Proposals to Stabilize and Improve the Individual Health Insurance Market

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ACAP
Association for Community Affiliated Plans

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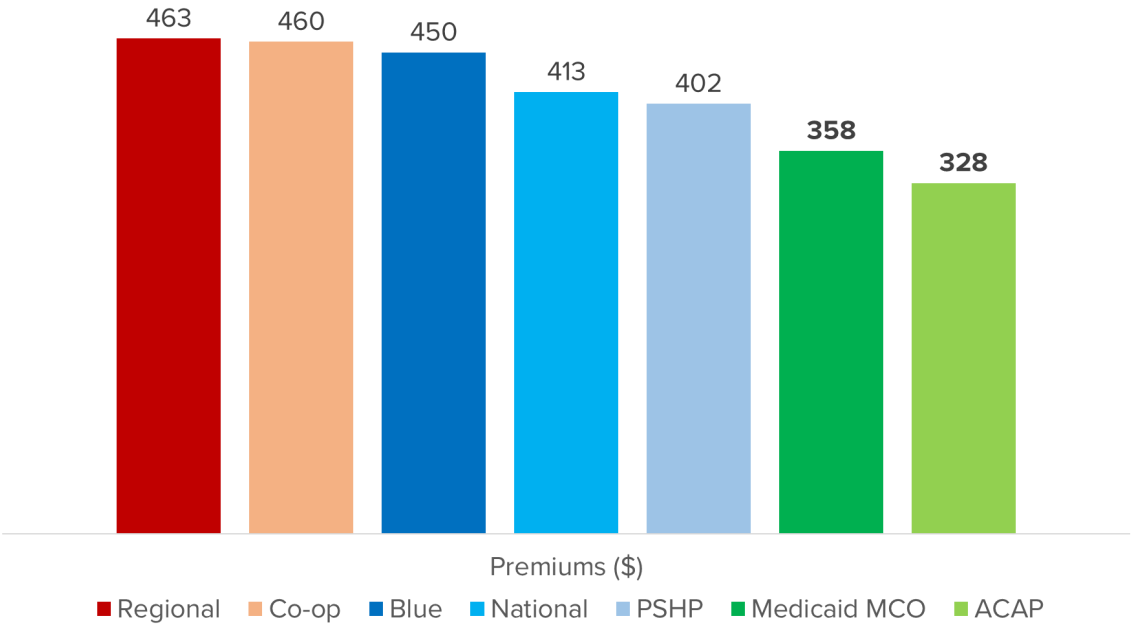
The landscape in the individual health insurance market has changed significantly over the last two years, necessitating a change in approach to stabilizing—and improving—the market. The individual-market Qualified Health Plans offered by issuers that also participate in Medicaid Managed Care tend to offer the lowest premiums *(see Figure 1)* and greater pre-deductible services. More than 13 million consumers purchase some form of comprehensive coverage on the individual market. Many more remain uninsured.

In recent years, the number of underinsured have also increased as deductibles have gone up and substandard coverage options have proliferated. Moving forward it is important to also consider the impact on underinsured consumers.

The Association for Community Affiliated Plans (ACAP) is working to address these challenges and has developed a set of recommendations targeted at improving the individual market risk pool and encouraging safety net health plan participation in the Marketplaces.

Figure 1.
Medicaid MCOs and ACAP-member Safety Net Health Plans tend to offer the lowest premiums in the Marketplace.
Median monthly premiums for a 27-year-old enrolled in a silver plan



Source: Analysis of Robert Wood Johnson Foundation HIX Compare, 2018

Summary of Proposals

- **Reinstate the successful Federal reinsurance program.**
- **Adjust the community rating ratio in Marketplaces from 3:1 to at least 5:1** to more accurately price actuarial risk.
- **Limit STLDI coverage** so that it is not renewable over the long term, and serves its intended role as a stopgap.
- **Require all short-term plans to have an end date of December 31** in a coverage year to coincide with open enrollment in Marketplaces.
- **Implement a surcharge for members over the age of 65** who purchase Marketplace coverage.
- **Permit safety net health plan issuers,** as defined in 26 CFR 57.2 (b)(iii)(E), to enter the individual market while limiting their exposure through **an enrollment cap based on risk-based capital.**
- **Provide for a rebate for young consumers** that choose to enroll and rarely—but appropriately—use the health care system.
- **Streamline enrollment by implementing a semi-automatic enrollment approach** to coverage that allows consumers to initiate the enrollment coverage through Medicaid, CHIP, or Marketplaces.

