cost sharing
- Mental health cost sharing
- Premium for age 27 female (nonsmoker)

Of the policies included in our research, about one-third were available through UnitedHealthcare, underwritten by Golden Rule Insurance Company. Figure 12 illustrates the distribution of carrier for all the STLD policies included in our research.

FIGURE 12: STLD POLICY CARRIERS INCLUDED IN MILLIMAN RESEARCH

POLICY CARRIER	PERCENT OF POLICIES
UnitedHealthcare	33%
Everest Reins. Company	25%
Companion Life Company	17%
Independence American Insurance Company	13%
National General Accident & Health	13%

Condition identification methodology

We used Milliman's 2016 and 2017 Consolidated Health Cost Guidelines Sources Database (CHSD) to identify the costs, prevalence rate, and incidence rate for each of the following conditions: lymphoma, heart attack, lung cancer, diabetes, and mental health/substance use disorder hospitalization. We included all members in the individual ACA-compliant marketplace who were under the age of 65 and had continuous enrollment in 2016 and 2017. We define prevalence rate as the proportion of members in 2017 who had a diagnosed condition. We then identified members as incident if the condition was newly emergent (i.e., a diagnosis was not present in 2016).

Because administrative claims data often missed diagnosis of diseases, we excluded individuals with a recent history of chemotherapy services from incident cases of lymphoma and lung cancer, and individuals with a recent history of antidiabetic drug utilization for the incidence of diabetes. Appendix B provides the rates of incidence and prevalence among individuals enrolled in a non-CSR ACA-compliant individual market policy for five select conditions. Low-income beneficiaries enrolled in CSR plans qualify for government subsidies, which may result in changes to individual incentives and market behavior, and are thus excluded from this analysis.

Qualified claims were identified throughout the analysis using the Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) codes and revenue codes. The below methodology describes how we identified patients with the following conditions:

1. Lymphoma: We identified patients with lymphoma as those who have either:
    a. At least one acute inpatient, emergency, or observation qualified claim that contains an ICD-10 CM diagnosis code for lymphoma in any position.
    b. At least two non-qualified claims on different dates of service that contain an ICD-10 CM diagnosis code for lymphoma in any position.
2. Heart attack: We identified patients with myocardial infarction as those with at least one acute inpatient, non-acute inpatient, emergency, observation, or outpatient qualified claim that contains at least one ICD-10 CM diagnosis code for a myocardial infarction in any position.
3. Lung cancer: We identified patients with lung cancer as those who have either:
    a. At least one acute inpatient, emergency, or observation qualified claim that contains an ICD-10 CM diagnosis code for lung cancer in any position.
    b. At least two non-qualified claims on different dates of service that contain an ICD-10 CM diagnosis code for lung cancer in any position.
4. Diabetes: We identified patients with diabetes as those who have any of the following:
    a. At least one acute inpatient qualified claim that contains an ICD-10 CM diagnosis code for diabetes.
    b. At least two outpatient, non-acute inpatient, emergency, or observation qualified claims on different dates of services that contain an ICD-10 CM diagnosis code for diabetes.
    c. At least one antidiabetic drug and at least one outpatient, non-acute inpatient, emergency, or observation qualified claim containing an ICD-10 CM diagnosis code for diabetes. National Drug Code (NDC) codes for antidiabetic drugs were identified as "ANTIDIABETICS" from MediSpan's major class field. This list was supplemented by similar drugs identified from the Healthcare Effectiveness Data and Information Set (HEDIS). Though it is a commonly used antidiabetic, metformin hydrochloride was excluded from the list of drugs because it has other uses, including weight loss and anticancer treatments.
5. Mental health/substance use disorder hospitalization: We identified patients with substance use disorder as those with any inpatient claim categorized as "Facility IP – Alcohol and Drug Abuse" using Milliman's HCG Grouper. The HCG Grouper uses services codes—diagnosis-related groups (DRGs), revenue codes, HCPCS, etc.—to assign claims-level service categories. The HCG Grouper defines "Facility IP – Alcohol

and Drug Abuse" to include both detoxification and rehabilitation confinements that are assigned to a substance use disorder diagnosis group using CMS's DRG coding system.

These algorithms were applied to 2016 and 2017 administrative claims data. Of members who were identified as having a cancer (lymphoma or lung cancer) in 2017, the member was excluded from the incident group if that person had a claim categorized as chemotherapy by Milliman's HCG Grouper in the 12 months prior to the earliest observed date of cancer diagnosis. Of members who were identified as having diabetes in 2017, the member was excluded from the incident group if that person had a claim containing an ICD-10 CM diagnosis code for diabetes in the 12 months prior to the earliest observed date of diabetes diagnosis.

Per patient costs include estimated monthly premium payments as well as member cost-sharing payments. Cost-sharing payments were calculated for those members with at least one condition in 2017, based on the month relative to the first diagnosis of their condition. Cost-sharing payments are separated into four categories that are impactful in terms of STLD versus ACA patient cost-sharing structures: medical, pharmacy, maternity, and mental health.

For each condition, monthly premium payments were estimated using 2019 premiums for the popular STLD and ACA-compliant bronze policy shown in Figure 3. For the ACA-compliant policy, the unsubsidized premium available for an individual at the average age of diagnosis for each of the five conditions was used. For the STLD policy, the premium available for an individual at the average age of diagnosis for each of the five conditions was used, adjusted for condition incidence between males and females.

LIMITATIONS

Our estimate of the impact of regulatory actions on 2020 premiums represents carrier expectations for rating period 2020 in the ACA-compliant individual market. The estimate of the future impact of regulatory actions on enrollment and premium, as well as the modeled patient out-of-pocket cost of an STLD policy, are based on a large sample of members enrolled in ACA-compliant individual coverage in 2017 in Milliman's Consolidated Health Cost Guidelines Sources Database (CHSD). Other subpopulations or time periods may exhibit different results.

