Patient Relief from Collapsing Health Markets

U.S. House of Representatives
Energy and Commerce Committee
Subcommittee on Health

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February 2, 2017

[*]The views expressed here are my own and not those of the American Action Forum. I thank Juliana Darrow, Tara O'Neill Hayes, and Christopher Holt for their assistance.

Chairman Burgess, Ranking Member Green, and members of the Subcommittee, thank you for the opportunity to testify today regarding ways in which policymakers may provide relief to participants in the Affordable Care Act's (ACA) collapsing health insurance markets.

The individual market is in dire need of improvement. Exchange enrollment is low, premiums are rising and insurers are leaving the market. However, actions can be taken to stabilize and even improve the individual marketplace until a replacement plan is fully implemented. There are several simple changes that, if enacted, will provide relief to both consumers and insurers. As I have previously testified, these common-sense improvements to the current law should have bipartisan support.

In this testimony, I hope to convey three main points:

1. Given current law, doing nothing is not an option. The ACA is in a downward spiral. Prices will continue to rise and insurers will continue to leave unless significant changes are made.

2. These reforms are good policy regardless of the performance of the markets or the political climate. They should receive bipartisan support.

3. While these changes will certainly help, they will not be enough to produce a vibrant individual market. More will need be done to stabilize the market until a replacement plan can be fully implemented.

Let me consider the reforms in turn.

Grace Periods

Under the Affordable Care Act (ACA), customers buying subsidized insurance coverage on the Exchanges are given a 90-day grace period during which insurers must continue offering coverage even if premiums are not paid. This means that consumers on the Exchange can receive coverage for twelve months while only paying for nine. Individuals can easily take advantage of this provision by not paying premiums but continuing to use care. Insurers are not allowed to cancel coverage even if the individual continues using medical care for 90 days.[1] This creates an uneven playing field for both insurers and tax payers because grace periods are often much shorter in the individual market off the Exchange. As of 2012, all but two states had grace period requirements of 30 or 31 days for plans offered in the individual market.[2]

Additionally, nonpayment does not prevent future insurance coverage. Health insurance companies cannot refuse enrollees that have had plans cancelled due to failure to make previous payments, or use premiums paid for new coverage to cover outstanding debt.[3] A McKinsey study found that 21 percent of Exchange plan enrollees in 2015 stopped paying for coverage at some point during the year. In 2016, half of those individuals (49 percent) repurchased the same plan they had stopped paying for the year before; two thirds (67

percent) of those same individuals had also stopped paying for coverage at some point during the 2014 plan year.[4]

Insurance companies are financially responsible for claims incurred only during the first month of missed premium payments, meaning that doctors are at risk of not being paid for care consumed at their offices for the last 60 days of a grace period. Plans on the Exchange have 34 percent fewer providers than commercial plans offered off the Exchange.[5] The risk of not being paid for up to two months may be contributing to this phenomenon.

When setting yearly premiums, insurers, and providers both must take the potential of nonpayment into account and therefore raise prices for everyone. These increased premiums are also passed on to the taxpayers who are responsible for subsidizing the cost of 84 percent of individuals purchasing insurance through the Exchange.[6] Aligning grace periods on and off the Exchange will level the playing field among consumers, and reducing the 90-day grace period could significantly diminish the risk of losses for insurers and providers. This would help stabilize the insurance market and decrease costs for all consumers and taxpayers.

Special Enrollment Periods

The ACA has allowed for over 30 circumstances in which an individual may enroll in an Exchange plan through a Special Enrollment Period (SEP).[7] Medicare allows just seven of these instances, while the Health Insurance Portability and Accountability Act (HIPAA) requires three.[8] Many individuals shopping for coverage on the Exchange take advantage of the ability to sign up for coverage throughout a plan year. Analysis by America's Health Insurance Plans (AHIP) shows that in the first two years of market place enrollment, up to one third of enrollees gained coverage through special enrollment periods.[9] Between February and June of 2015 nearly 950,000 people signed up for coverage through SEPs on healthcare.gov.[10] The abundance of qualifying circumstances and the lack of a robust SEP eligibility verification process undermines the business model that insurers rely on and destabilizes the market. Too much SEP flexibility can cause individuals to wait until they are sick to enroll in coverage; this would be like waiting for your house to catch fire before buying homeowners insurance.

Multiple large insurers have tabulated statistics and expressed concerns about the misuse of SEPs. Individuals enrolling through SEPs had health care costs 24 percent higher than individuals who enrolled during open enrollment in the first three months of coverage in 2014.[11] Data from Covered California shows that cost differences between customers who enroll through SEPs were 15 percent to 50 percent higher than those who enrolled during open enrollment in the four largest state plans.[12] UnitedHealth reports that more than 20 percent of its marketplace customers did not sign up during open enrollment and that those customers use 20 percent more health care.[13] Blue Cross Blue Shield Association calculates that exchange customers using SEPs are 55 percent more expensive than the enrollees who are covered through open enrollment.[14]

Individuals who enroll in coverage during SEPs are also more likely to drop coverage. Anthem reports that enrollees who use SEPs are more than twice as likely to drop coverage after a short period of time. Aetna reports that SEP enrollees stay on a plan for less than four months, on average, while enrollees who sign up during open enrollment maintain coverage for an average of eight to nine months.[15]

Instituting a formal process requiring documentation for eligibility verification will help to reduce the number of individuals taking advantage of the current enrollment system. Requiring eligibility to be verified prior to coverage becoming effective would reduce the number of fraudulent claims. To protect individuals who are eligible and in need of urgent care, coverage could be made retroactive to the day of application, once eligibility was confirmed. Congress should also be informed of the number of individuals who attempt to enroll during an SEP but are unable to do so. Information on whether enrollment was not permitted because the individual did not submit necessary documentation or because the documentation was invalid should also be provided. This will allow policymakers to make more informed decisions on needed policy changes.

