Repeal, replace, or reform: Key policy discussions affecting the individual health insurance market

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While the specific details surrounding the repeal, replacement, or reform of the Patient Protection and Affordable Care Act (ACA) are still unknown, a number of policy ideas are emerging from the incoming Trump administration and the Republican Party. Market dynamics under healthcare reform will depend on how various policy components interact with one another. Here we highlight several key policy discussions to monitor that will have a significant impact on individual health issuers going forward.[1] Specifically, this paper examines the following issues: continuous coverage provisions, the role of high-risk pools and open enrollment, premium and cost-sharing subsidies, tax treatment of individual and group health insurance premiums, and coverage restrictions.

Health insurance coverage requirements

The coverage requirements under the ACA, particularly the individual mandate, have been heavily debated. In lieu of a mandate, many reform proposals might instead allow issuers to charge higher premiums and/or apply preexisting condition exclusions to individuals who have not maintained continuous coverage. A coverage mandate and a continuous coverage provision have similarities. However, there are important differences that lawmakers, regulators, and issuers should weigh to assess the potential impact of trading one mechanism for another.

WHY ARE REQUIREMENTS FOR COVERAGE IMPORTANT?

Some form of coverage requirement is essential to a well-functioning health insurance marketplace, particularly if that marketplace is guaranteed issue. Coverage requirements typically use "carrots" (incentives to purchase coverage) and "sticks" (penalties for not purchasing coverage). Both are intended to motivate purchasing behavior and help ensure that people do not wait to sign up for coverage until they get sick. Otherwise, there are not enough healthy members in the risk pool to keep prices affordable.

Below, we compare the "carrots" and "sticks" under both ACA and the current reform proposals. For a more detailed discussion related to these incentives and penalties, please refer to the Milliman white paper "Adverse Selection and the Individual Mandate"[2] by Thomas Snook and Ronald Harris.

HOW DOES THE INDIVIDUAL MANDATE UNDER ACA COMPARE WITH A CONTINUOUS COVERAGE PROVISION?

Both mechanisms have the same purpose: to encourage people to purchase coverage in a guaranteed issue market *prior* to the occurrence of a health event. Under ACA, individuals who did not have minimum coverage for the year are assessed a penalty when they file their tax returns. This results in the following dynamic:

1. The ACA's mandate is easier to enforce with individuals who pay income taxes and get a refund, but difficult to enforce with everyone. This restricts the number of people from whom the government can collect this tax.
2. The ACA mandate tax is paid to the federal government rather than used directly to reduce rates in the market. Indirectly, taxes collected under the mandate could be used to fund premium and/or cost-sharing reduction subsidies.
3. The ACA mandate tax is only visible via tax refunds. That can limit its impact because, by then, the taxpayer's health insurance decision has occurred over a year in the past. This lack of visibility is especially true for those who do not scrutinize their tax returns. Critics of ACA also believe the tax penalty was not large enough to motivate healthier individuals to purchase health insurance.

In contrast to the ACA mandate, the proposed continuous coverage provisions generally take the form of an underwriting rule permitted by law. Individuals are not required to obtain coverage but are subject to premium rate-ups, preexisting condition exclusions, or both should they fail to maintain continuous coverage during the past 12 or 18 months. The greater the number of months without coverage during that period, the longer the premium surcharge or exclusion would apply and/or the larger such a surcharge might be.

1 This briefing includes a general discussion of various Republican proposals posed to date. They include, but are not limited to, the following proposals, bills, and frameworks, along with various discussions happening throughout the nation:
Ryan, Paul. *A Better Way: Our Vision for a Confident America*. June 22, 2016.
Empowering Patients First Act of 2015, H.R. 2300, 114th Cong. (2015).
American Health Care Reform Act of 2017, 115th Cong. (2017).

2 See http://www.milliman.com/uploadedFiles/insight/research/health-rr/adverse-selection-individual-mandate.pdf

Another practical difference between the proposed continuous coverage provisions and the ACA mandate is that if a person does not maintain continuous coverage and he or she is subject to a premium rate-up due to a pre-existing condition, that additional premium from the rate-up would be paid directly to the entity assuming the risk of loss (here, the issuer rather than the government). Issuers use these additional revenues to cover the cost of the additional conditions found during medical underwriting plus any conditions not found during medical underwriting but known about by the applicant (i.e., adverse selection). The premium rate-ups and/or preexisting condition exclusions result in lower rates for individuals maintaining continuous coverage.