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Appendices

APPENDIX A: ILLUSTRATIVE PLAN DESIGN COMPARISON WITH A SILVER POLICY

		POPULAR ACA-COMPLIANT SILVER PLAN**			
POLICY FEATURE	**POPULAR STLD PLAN***	**SILVER – NO CSR**	**SILVER – CSR 250**	**SILVER – CSR 200**	**SILVER – CSR 150**
Initial duration	6 months	12 months	12 months	12 months	12 months
Deductible	$12,500	$6,000	$2,625	$0	$0
Member cost-sharing	Coinsurance, 30%	Coinsurance, 40%	Coinsurance, 40%	Coinsurance, 40%	Coinsurance, 25%
Maximum out-of-pocket limit	$22,500	$7,900	$6,300	$2,600	$1,000
Policy maximum coverage limit	$2,000,000	N/A	N/A	N/A	N/A
Prescription drug coverage	Not covered	Covered	Covered	Covered	Covered
Mental health service coverage	Not covered	Covered	Covered	Covered	Covered
Maternity service coverage	Not covered	Covered	Covered	Covered	Covered

* Reflects the plan design for the Short Term Medical Value Select A policy, offered by UnitedHealthcare.
** Reflects the plan design for the Ambetter Balanced Care 11 (2019) ACA-compliant silver policy, offered by Ambetter of Peach State Inc. in 2019.

APPENDIX B: INCIDENCE OF NEW DIAGNOSES AND PREVALENCE OF SELECT CONDITIONS

Appendix B-1. Summary of Incidence of New Diagnoses and Prevalence of Select Conditions in 2017

INCIDENCE OF NEW DIAGNOSES AND PREVALENCE OF DIAGNOSED SELECT CONDITIONS IN 2017 AMONG ACA INDIVIDUAL MARKET NON-CSR ENROLLEES

CONDITION	INCIDENCE	PREVALENCE
Lymphoma	0.12%	0.23%
Heart attack	0.22%	0.29%
Lung cancer	0.05%	0.09%
Diabetes	1.53%	4.82%
MH/SUD hospitalization	0.09%	0.10%

Appendix B-2. Detailed Summary of Incidence of New Diagnoses and Prevalence of Select Conditions by Metallic Tier in 2017

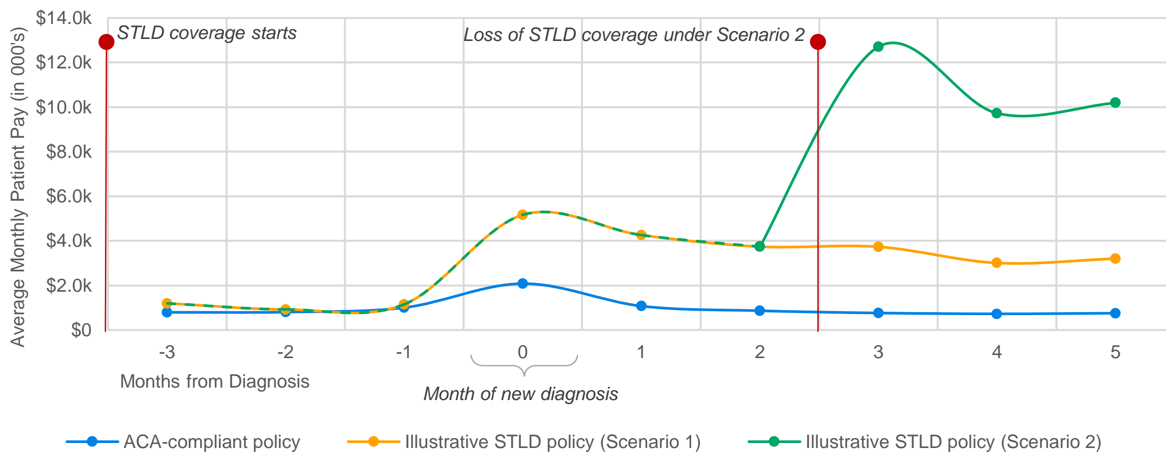
DETAILED INCIDENCE OF NEW DIAGNOSES AND PREVALENCE OF DIAGNOSED SELECT CONDITIONS IN 2017 AMONG ACA INDIVIDUAL MARKET, BY METALLIC TIER

CONDITION	CATASTROPHIC	BRONZE	NON-CSR SILVER	GOLD	PLATINUM
Expected actuarial value (AV)	<60%	60%	70%	80%	90%
Incidence of a new diagnosis					
Lymphoma	0.01%	0.08%	0.14%	0.18%	0.13%
Heart attack	0.01%	0.16%	0.26%	0.31%	0.28%
Lung cancer	0.00%	0.04%	0.07%	0.06%	0.10%
Diabetes	0.13%	1.15%	1.90%	1.94%	0.99%
MH/SUD hospitalization	0.08%	0.05%	0.08%	0.21%	0.38%
Condition prevalence					
Lymphoma	0.01%	0.16%	0.24%	0.40%	0.58%
Heart attack	0.01%	0.21%	0.33%	0.44%	0.61%
Lung cancer	0.00%	0.06%	0.11%	0.14%	0.28%
Diabetes	0.25%	3.24%	5.67%	7.69%	10.36%
MH/SUD hospitalization	0.08%	0.06%	0.09%	0.24%	0.58%