Providing Consumers with Quality Coverage Options

Reinsurance

Reinsurance is an effective market stabilization tool. It limits issuers' exposure to high-cost, unpredictable medical expenses incurred by their members. The Affordable Care Act's reinsurance program, largely regarded as a success, was phased out after 2016. Since then, several states have implemented or received 1332 waiver approval to implement their own reinsurance program. **There are important benefits to both state and federal reinsurance options. ACAP urges Congress to consider reinstating a federal reinsurance program.**

Community Rating

To constrain the massive swings in premiums based on a consumer's age, plans participating in Marketplaces are limited to charging adults at opposite ends of the age spectrum to a 3:1 ratio. Actuarial analyses suggest that a more appropriate community rating ratio would be at least 5:1. This would adjust the premiums by lowering costs for younger consumers that are more price-sensitive, thus improving the risk pool. **ACAP urges Congress to adjust the community rating ratio to at least 5:1.**

Limit STLDI

ACAP and other issuer trade associations categorically oppose the 2018 expansion of short-term, limited-duration insurance plans (STDLI), which are not defined as "individual health insurance" under the law and generally evade state and Federal requirements around individual health insurance. Originally created under HIPAA to prevent a gap in coverage that might otherwise lead to a waiting period for pre-existing conditions under employer-sponsored coverage, STLDI plans have only recently been used as an alternative to individual health insurance. STLDI plans do not meet minimum essential coverage requirements and are permitted to engage in underwriting, rescissions, gender rating, lifetime and annual coverage limitations, and denying coverage for pre-existing conditions.

Permitting such practices—whether in the form of STLDI or other non-compliant "coverage" such as health care sharing ministries segments the risk pool by removing many of the healthiest members—would increase costs for remaining consumers looking to purchase comprehensive coverage.

ACAP urges Congress to limit STLDI coverage so that it is not renewable over the long term, and serves its intended role as a short-term stopgap rather than comprehensive coverage.

Additionally, ACAP urges Congress to require that all STLDI products end by December 31st of the purchase year to assure that consumers can reevaluate all their options and have the opportunity to purchase comprehensive coverage during the annual open enrollment period.

Adjusting Premiums for Medicare Non-Enrollment

ACAP-member QHP issuers are experiencing higher-than-expected enrollment of Medicare-aged consumers. In fact, **ACAP plans report that on average, 10 percent of their on-Marketplace enrollment is adults 65 and over.** Some consumers are as old as 90. The ACA did not contemplate such consumers purchasing individual market coverage, as the expectation was that anyone over age 64 would enroll in Medicare. While CMS has instituted processes to limit Marketplace enrollment of Medicare-eligible consumers, such efforts have not effectuated adequate change. Instead, **ACAP suggests implementing a surcharge for Medicare-aged consumers purchasing individual market coverage.** This would be similar to the late enrollment penalty surcharge for Medicare Parts B and D and will control premiums for other consumers.

Providing Consumers with Incentives

Increased Subsidies

As premiums and deductibles have risen, fewer consumers have access to affordable coverage. Additionally, there are many cases of consumers under 400 percent of poverty who go without federal premium tax credit subsidies, even though they are eligible based on their income level. The premium spread between different issuers may result in consumers receiving little to no assistance in purchasing coverage that meets their health care needs.

Specifically, we have seen that even for consumers under 400 percent of the Federal Poverty Level, if the premium of the second-lowest cost silver plan is not below the consumer's designated income percentage (capped at 9.86 percent of income), he or she will not receive any subsidy. For others, the subsidies are quite small—sometimes just a few dollars. Likewise, there are many consumers over 400 percent FPL for whom coverage is not affordable.