Finally, similar to coverage mandates, the concept of continuous coverage is often criticized because it reintroduces rating mechanisms from the past when the uninsured rate was higher. Some commentators note certain variations of continuous coverage provisions can be onerous, locking people out of either a standard premium rate or the standard risk pool for too long. Others note that there is nothing to compel healthy people to buy insurance until they need it, which may lead to less healthy standard risk pools. Providers raise concerns about an increase in the uninsured population that has historically led to more bad debt because consumers often could not cover the full cost of their care. Balancing issues like this with fair incentives will be important for lawmakers to address.

The table in Figure 1 compares two coverage requirements (i.e., the ACA mandate and continuous coverage provisions under current proposals).

The role of high-risk pools and open enrollment

In current Republican proposals, the market provisions of continuous coverage, high-risk pools, and open enrollment are intended to work together to help create affordable rates with reasonable access. As noted previously, continuous coverage provisions allow issuers to apply surcharges and exclusions where individuals wait to purchase coverage. Open enrollments are periods of time when those exclusions and surcharges are limited such that individuals can obtain coverage of a type and at a rate level that they otherwise could not outside the open enrollment period. High-risk pools provide a safety net of health plan options for consumers where those surcharges and exclusions might otherwise make coverage unaffordable.

Questions to consider as legislation is formulated around the interaction of continuous coverage provisions, high-risk pools, and open enrollment include:

1. **Can open enrollment period enrollees be placed into high-risk pools?** If those who enroll during the open enrollment period cannot be placed into high-risk pools (a protection some would argue is appropriate), then more high-risk individuals will be in the standard pool. This will result in higher standard pool rates because issuers will need to spread the costs of higher-risk enrollees across the standard pool due to the restrictions during the open enrollment period. States could use a risk adjustment mechanism to rebalance open enrollee costs among issuers, but this will have no effect on the overall market premium levels or affordability. States should also carefully consider technical components of risk adjustment to ensure the program works as intended. Reinsurance programs could also help with rebalancing the pool and improving affordability if reliably and adequately funded by the government.
2. **Will there be a penalty for enrolling outside of open enrollment?** Exposure to more underwriting or automatic placement in high-risk pools (regardless of health status) could function like a penalty for late enrollees. Alternatively, late enrollment penalties could apply, much like those in effect with Medicare today, in addition to any additional premium surcharges related to preexisting conditions. The specifics of this penalty, however, could adversely affect the purchasing decisions of healthy individuals, who are critical to a robust, balanced standard risk pool.
3. **How will state high-risk pools be funded?** High-risk pool funding has historically been challenging. Republican proposals typically include federal funding for these programs over a period of time. Whether the amounts proposed are sufficient to cover costs will depend in large part on the total number of enrollees covered by these pools and the level of premium subsidization states provide for members. The interaction between continuous coverage and open enrollment policies noted above will affect the total size of the high-risk pools. If other assessments are needed, various stakeholders, including issuers, providers, insureds, and state taxpayers, may be expected to contribute toward the cost of operating high-risk pools.

FIGURE 1: COMPARISON OF COVERAGE REQUIREMENTS: THE ACA MANDATE VS. CONTINUOUS COVERAGE PROVISIONS

	ACA MANDATE	PROPOSED CONTINUOUS COVERAGE PROVISIONS
Monetary disincentives to enroll	Potentially higher taxes	Higher premium rates and/or coverage exclusions for those not maintaining continuous coverage
Disincentives paid to	Government	Issuers
Disincentives paid by	Uninsured individuals	Individuals without prior period of continuous coverage
Enforcement	Required by law	Ratings/exclusions permitted by law
Disincentive prorated?	Yes, mandate only paid for portion of year without coverage	Yes, preexisting condition exclusion period can be reduced for amount of continuous coverage insured has prior to enrolling in individual coverage

4. **Will interstate sales introduce unintended consequences?** Many proposals discuss the potential for issuers to leverage the regulatory framework of a single state across every state where the issuer does business. This could complicate how federal dollars should be allocated to state-run high-risk pools, especially if the allocation criteria contemplates a state's overall risk profile. More details on this concept are discussed in a later section.