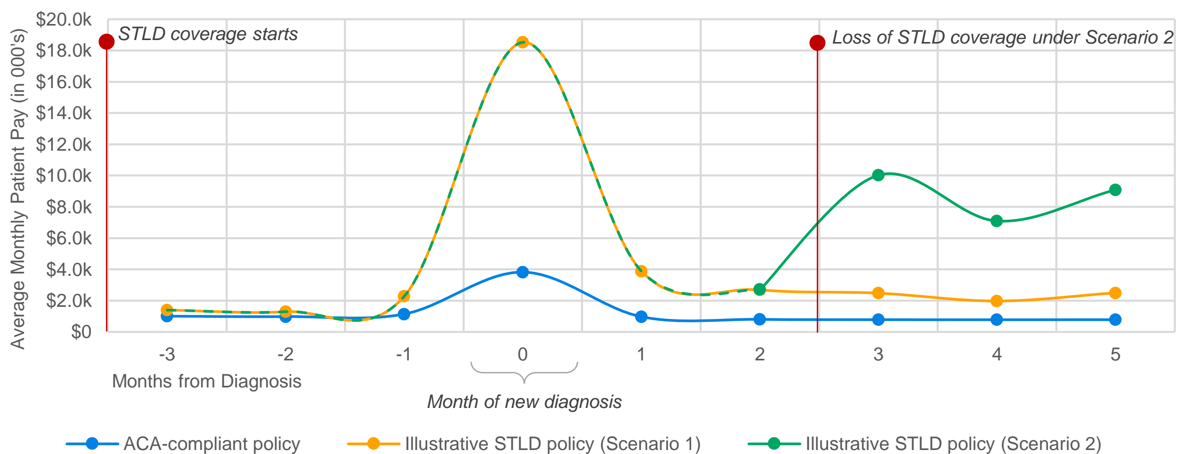
APPENDIX C: MONTHLY PER PATIENT OUT-OF-POCKET EXPENSES BY CONDITION

Note: See Figure 5 above for STLD scenario definitions. Patient out-of-pocket costs include estimated monthly premium expenses as well as member cost-sharing payments.

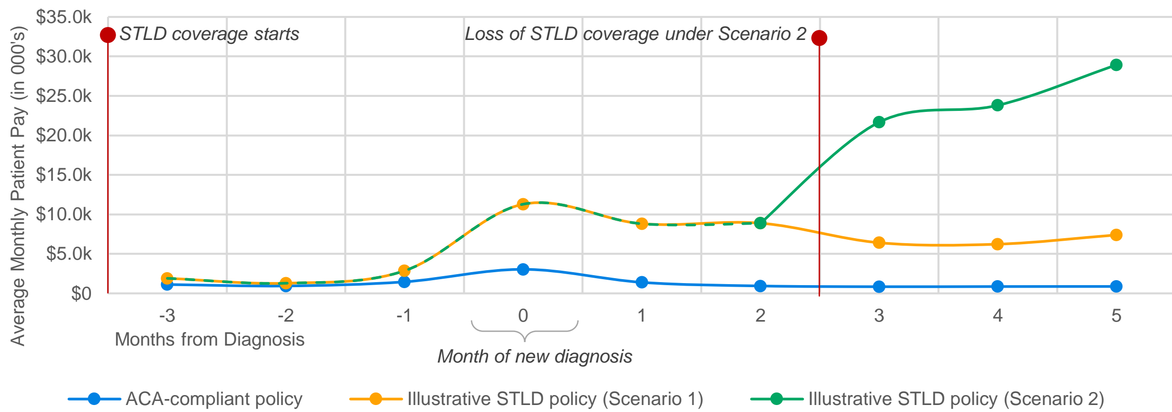
MONTHLY TOTAL PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) PER MONTH IN THOUSANDS FOR ACA-COMPLIANT INDIVIDUAL MARKET NON-CSR ENROLLEES WITH A NEW DIAGNOSIS OF LYMPHOMA IN 2017 (N = 414)



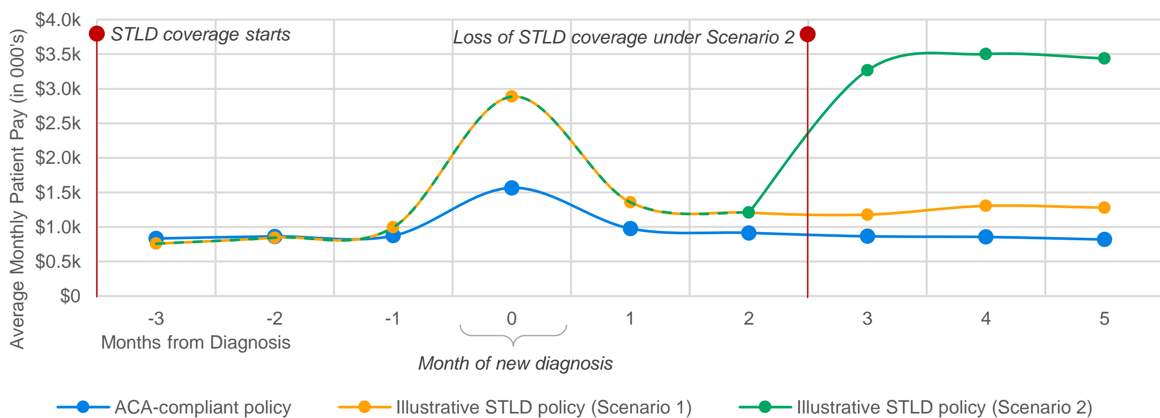
MONTHLY TOTAL PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) PER MONTH IN THOUSANDS FOR ACA-COMPLIANT INDIVIDUAL MARKET NON-CSR ENROLLEES WITH A NEW DIAGNOSIS OF A HEART ATTACK IN 2017 (N = 772)



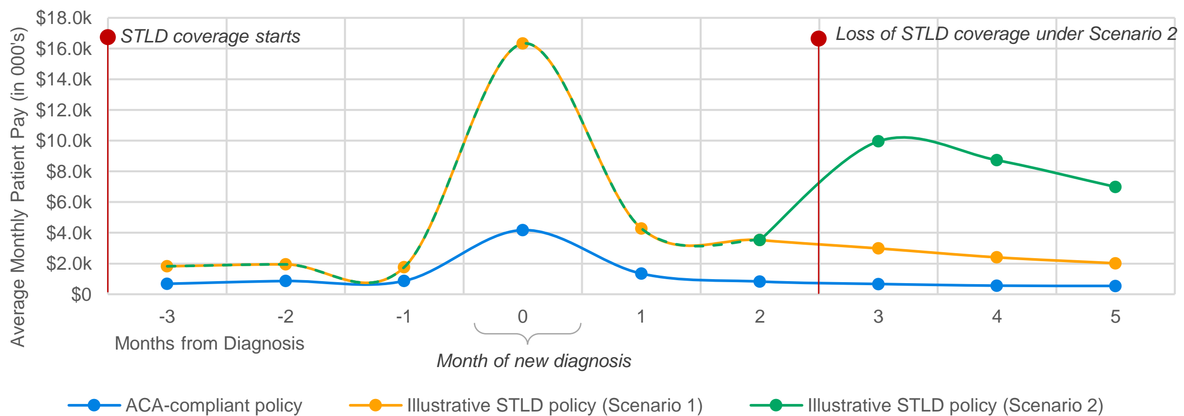
MONTHLY TOTAL PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) PER MONTH IN THOUSANDS FOR ACA-COMPLIANT INDIVIDUAL MARKET NON-CSR ENROLLEES WITH A NEW DIAGNOSIS OF LUNG CANCER IN 2017 (N = 194)