Age Rating Bands

The ACA only allows for a 3:1 difference in premiums between the youngest and oldest individuals in an insurance pool. However, average health care expenses for a 64 year old are 4.8 times greater than that of a 21 year old.[16] Because this 3:1 rating does not reflect the actual difference in health care costs between the young and the elderly, it artificially inflates premiums for younger and healthier individuals forcing them to further subsidize coverage of older and typically sicker individuals.

These high premiums have caused low enrollment of young adults on the Exchange. In 2016, 3.5 million young adults (18-34) enrolled in Exchange plans. This represented only 28 percent of enrollees even though this age group was anticipated to make up around 40 percent of the enrollee population.[17] According to US Census data, the uninsured rate for those aged 19-34 is 4.6 percent higher than the uninsured rate for those aged 35-64.[18]

Increased enrollment among young adults would contribute to market stability by infusing the risk pool with more low-risk individuals. Adjusting the age rating limit to allow premiums to reflect the pre-ACA average cost difference of 5:1 would reduce premiums and remove some of the financial disincentive preventing younger people from purchasing insurance. This is a standard provision across ACA replacement plans, because better aligning premiums with costs is the only way to allow insurance to work without excessive regulations.

Continuous Coverage

Continuous coverage provisions are a standard feature of many ACA replacement plans. This type of policy serves as an alternative to the individual mandate. In addition to the intrusion on individual liberty, the individual mandate has proved to be less effective than expected. Many individuals, particularly the younger, healthier individuals just discussed,

choose to forego insurance, and pay the associated penalty instead of purchasing coverage they do not want or need. Preliminary Internal Revenue Service reports state that 6.5 million people paid the penalty for not having coverage in 2015. An additional 12.7 million people were exempted from the mandate.[19] Based on calculations made from Congressional Budget Office projections, AAF estimates that 2.7 million people were expected to pay the penalty in 2015.[20] This large difference in reality compared to projections suggests that the individual mandate is a flawed and ineffective mechanism for ensuring insurance coverage for Americans.

The continuous coverage model, on the other hand, incentivizes individuals to purchase coverage without taxing those who choose to go without. Under such a policy, any individual who remains continuously covered would be permanently protected against medical underwriting in which insurers set premiums based on one's health status. This incentivizes both healthy and unhealthy individuals to enroll and maintain coverage. People with pre-existing conditions who were already insured would simply have to maintain coverage to benefit from these protections. Everyone who is currently uninsured, whether having a pre-existing condition or not, would be provided a one-time open enrollment period to gain coverage so they, too, could receive the benefit. This protection would especially incentivize young individuals to buy insurance because they would be guaranteed relatively low premiums throughout their lifetime. Again, bringing these individuals into the market would greatly stabilize the insurance risk pool, which would allow insurers to compete for these new market entrants by providing policies with lower premiums and greater benefits. Continuous coverage requirements would also incentivize insurers to invest in preventive and wellness services that will keep their consumers healthy and their costs down as they age.

Conclusion

Substantial reform is imperative to ensure a successful health insurance market, but in the meantime, enacting legislation that resolves at least some of the problems in the short term is essential. The changes discussed here today, while necessary, will not fix everything. Additional financial resources will also be needed to both keep insurers in the individual market and the millions of individuals relying upon them for coverage.

Notes

[1] https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/
[2] State Laws Requiring Grace Periods for Premium Payments. Rep. Washington, D.C.: America's Health Insurance Plans, 2012. Print.
[3] https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/
[4] http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf
[5] http://avalere.com/expertise/managed-care/insights/exchange-plans-include-34-percent-fewer-providers-than-the-average-for-comm
[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html
[7] https://ahip.org/wp-content/uploads/2016/03/AHIP-BCBSA-SEP-Analysis-Feb16.pdf
[8] https://www.americanactionforum.org/testimony/common-sense-solutions-improve-affordable-care-act-simple-changes-can-go-long-way/#_edn3
[9] https://ahip.org/wp-content/uploads/2016/03/AHIP-BCBSA-SEP-Analysis-Feb16.pdf
[10] https://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=1
[11] https://ahip.org/wp-content/uploads/2016/03/AHIP-BCBSA-SEP-Analysis-Feb16.pdf
[12] http://board.coveredca.com/meetings/2016/2-18/PPT-Covered%20California%20SEP%20Policy.pdf
[13] https://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=1
[14] http://www.politico.com/story/2016/01/gaming-obamacare-insurance-health-care-217598
[15] https://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=1
[16] https://www.americanactionforum.org/insight/age-bands-affordable-care-act/
[17] https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf
[18] http://www2.census.gov/programs-surveys/demo/tables/p60/257/table2.pdf
[19] https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf
[20] AAF projection is based on the total amount of expected revenue from payment of penalties in 2015 divided by 2 percent of the national median income that year, as the penalty in 2015 was either $325 or 2 percent of income, whichever was greater. Thus, this is a low estimate of the number of individuals who were expected to pay the penalty in 2015.