Premium and cost-sharing subsidies

A majority of people enrolled in ACA health plans in the individual market receive Advanced Premium Tax Credits (APTCs) and a portion of those individuals also receive cost-sharing reduction (CSR) subsidies.[3,4] Below, we highlight two key developments to watch related to subsidies as policies unfold.

1. THE IMPACT OF *HOUSE VS. BURWELL* ON CURRENT CSR SUBSIDIES

The House of Representatives sued the Obama administration, alleging that CSRs are being paid without a Congressional appropriation. The District Court ruled in favor of the House on the merits and the Obama administration appealed this decision. The court, at the request of the House, has stayed the case until February, after the new administration takes office. Two CSR recipients sought to intervene in the case, concerned that their interests are no longer represented with a new administration that may not wish to continue the appeal. However, the court denied their request so the stay remains in effect until February.

Because the Trump administration can simply choose not to continue paying CSR subsidies, issuers are concerned the federal government may no longer fund CSRs *even though eligible policyholders will still be entitled to the CSR subsidies*. Under this scenario, the timing of the change in funding will affect the stability of the individual market. Issuers fear CSR payments will cease immediately, which could result in one of the two following scenarios:

1) If allowed by state insurance departments and the federal government, some issuers would seek premium increases to compensate for the CSR subsidies the issuers must now fund. This would cause any issuer with significant exchange enrollment to be at a competitive disadvantage compared with competitors who choose to provide coverage off-exchange only. In addition, the increases in premiums for enrollees eligible for APTCs would cause a corresponding increase in the total premium subsidies paid by the federal government.

2) Some issuers with CSR enrollees might potentially discontinue coverage. The Qualified Health Plan (QHP) agreement appears to allow issuers with cause to immediately decertify as QHPs in the event that CSR subsidies are not funded. But the agreement also notes that QHP issuers must still abide by any state laws that require coverage for a full plan year, even if they terminate the QHP agreement. Whether issuers can terminate coverage midyear if CSRs are defunded will therefore depend on state law.

If CSR subsidies are not eliminated until 2018 (rather than immediately), then one of the scenarios above could apply to that benefit year, especially if the case is decided after rates for 2018 have been filed. Absent other regulatory changes, the defunding of CSRs would make it challenging for the incoming administration to maintain a viable individual marketplace in the near term. Issuers will want to monitor these developments and take corrective action as necessary.

2. FUTURE PREMIUM AND COST-SHARING SUBSIDY CALCULATIONS

Premium and cost-sharing subsidies in most Republican proposals are structured in a way that is different from the current APTCs and CSRs. The following points describe how subsidies are structured under various Republican proposals:

- Age-adjusted premium subsidies are common in many proposals, though they are typically lower than current ACA premium subsidies. The reason for the lower subsidies is that they assist an individual in the standard risk pool (as opposed to high-risk pools), where premiums are intended to be materially lower than current ACA premiums, given the anticipated healthier risk profile of the standard pool. Whether the standard pool rates are actually lower, and to what degree, is uncertain at this point and depends on the final structure of any legislation in its totality.
- Subsidies for standard pool enrollees do not vary by income. It will be important to understand projections for the standard pool premium levels relative to the new APTCs when determining how affordability will change for an issuer's members. It appears lawmakers have the expectation that, in some instances, subsidies will be large enough to cover the entire premium for high-deductible health plans (HDHPs) and contribute to an individual's health savings account (HSA).
- Subsidies for high-risk pool enrollees might vary by income, similar to those of ACA. This could be an issue left to the states, with funding for such subsidies potentially not entirely borne by the federal government, as it is today.
- It is possible a tax deduction for premiums would be allowed in the individual market, likely *in place* of premium subsidies (more on this later).