MONTHLY TOTAL PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) PER MONTH IN THOUSANDS FOR ACA-COMPLIANT INDIVIDUAL MARKET NON-CSR ENROLLEES WITH A NEW DIAGNOSIS OF DIABETES IN 2017 (N = 5,415)



MONTHLY TOTAL PATIENT OUT-OF-POCKET COSTS (PREMIUM + MEMBER COST SHARING) PER MONTH IN THOUSANDS FOR ACA-COMPLIANT INDIVIDUAL MARKET NON-CSR ENROLLEES WITH A NEW DIAGNOSIS OF A MH/SUD HOSPITALIZATION IN 2017 (N = 308)



APPENDIX D: CLASSIFICATION OF DEGREE OF STLD REGULATION BY STATE

CURRENT DEGREE OF STLD REGULATION BY STATE

MARKET	DEGREE OF STLD REGULATION	STLD POLICY RESTRICTIONS*
Alabama	Full impact	
Alaska	Full impact	
Arizona	Full impact	
Arkansas	Full impact	
California	Restricted impact	Banned.
Colorado	Restricted impact	Plans are technically allowed, but with significant restrictions; the state's remaining short-term insurers stopped offering plans as of 2019.
Connecticut	Restricted impact	Limits to six months with no renewals; also required to cover EHBs in 2019. No short-term insurers offer policies as of December 2019.
Delaware	Moderate impact	Limits to three months, no renewals.
District of Columbia	Moderate impact	Limits to three months, no renewals.
Florida	Full impact	
Georgia	Full impact	
Hawaii	Restricted impact	Limits plans to three months, but no insurers offer plans now that the state's new rules are in effect.
Idaho	Full impact	Federal limit on initial term, renewals are not permitted.
Illinois	Moderate impact	Limits to six months, no renewals.
Indiana	Full impact	As of July 1, 2019, STLD plans followed federal guidelines (up to 364 days, and total duration, including renewals, of up to 36 months).
Iowa	Full impact	
Kansas	Full impact	Federal limit on initial term, only one renewal permitted.
Kentucky	Full impact	
Louisiana	Moderate impact	Limited to six months only if the insurer looks back more than 12 months to determine preexisting conditions.
Maine	Restricted impact	State regulations limit STLD plans to only be sold in-person starting January 2020. No carriers have chosen to offer STLD plans in 2020.
Maryland	Moderate impact	Limit to three months, no renewals.
Massachusetts	Restricted impact	Banned.
Michigan	Moderate impact	Limits to six months, no renewals.
Minnesota	Moderate impact	Limits to six months.
Mississippi	Full impact	
Missouri	Moderate	Limits to six months, but allows a plan to be renewed for up to 36 months.
Montana	Full impact	
Nebraska	Full impact	
Nevada	Moderate impact	Limits to six months, no renewals.
New Hampshire	Moderate impact	Limits to six months.
New Jersey	Restricted impact	Banned.
New Mexico	Restricted impact	State regulations limit the plans to three months and prohibit renewals, but no insurers are offering plans as of mid-2019.
New York	Restricted impact	Banned.
North Carolina	Full impact	
North Dakota	Moderate impact	Limits to six months.

MARKET	DEGREE OF STLD REGULATION	STLD POLICY RESTRICTIONS*
Ohio	Full impact	Federal limit on initial term, renewals not permitted.
Oklahoma	Full impact	Starting November 2019, STLD plans will be allowed to have 365-day terms and total duration of up to 36 months (currently limited to six months, no renewals).
Oregon	Moderate impact	Limit to three months.
Pennsylvania	Full impact	
Rhode Island	Restricted impact	Significant regulations for entry. No STLD plans approved for sale in Rhode Island for several years.
South Carolina	Moderate impact	11-month maximum initial term, and 33-month maximum duration.
South Dakota	Moderate impact	Policies lasting longer than six months are required to be guaranteed renewable, which effectively limits the short-term market to plans with durations of six months or less.
Tennessee	Full impact	
Texas	Full impact	
Utah	Full impact	363-day maximum initial term, and renewals are not permitted.
Vermont	Restricted impact	There are no short-term plans available in Vermont, but legislation was also enacted in 2018 to limit short-term plans to three months and prohibit renewals.
Virginia	Full impact	Limits to six months, no renewals, but allows plans issued via out-of-state associations to follow federal regulations (initial terms of up to 364 days and 36-month maximum duration).
Washington	Restricted impact	Limits short-term plans to three months and prohibits renewals, but no insurers offer plans now that the state's new rules are in effect.
West Virginia	Full impact	
Wisconsin	Full impact	Federal limit on initial term, total duration limited to 18 months.
Wyoming	Full impact	

* Based on research available at healthinsurance.org.[25]