Increasing tax credits—whether by age or income—would improve affordability for the young, healthy consumers that currently are not purchasing coverage due to cost, again improving the entire risk pool.

"Young Invincibles" Rebate

Younger, healthy consumers in particular tend to weigh the cost-benefit analysis of purchasing coverage—making a decision to forego coverage as they do not believe they will need it. However, it is exactly for unanticipated expenses that insurance is designed. And with the repeal of the individual mandate, there are significantly fewer incentives for young individuals to purchase coverage.

Accordingly, **ACAP proposes a rebate for young consumers that choose to enroll and rarely—but appropriately—use the health care system.**

Appropriate utilization of primary and preventive care would be excluded from the calculation. On the other hand, decreased utilization of high-cost services as a result of utilizing preventative services would be included in the calculation. The rebate could be financed by reducing the issuer's Medical Loss Ratio or through pass-through funding generated by the resulting premium decrease correlated with increased participation of young, healthy consumers.

Encouraging Competition and Innovation

Enrollment Caps for Safety Net Health Plans

ACAP urges Congress to foster greater competition in the individual market, by making it easier for small, Medicaid-focused health plans to participate. Medicaid-focused issuers' ability to offer individual market coverage through enrollment caps could lead to new entrants offering comprehensive coverage and improved competition from lower-priced plans—thereby reducing premiums marketwide.

Data show that Medicaid Managed Care Organizations also offering individual market coverage, and Safety Net Health Plans in particular, tend to charge the lowest premiums in their respective markets *(see Figure 1, page 2)*. Additional Medicaid plans entering the individual market can be expected to drive down premiums through competition. But many such plans have hesitated to enter the individual market due to inexperience in pricing, collecting premiums, and other operational differences between the Medicaid and individual markets.

Medicaid plans have expressed still greater concern with the financial risk associated with guaranteed issue, which may put an issuer's Medicaid line of business at risk if they cannot limit either potential outlays or enrollment.

Safety Net Health Plans are mission-driven plans that serve low-income and vulnerable populations and receive more than 80 percent of gross revenues from government programs that target low-income, elderly, or disabled populations. The risk-based capital for Marketplace participation is greater than for Medicaid due to the potential losses from taking on an unlimited number of enrollees, keeping some such issuers away from individual market participation. However, permitting plans with greater than 80 percent government business to limit their exposure in the individual market through an enrollment cap would serve to foster entrance of numerous new players in the market, increasing competition and exerting downward pressure on premiums.

We urge Congress to permit not-for-profit, Medicaid-focused issuers, as defined in 26 CFR 57.2 (b)(iii)(E), to enter the individual market while limiting their exposure through an enrollment cap based on their risk-based capital.

Tax-Based Streamlined Enrollment

Another approach that has been considered is automatic enrollment., Operational challenges have forestalled efforts to date to implement such an approach at the federal level. However, **Maryland will soon implement a state-based, semi-automatic, streamlined enrollment approach to coverage.** Unlike federal proposals, it will be voluntary to start—allowing residents to check a box on their tax forms to initiate an automatic eligibility determination. Consumers found to be eligible for Medicaid or CHIP will be given an opportunity to enroll in coverage, or automatically enrolled into a default plan if no choice is made. Consumers with incomes above Medicaid or CHIP eligibility levels will receive a brief special enrollment period and be contacted by the Exchange to enroll in coverage.

While exact operational and implementation provisions have yet to be finalized, such an approach has the possibility to both greatly increase the number of consumers enrolled in comprehensive coverage, but also to improve the individual market risk pool. There are legitimate concerns that consumers may use this as an opportunity to wait and purchase coverage a few months into the year. But a surcharge for late enrollment would mitigate the perverse incentive to delay enrollment.

We look forward to the implementation of Maryland's Easy Enrollment Health Insurance Program and urge Congress to consider the potential for a similar approach at the federal level.

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