3 ASPE (October 2016). About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies.

4 ASPE (December 2015). Potential Fiscal Consequences of Not Providing CSR Reimbursements.

Whether subsidy payments vary by geography or a person's health status will also be important items to monitor. Understanding how the change in premium rating and subsidies affects a given issuer's price point will be critical given the price sensitivity exhibited by the individual ACA market.[5]

Tax treatment of individual and group health insurance premiums

Various Republican proposals have discussed the possibility of changing the way health insurance premiums are treated by federal income tax law. Common ideas include:

- **Repealing the excise "Cadillac" employer tax and replacing it with a maximum individual tax-deductible amount for health insurance premiums.** Critics of the excise tax argue that taxing premiums in excess of a threshold via income tax is more equitable (regardless of income tax bracket) than a flat employer excise tax that would likely be passed onto employees. Many employers have prepared for the excise tax by managing plan costs and benefits in an attempt to avoid triggering the excise tax (once it goes into effect). Whether maximum thresholds for group health benefits' tax deductibility will have an effect similar to employers' strategies or will cause employees to choose leaner health insurance plans remains to be seen.

  Another important detail to watch is how premium thresholds for the tax exclusion are adjusted for geographic location, given the wide variation in health costs throughout the country. This was a common criticism of the excise tax and it has been addressed in some Republican proposals.

  Most Republican proposals support the idea that employee contributions to an HSA would not count as health insurance premiums for purposes of assessing the exclusion. Again, this is in contrast to regulatory guidance around the excise tax that such contributions would count toward the excise tax thresholds. Such a change in policy could encourage adoption of consumer-driven plan options.

- **Allowing an employer group's employees to use employer contributions toward health coverage in the individual market on a pre-tax basis (in lieu of enrolling in the employer's plan).** Under the recently passed 21st Century Cures Act, this policy is now allowed for the small group market via health reimbursement arrangements, but could be revised or expanded under future proposals. This policy partially levels the tax playing field between individual and group coverage and may cause some employers to adopt a hands-off, defined contribution approach to providing health insurance to employees. However, more money might be required to "make employees whole" if the individual risk pool is less healthy than the group market risk pool. In addition, any legal requirement where employers must encourage employees to shop in the individual market could disrupt employer risk pools as healthier employees shop for standard rates and less healthy members attempt to avoid premium rate-ups, condition exclusions, or high-risk pools by staying on employer-sponsored coverage.

- **Excluding individual premiums from federal income tax, similar to group coverage.** If such a policy replaces federal premium or cost-sharing subsidies, as is suggested by some proposals, it is probable that individuals who receive subsidies today would no longer find coverage affordable in the individual market unless states cover their costs. In addition, this policy may have limited impact driving health insurance decisions because not everyone scrutinizes their tax returns. However, this policy could change the way some employers provide benefits to their employees (as described in the previous bullet).

These are variations on a theme and each has different consequences fiscally for the federal government, individual purchasers, and the commercial health insurance landscape as a whole.

Coverage restrictions

Another common element found in many Republican repeal proposals is the movement toward deferring coverage restriction regulations to the states rather than the federal government. Here we discuss several key policies of ACA that will likely be repealed and their possible replacements.

FEDERALLY MANDATED MINIMUM BENEFITS

ACA requires health plans in the individual and small group markets to cover essential health benefits (EHBs), which include services related to maternity, mental health and substance abuse, and pediatric dental. ACA further prohibits issuers from managing risk through underwriting loads, riders, annual or lifetime limits, or other coverage restrictions. It is unclear whether any federally mandated benefits will remain in new legislation and, if so, whether issuers will be allowed to manage the risk associated with those benefits. To date, few restrictions appear in Republican proposals other than for certain services like maternity that may not be eligible for preexisting condition exclusions.

Congress may leave states to define minimum coverage levels as well as their own rules around how issuers can manage risk. If such legislation passes, states may simply revert to their pre-ACA rules on mandated benefits. For example, prior to ACA, many issuers used riders to provide maternity and prescription drug benefits, limited annual payments for behavioral health coverage, and covered pediatric dental under a supplemental

5 ASPE (October 2016). Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace.

policy. In general, these regulatory policies shifted the costs associated with these benefits to the individuals most likely to use them. It will be important for issuers to work with state regulators, particularly in states facing increased political pressure to maintain the high levels of coverage required by ACA and its risk-neutral approach to rating.