APPENDIX E: PREMIUM IMPACT OF REGULATORY ACTIONS IN ACA INDIVIDUAL MARKET, 2020

Appendix E-1. Average Statewide Premium Impact of Regulatory Actions

AVERAGE STATEWIDE IMPACT OF REGULATORY ACTIONS ON 2020 ACA-COMPLIANT INDIVIDUAL MARKET PREMIUMS

MARKET	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
States with full STLD expansion	**-0.4%**	**4.3%**
Alabama	3.4%	N/A
Alaska	0.0%	N/A
Arizona	-0.4%	4.6%
Arkansas	2.2%	N/A
Florida	0.3%	N/A
Georgia	-1.2%	1.3%
Idaho	6.1%	6.9%
Indiana	12.8%	2.2%
Iowa	-8.9%	4.0%
Kansas	-0.2%	8.2%
Kentucky	3.5%	3.0%
Mississippi	-0.5%	0.0%
Montana	-13.1%	10.7%
Nebraska	-6.9%	1.7%
North Carolina	-5.5%	N/A
Ohio	2.5%	3.0%
Oklahoma	2.7%	N/A
Pennsylvania	3.1%	5.9%
Tennessee	0.6%	N/A
Texas	-0.7%	N/A
Utah	-2.0%	0.0%
Virginia	-4.5%	6.0%
West Virginia	6.8%	5.0%
Wisconsin	-4.4%	7.6%
Wyoming	1.6%	N/A
States with moderate STLD expansion	**-1.2%**	**3.0%**
Delaware	-19.0%	3.7%
District of Columbia	9.1%	N/A
Illinois	-0.4%	N/A
Louisiana	11.9%	N/A
Maryland	-8.7%	0.0%
Michigan	-2.5%	4.7%
Minnesota	-1.6%	2.0%
Missouri	-1.9%	2.8%
Nevada	1.8%	4.0%
New Hampshire	-1.4%	-3.4%

MARKET	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
North Dakota	-3.2%	-1.5%
Oregon	1.2%	3.6%
South Carolina	-3.9%	N/A
South Dakota	5.9%	1.5%
States restricting STLD policies	**1.8%**	**-1.2%**
California	1.0%	-2.6%
Colorado	-21.2%	5.0%
Connecticut	7.1%	1.2%
Hawaii	-4.1%	1.2%
Maine	-1.2%	3.6%
Massachusetts	5.6%	0.0%
New Jersey	8.7%	0.0%
New Mexico	2.0%	0.0%
New York	8.7%	1.5%
Rhode Island	-0.6%	0.0%
Vermont	11.6%	0.4%
Washington	-3.5%	0.8%
Nationwide average	**0.2%**	**1.0%**

* Excludes insurers that did not publicly quantify a rate impact in their publicly available rate filing materials for rating period 2020. “N/A” indicates that there were no insurers in the market who quantified a rate impact.

Appendix E-2. Average Carrier-Level Premium Impact of Regulatory Actions

AVERAGE CARRIER-LEVEL IMPACT OF REGULATORY ACTIONS ON 2020 ACA-COMPLIANT INDIVIDUAL MARKET PREMIUMS

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
AK	Moda Assurance Company	N/A	N/A
AK	Premera Blue Cross Blue Shield of Alaska	0.0%	N/A
AL	Blue Cross Blue Shield of Alabama	3.3%	N/A
AL	Bright Health Insurance Company of Alabama, Inc.	9.0%	N/A
AR	Celtic Insurance Company	1.9%	N/A
AR	QCA Health Plan, Inc.	0.6%	N/A
AR	QualChoice Life and Health Insurance Company, Inc.	0.5%	N/A
AR	USAble Mutual Insurance Company	2.9%	N/A
AZ	Blue Cross Blue Shield of Arizona, Inc.	-0.1%	10% (IM, STLD, AHP)
AZ	Bright Health Company of Arizona	0.1%	0%
AZ	Cigna HealthCare of Arizona, Inc.	-3.1%	N/A
AZ	Health Net of Arizona	-0.4%	1% (IM)
AZ	Oscar Health Plan, Inc.	-5.7%	10% (IM, STLD, "market volatility")
CA	Anthem Blue Cross (DMHC)	-8.0%	-2.5%
CA	California Physician's Service, dba Blue Shield of California	3.6%	-0.5% (IM)
CA	Chinese Community Health Plan	16.5%	0%

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
CA	Health Net of California	-2.9%	-0.7% (IM)
CA	Kaiser Foundation Health Plan, Inc.	0.6%	-5% (IM)
CA	L.A. Care Health Plan	1.9%	-5% (IM)
CA	Molina Healthcare of California	1.3%	-5.7% (IM)
CA	Oscar Health Plan of California	-9.9%	-3% (IM)
CA	Santa Clara County (Valley Health Plan)	0.6%	N/A
CA	Sharp Health Plan	-6.7%	-4.8% (IM)
CA	Sutter Health Plan (Sutter Health Plus)	4.9%	-10% (IM)
CA	Western Health Advantage	2.3%	-5.5% (IM)
CO	Bright Health Insurance Company	-20.1%	N/A
CO	Cigna Health and Life Insurance Company	-23.4%	N/A
CO	Denver Health Medical Plan, Inc.	-29.2%	N/A
CO	Friday Health Plans	-26.4%	N/A
CO	HMO Colorado, Inc.	-25.5%	N/A
CO	Kaiser Foundation Health Plan of Colorado	-15.6%	N/A
CO	Oscar Insurance Company	N/A	N/A
CO	Rocky Mountain HMO	-33.4%	5% (IM)
CO	Rocky Mountain Hospital And Medical Service, Inc., D.B.A. Anthem Blue Cross And Blue Shield	-12.5%	N/A
CT	Anthem Health Plans	6.5%	1%
CT	ConnectiCare Benefits	6.9%	1% (IM)
CT	ConnectiCare Inc.	-11.2%	1% (IM)
CT	ConnectiCare Insurance	10.5%	2.4% (IM)
DC	CareFirst BlueChoice, Inc.	7.7%	N/A
DC	GHMSI	10.8%	N/A
DC	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	5.0%	N/A
DE	Highmark BCBSD Inc.	-19.0%	3.7% (IM)
FL	AvMed, Inc.	-15.1%	N/A
FL	Blue Cross and Blue Shield of Florida Inc.	-1.1%	N/A
FL	Bright Health Insurance Company of Florida	N/A	N/A
FL	Celtic Insurance Company	1.9%	N/A
FL	Cigna Health and Life Insurance Company	-8.4%	N/A
FL	Florida Health Care Plan Inc.	3.8%	N/A
FL	Health First Commercial Plans, Inc.	-8.0%	N/A
FL	Health Options, Inc.	1.0%	N/A
FL	Molina Healthcare of Florida, Inc.	-2.9%	N/A
FL	Oscar Insurance Company of Florida	2.9%	N/A
GA	Alliant Health Plans	-14.6%	N/A
GA	Ambetter of Peach State Inc.	-2.4%	0% (STLD, AHP)
GA	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	4.3%	N/A
GA	CareSource Georgia Co.	N/A	3% (IM)
GA	Kaiser Permanente	1.6%	6.5% (IM, STLD, AHP)