States may also be allowed (but not be required) to establish a "plan portal" that allows customers to easily compare benefits, networks, and price between plans. Unlike ACA exchanges, however, proposed legislation authorizing such portals prohibits them from directly enrolling individuals in health insurance plans. Issuers will want to consider how likely potential customers are to use such plan portals under the new healthcare law when designing their benefit packages.

AGE AND GENDER RATING

Republicans appear willing to allow wider age band rating as opposed to the three-to-one age band required by ACA. Wider age bands generally reduce premiums for younger individuals and raise premiums for older individuals. The final net premium paid by the customer, however, will also depend on levels of subsidization and any underwriting load that may be applied. It will not become clear how affordability of coverage will change for various demographic cohorts until the relationship between age rating, subsidies, underwriting rules, and high-risk pool eligibility is clearly defined.

Relatedly, gender rating was common in the individual market in many states prior to ACA. Most Republican proposals have generally been silent on gender rating, which would most likely make it an issue for states to decide. When combined with wider age bands, issuers could price for the risk posed by various mandated benefits that affect different age and gender cohorts more accurately.

ANCILLARY PRODUCTS

Other decisions must be made about how to handle non-major-medical commercial products such as short-term medical and fixed indemnity. Neither short-term medical nor fixed indemnity products satisfy the minimum essential coverage requirements of ACA, so purchasers must still pay the penalty absent other coverage. It is not clear whether these products would satisfy continuous coverage requirements under Republican reform. In general, an increase in the commercial viability of ancillary products may cause adverse selection and put upward pressure on the major medical risk pool. As issuers evaluate future opportunities selling ancillary products, they should pay close attention to the comparative price of major medical coverage for certain key demographic cohorts, the details of any continuous coverage requirements, and the challenges of properly explaining these products to consumers.

SELLING ACROSS STATE LINES

Another policy proposal that appears to have broad Republican support is allowing issuers to sell across state lines. Such proposals would allow issuers to designate a "primary state" whose laws govern their sale of insurance regardless of the laws in the customer's state of residence, with certain limited exceptions. The theory is that customers will find lower rates if they are able to purchase policies issued by plans operating in more passive regulatory states.

For example, consider two theoretical states with different regulatory approaches. State A prohibits medical underwriting, requires a three-to-one age curve without gender rating, and mandates a high level of minimum coverage. By contrast, State B allows medical underwriting, provides for a five-to-one age curve by gender, and mandates a lower level of minimum coverage. State A's regulatory approach has the effect of shifting costs toward younger, healthier individuals who do not anticipate using their plan while State B's regulatory approach has the effect of shifting costs toward older, sicker individuals who are more likely to use medical services. All else being equal, young and healthy residents of State A would therefore achieve lower rates if they could purchase a policy under the laws of State B. If these crossover members were attributed to State B's risk pool, the risk pool of State A would deteriorate if issuers could sell to residents of State A coverage that complied only with the laws of State B. This could be especially impactful if risk adjustment mechanisms are still used at the state level.

Issuers are not, however, likely to have absolute authority to apply the laws of their preferred jurisdiction to every state in which they wish to sell. Republican proposals preserve states' authority to regulate network access and adequacy. Because network building is the costliest barrier to entry for health plans in a new geographic region, few issuers today would be able to take advantage of this policy on a nationwide scale. Still, even regional health plans may want to appraise the actuarial risk profile of other states in which building a network is feasible to evaluate whether new growth opportunities exist under another state's regulatory framework.

Concluding thoughts

Many concepts explored in this paper involve policies that may be used to reform the health insurance industry. The ultimate success of reform efforts will depend on how lawmakers deploy these instruments to work in harmony. We encourage issuers and other stakeholders to deepen their technical understanding of these concepts to help them fuel successful strategies as the next generation of healthcare reform takes hold.

LIMITATIONS

Fritz Busch and Scott Weltz are consulting actuaries with Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to issue this report and render the actuarial opinion contained herein. Nick Krienke is an actuarial analyst with Milliman who also authored this report. This report should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. The report reflects the authors' findings and opinions. The report reflects a current understanding of ACA and the questions emerging from potential changes to current legislation and regulations. As legislation develops and regulations change, answers may emerge that prompt new questions. We ask that this report be distributed only in its entirety because extracts of this report taken in isolation may be misleading.

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