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
GA	Oscar Health Plan of Georgia	N/A	N/A
HI	Hawaii Medical Service Association	-3.2%	N/A
HI	Kaiser Foundation Health Plan, Inc.	-5.4%	1.2% (IM)
IA	Medica Insurance Company	-11.3%	4% (IM, STLD, Iowa Farm Bureau, AHP)
IA	Wellmark Health Plan of Iowa, Inc	4.7%	N/A
IA	Wellmark Value Health Plan, Inc	4.8%	N/A
ID	Blue Cross of Idaho Health Service	4.7%	N/A
ID	Mountain Health Co-Op	5.8%	N/A
ID	PacificSource Health Plans	2.4%	6.92% (IM, STLD)
ID	Regence BlueShield of Idaho	0.9%	N/A
ID	SelectHealth	7.9%	N/A
IL	Blue Cross Blue Shield of Illinois	0.4%	N/A
IL	Bright Health Insurance Company of Illinois	N/A	N/A
IL	Celtic Insurance Company	-7.4%	N/A
IL	Cigna HealthCare of Illinois, Inc.	-0.6%	N/A
IL	Health Alliance Medical Plans	-4.0%	N/A
IL	MercyCare HMO, Inc.	N/A	N/A
IL	Quartz Health Benefit Plans Corporation	5.5%	N/A
IN	Anthem Insurance Companies, Inc.	3.0%	0%
IN	CareSource Indiana Inc.	4.9%	5% (IM)
IN	Celtic Insurance Company (MHS/Ambetter)	19.0%	0%
KS	Blue Cross and Blue Shield of Kansas, Inc.	3.0%	~9.5% (7.5% IM; 2% STLD)
KS	Cigna Health and Life Insurance Company	N/A	N/A
KS	Medica Insurance Company	-3.2%	0.7% (IM, STLD, Kansas Farm Bureau, AHP)
KS	Oscar Insurance Company	N/A	N/A
KS	Sunflower State Health Plan, Inc.	-8.7%	N/A
KY	Anthem Health Plans of Kentucky, Inc.	9.7%	1.5% ("Selective lapsation due to market contraction")
KY	CareSource Kentucky Co.	-4.5%	5% (IM)
LA	CHRISTUS Health Plan Louisiana	N/A	N/A
LA	HMO Louisiana, Inc.	12.3%	N/A
LA	Louisiana Health Service & Indemnity Company	10.7%	N/A
LA	Vantage Health Plan, Inc.	5.5%	N/A
MA	AllWays Health Partners	0.0%	N/A
MA	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc	8.3%	0%
MA	BMCHP	7.0%	N/A
MA	ConnectiCare of Massachusetts, Inc.	-1.6%	0%
MA	Fallon Health	3.0%	N/A
MA	Fallon Life & Health Ins. Co., Inc.	5.7%	N/A
MA	Harvard Pilgrim Health Care	-0.3%	0%
MA	Health New England	4.9%	0%
MA	HPHC Insurance Company, Inc.	1.8%	0%

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
MA	Tufts Associated Health Maintenance Organization, Inc.	3.7%	0%
MA	Tufts Health Public Plans	3.0%	0% (AHP)
MA	Tufts Insurance Company	3.7%	0%
MA	UnitedHealthcare Insurance Company	2.7%	0%
MD	CareFirst BlueChoice	-14.7%	N/A
MD	CareFirst CFMI	-1.4%	N/A
MD	CareFirst GHMSI	-1.4%	N/A
MD	Kaiser	-5.2%	0%
ME	Anthem Health Plans of Maine, Inc.	-2.0%	N/A
ME	Community Health Options	2.9%	~6% (IM offset by Medicaid Expansion)
ME	Harvard Pilgrim Health Care, Inc.	-7.0%	-0.5% for Medicaid Expansion
MI	Alliance Health and Life Insurance Company	0.0%	0%
MI	Blue Care Network of Michigan	-1.2%	5% (IM, "uncertainty of the market")
MI	Blue Cross Blue Shield of Michigan	-7.7%	5% (IM, "uncertainty of the market")
MI	Health Alliance Plan of Michigan	0.0%	0%
MI	McLaren Health Plan Community	-5.9%	5% (IM)
MI	Meridian Health Plan of Michigan	-3.6%	2% (IM)
MI	Molina Healthcare of Michigan, Inc.	-8.8%	0% (IM)
MI	Oscar Insurance Company	8.3%	N/A
MI	Physicians Health Plan	0.6%	5% (IM)
MI	Priority Health	-0.1%	N/A
MI	Total Health Care USA, Inc.	-2.5%	4% (IM, STLD)
MN	Blue Plus	-1.5%	5% (IM, STLD)
MN	Group Health (HealthPartners)	-1.3%	2% (IM, STLD, AHP)
MN	Medica Insurance Company	-1.0%	1% (IM, STLD, AHP)
MN	PreferredOne Insurance Company	-20.5%	N/A
MN	UCare	0.1%	0%
MO	Celtic Insurance Company	-7.4%	2.8% (IM)
MO	Cigna Health and Life Insurance Company	0.9%	N/A
MO	Cox Health Systems Insurance	N/A	1% (IM)
MO	Healthy Alliance Life Insurance Company	4.6%	N/A
MO	Medica Insurance Company	2.8%	N/A
MO	Oscar Insurance Company	N/A	N/A
MO	SSM Health Insurance Company	N/A	N/A
MS	Ambetter of Magnolia Inc.	-1.1%	0% (STLD, AHP)
MS	Blue Cross & Blue Shield of Mississippi	2.3%	N/A
MS	Molina Healthcare of Mississippi, Inc.	N/A	N/A
MT	HCSC (Blue Cross Blue Shield of Montana)	-14.1%	N/A
MT	Montana Health Co-Op	-11.8%	16.3% (IM)
MT	PacificSource	-13.4%	1.4% (IM)
NC	Ambetter of North Carolina	-11.1%	N/A
NC	Blue Cross Blue Shield of North Carolina	-5.5%	N/A

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
NC	Bright Health Company of North Carolina	N/A	N/A
NC	CIGNA HealthCare of North Carolina	-4.6%	N/A
ND	Blue Cross Blue Shield of North Dakota	-0.5%	N/A
ND	Medica	-17.0%	-1.5%
ND	Sanford	-14.4%	N/A
NE	BlueCross BlueShield of Nebraska	N/A	N/A
NE	Bright Health Insurance Company	N/A	N/A
NE	Medica Insurance Company	-6.9%	1.7% (IM, STLD, AHP)
NH	Celtic Insurance Company	4.5%	-3.4% (regulatory and market uncertainties)
NH	Harvard Pilgrim HealthCare	-4.3%	N/A
NH	Matthew Thornton Health Plan, Inc.	-2.4%	N/A
NJ	AmeriHealth HMO, Inc.	11.2%	0%
NJ	AmeriHealth Ins. Co. of New Jersey	11.0%	0%
NJ	Horizon Healthcare of New Jersey, Inc. (HMO)	9.9%	N/A
NJ	Horizon Healthcare Services, Inc.	6.5%	N/A
NJ	Oscar Garden State Insurance Corp.	16.6%	N/A
NJ	Oxford Health Insurance, Inc.	18.9%	N/A
NM	HCSC (Blue Cross Blue Shield of NM)	-6.0%	N/A
NM	Molina Healthcare of New Mexico	-1.8%	N/A
NM	New Mexico Health Connections	1.9%	0%
NM	Presbyterian Health Plan, Inc.	16.7%	0%
NM	True Health New Mexico	N/A	N/A
NV	Health Plan of Nevada	-0.9%	4% (IM)
NV	HMO Colorado Inc. dba HMO Nevada	1.0%	N/A
NV	Hometown Health Plan, Inc.	1.0%	N/A
NV	Hometown Health Providers Ins. Co. Inc.	1.0%	N/A
NV	Rocky Mountain Hospital and Medical Service, Inc.	12.9%	N/A
NV	Sierra Health and Life Ins Company, Inc.	2.2%	4% (IM)
NV	SilverSummit Healthplan, Inc.	4.5%	N/A
NY	Aetna Life Insurance Company	15.5%	N/A
NY	Capital District Physicians Health Plan	5.5%	N/A
NY	Emblem (HIP)	13.5%	1.5% (IM)
NY	Excellus Health Plan	6.3%	3.3% (IM)
NY	Fidelis Care (New York Quality Healthcare Corp.)	6.8%	1.5% (IM)
NY	Healthfirst Insurance Company, Inc.	11.9%	1.5% (IM)
NY	HealthFirst PHSP, Inc.	8.2%	1.5% (IM)
NY	HealthNow New York, Inc.	4.2%	0%
NY	HealthPlus HP, LLC (Formerly Empire)	0.0%	N/A
NY	Independent Health Benefits Corporation (IHBC)	1.7%	0%
NY	MetroPlus Health Plan	7.6%	0%
NY	MVP Health Plan Inc.	7.2%	1% (IM)

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
NY	Oscar Insurance Corporation	14.0%	N/A
NY	United Healthcare of New York, Inc.	15.0%	N/A
OH	AultCare Insurance Company	9.5%	13% (IM) and 2% (STLD)
OH	Buckeye Community Health Plan	4.7%	0%
OH	CareSource	-5.3%	3% (IM)
OH	Community Insurance Company	12.1%	N/A
OH	Medical Health Insuring Corp. of Ohio	8.3%	N/A
OH	Molina Healthcare of Ohio, Inc.	-10.1%	0%
OH	Oscar Buckeye State Insurance Corporation	7.3%	N/A
OH	Oscar Insurance Corporation of Ohio	2.1%	5%
OH	Paramount Insurance Company	0.8%	5.6% (IM; STLD/AHPs)
OH	Summa Insurance Company	6.9%	N/A
OH	The Health Plan of West Virginia, Inc.	4.9%	N/A
OK	Blue Cross and Blue Shield of Oklahoma	3.0%	N/A
OK	Bright Health Insurance Company	N/A	N/A
OK	CommunityCare HMO, Inc.	10.4%	N/A
OK	GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO	0.0%	N/A
OK	Medica Insurance Company	-9.4%	N/A
OR	Bridgespan Health Company	1.5%	N/A
OR	Health Net Health Plan of Oregon, Inc.	8.9%	2.3% (IM)
OR	Kaiser Foundation Health Plan of the Northwest	5.8%	N/A
OR	Moda Health Plan, Inc.	-5.2%	0%
OR	PacificSource Health Plans	6.1%	2.1% (IM)
OR	Providence Health Plan	0.4%	6% (IM)
OR	Regence BlueCross BlueShield of Oregon	5.5%	N/A
PA	Capital Advantage Assurance Company	0.2%	5% (IM)
PA	Capital Advantage Insurance Company	-3.8%	6% (IM)
PA	First Priority Health	-1.8%	6% (IM)
PA	Geisinger Health Plan	6.5%	6% (IM)
PA	Geisinger Quality Options	7.8%	6% (IM)
PA	Highmark Benefits Group	N/A	6% (IM)
PA	Highmark Choice Company	-2.2%	6% (IM)
PA	Highmark Coverage Advantage	N/A	6% (IM)
PA	Highmark Health Insurance Company	N/A	6% (IM)
PA	Highmark Inc.	-1.2%	6% (IM)
PA	Keystone Health Plan Central	-8.0%	6% (IM)
PA	Keystone Health Plan East	5.4%	6% (IM)
PA	Oscar Health Plan of Pennsylvania, Inc.	N/A	6% (IM, STLD)
PA	Pennsylvania Health & Wellness, Inc.	-1.5%	6% (IM)
PA	QCC Insurance Company, Inc.	5.2%	6% (IM)
PA	UPMC Health Coverage Inc.	-1.5%	6% (IM)

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
PA	UPMC Health Options Inc.	0.0%	6% (IM)
RI	Blue Cross & Blue Shield of Rhode Island	-1.4%	0%
RI	Neighborhood Health Plan of Rhode Island (NHPRI)	0.3%	0%
SC	Absolute Total Care	-2.3%	N/A
SC	BlueChoice HealthPlan Inc.	-7.3%	N/A
SC	BlueCross BlueShield of SC	-3.8%	N/A
SC	Bright Health Company of South Carolina, Inc.	N/A	N/A
SC	Molina Healthcare of South Carolina, Inc.	N/A	N/A
SD	Avera Health Plans, Inc.	5.5%	1.5% (IM)
SD	Sanford Health Plan	7.5%	N/A
TN	BlueCross BlueShield of Tennessee, Inc.	1.4%	N/A
TN	Bright Health	2.9%	N/A
TN	Celtic/Ambetter Insurance	-1.6%	N/A
TN	Cigna	-5.7%	N/A
TN	Oscar Health	-8.3%	N/A
TX	Blue Cross Blue Shield of Texas	-2.0%	N/A
TX	Celtic Insurance Company	2.3%	N/A
TX	CHRISTUS Health Plan	-4.2%	N/A
TX	Community Health Choice	-1.6%	N/A
TX	Insurance Company of Scott & White	-8.3%	N/A
TX	Molina Healthcare of Texas, Inc.	-4.4%	N/A
TX	Oscar Insurance Company	0.1%	N/A
TX	Scott & White Health Plan	1.3%	N/A
TX	Sendero Health Plans, Inc.	-3.2%	N/A
TX	SHA LLC dba FirstCare Health Plans	14.0%	N/A
UT	BridgeSpan Health Company	-10.0%	N/A
UT	Cigna Health and Life Insurance Company	N/A	N/A
UT	Molina Healthcare of Utah, Inc.	-11.7%	0% (IM)
UT	Regence BlueCross BlueShield of Utah	-9.9%	N/A
UT	SelectHealth	-2.0%	N/A
UT	University of Utah Health Insurance Plans	-1.4%	N/A
VA	CareFirst BlueChoice, Inc.	-15.2%	N/A
VA	Cigna Health and Life Company	1.3%	N/A
VA	Group Hospitalization and Medical Services, Inc.	10.1%	N/A
VA	Healthkeepers, Inc.	-5.6%	7% (Partially IM and "potential movement into other markets")
VA	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	-5.5%	4% (IM)
VA	Optima Health Insurance Company	-19.6%	N/A
VA	Optima Health Plan	-20.5%	6% (IM, AHPs)
VA	Oscar Insurance Company	N/A	N/A
VA	Piedmont Community HealthCare HMO, Inc.	-14.7%	2.4% (0.4% STLD/AHPs; "ACA Uncertainty")
VA	Virginia Premier Health Plan, Inc.	5.7%	N/A

ST.	CARRIER	OVERALL 2019-2020 AVERAGE PREMIUM CHANGE	2020 PREMIUM IMPACT OF REGULATORY ACTIONS*
VT	Blue Cross Blue Shield of Vermont (BCBSVT)	12.5%	0.7% (AHP)
VT	MVP Health Care (MVP)	10.1%	0%
WA	Asuris Northwest Health Plan	-1.7%	N/A
WA	Bridgespan Health Company	2.6%	N/A
WA	Coordinated Care Corp.	0.3%	3% (IM and regulatory uncertainty)
WA	Health Alliance Northwest Health Plan	-5.7%	N/A
WA	Kaiser Foundation Health Plan of the Northwest	5.2%	2.1% (Primarily IM)
WA	Kaiser Foundation Health Plan of Washington	-4.6%	0%
WA	Lifewise Health Plan of Washington	-3.9%	0%
WA	Molina Healthcare of Washington	-9.3%	0.0%
WA	PacificSource Health Plans	N/A	0%
WA	Premera Blue Cross	-8.8%	0%
WA	Providence Health Plan	N/A	5% (IM)
WA	Regence BlueCross BlueShield of Oregon	-2.5%	N/A
WA	Regence Blue Shield	-2.4%	N/A
WI	Aspirus Arise Health Plan of Wisconsin, Inc.	0.4%	19% (IM)
WI	Children's Community Health Plan	-16.8%	N/A
WI	Common Ground Healthcare Cooperative	-9.3%	N/A
WI	Compcare Health Services Insurance Corporation	16.8%	N/A
WI	Dean Health Plan	8.2%	6%
WI	Group Health Cooperative of South Central Wisconsin	-4.4%	N/A
WI	HealthPartners Insurance Company	-9.3%	N/A
WI	Medica Community Health Plan	-12.2%	N/A
WI	MercyCare HMO, Inc.	6.0%	2.7% (IM) and 0.3% (STLD)
WI	Molina Healthcare of Wisconsin, Inc.	-9.9%	1.9% (IM)
WI	Network Health	-7.4%	N/A
WI	Quartz Health Benefit Plans Corporation	-1.3%	N/A
WI	Security Health Plan of Wisconsin, Inc.	4.7%	N/A
WI	Wisconsin Physicians Service Insurance Corporation	-11.9%	19% (IM)
WI	WPS Health Plan, Inc.	-1.4%	19% (IM)
WV	CareSource West Virginia Co.	9.1%	5% (IM)
WV	Highmark West Virginia, Inc.	5.9%	5% (IM)
WV	The Health Plan of West Virginia, Inc.	6.5%	0%
WY	Blue Cross Blue Shield of Wyoming	1.6%	N/A

* "N/A" indicates that a carrier did not publicly quantify a rate impact, including instances where insurers did not mention the individual mandate, STLD, or AHPs at all; mentioned an impact of these factors but did not explicitly quantify the rate impact; or quantified the rate impact but redacted the amount from public filings. A value of "0%" indicates that the insurer did publicly quantify the impact and specified that it was 0%. "IM" refers to the uncertainty about and/or repeal of the individual mandate penalty. "STLD" refers to short-term limited-duration policies. "AHPs" refers to association health plans.

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