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The Future of the Affordable Care Act Week 6: Focus on the Individual Health Insurance Market

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A recent report from the nation's top actuaries takes a sobering look at the challenges policy makers face in creating a viable individual (i.e., non-group) health insurance market—a critical component of any plan to replace the Affordable Care Act. Published by the American Academy of Actuaries, the report, entitled *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* outlines, without a hint of partisanship, the necessary conditions for a sustainable individual market, examines the extent to which those conditions are c*urrently* being satisfied, and discusses the implications of proposed changes to either improve the ACA insurance market reforms or (as is most likely the case) replace them with an alternative approach.

The paper offers an unvarnished explanation of the impact of the relevant actuarial principles that informed the ACA and that must be negotiated in the process of its replacement. Any policy maker hoping to expand (or at least to expand access to) health insurance coverage, control rising health care costs, and increase the quality of medical outcomes—the three goals of the ACA—would be well advised to read this paper. The actuarial principles expounded in the paper appear to transcend law and politics and any ACA replacement plan that fails to take them in account may face significant, if not insurmountable, hurdles in achieving its objective.

Introduction

According to the Kaiser Family Foundation, about half of the U.S. population is covered by employer-sponsored-insurance (ESI). Another 35% are covered by Medicare and Medicaid. The remainder of the population—about 15% —is either uninsured or covered in the individual market. Some of the uninsured are eligible for, but not enrolled in, Medicaid. Consequently, the challenge for expanding coverage is felt most acutely in the individual market and Medicaid. While the ACA expanded Medicaid, thereby taking some pressure off the individual market, a common, if not universal, theme of the proposals to replace the ACA include, at a minimum, a return to pre-ACA Medicaid coverage. Such a change will inevitably increase the number of individuals who will seek coverage in the non-group markets.

The ACA's approach to expanding coverage relies on the combination of an individual mandate (i.e., a requirement that U.S. citizens either purchase coverage or pay a tax penalty) together with a requirement that insurance carriers cover all applicants without regard to pre-existing conditions (i.e.,

guaranteed issue and renewability requirements). The individual mandate and the guaranteed issue and renewability requirements were of a single piece that together were intended to establish one large and stable risk pool of covered lives. Proper management of this risk pool is an essential feature of a functioning individual market.

The paper asserts that the following items are necessary for a sustainable individual health insurance market:

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Slow spending growth and high quality of care.

These observations are not new, and should not surprise anyone. Hence, for purposes of this post, we assume that each reflects sound actuarial principles.

Selected Highlights

Set out below is a sampling of the paper's findings and conclusions.

- ***Incentives to obtain and maintain coverage***

One way to ensure broad-based participation in the non-group market is to strengthen the incentives to purchase coverage. The ACA imposes only modest penalties for failing to obtain and maintain coverage. In addition, the ACA made it relatively easy to move in and out of coverage using longer grace periods for non-payment of premiums and generous (some would argue overly so) special enrollment periods (SEPs) to determine eligibility. The replacement plans shun the individual mandate in favor of a continuous coverage requirement that was first adopted in the group markets by the Health Insurance Portability and Accountability Act of 1996.

A continuous coverage requirement will need to address and limit the above-identified ACA shortcomings. Under a continuous coverage regime, plans will be able impose penalties for late or delayed enrollment. For example, a plan might withdraw pre-existing condition coverage protections for late enrollees or for those who haven't had continuous coverage for a specified period, such as 18 months. Carriers would be free to underwrite these individuals. Individuals with pre-existing conditions could, thus, be denied coverage altogether, provided access to less generous plans only, or get charged higher premiums based on their health conditions.

- ***State high risk pools***

Recognizing that some "high-cost enrollees" may be unable to obtain insurance under a continuous coverage regime, many of the ACA replacement proposals would place those individuals in state high-risk pools, thus reducing average premiums in the standard risk pool for healthy individuals. High-risk pools are not new, nor have they been particularly successful. According to the paper, "Enrollment

has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss." It is here that the full force of actuarial laws is experienced first-hand. Again from the paper:

> Substantial funding would be likely be required for high-risk pools to be sustainable. In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums.

The ACA eschewed high-risk pools and instead used tax-financed funds to help low-income individuals. One wonders whether such funds might be better applied to reimbursing the costs of high-risk enrollees.

- ***Modified community rating—consequences and tradeoffs***

The ACA's modified community rating rules have come under harsh criticism by Republican lawmakers and conservative think tanks and policy shops. These are the rules that cap premiums paid by older individuals relative to the premiums paid by younger people. The ACA set the ratio at 3:1. ACA critics say this has the effect of shifting a large portion of health care costs to younger, healthier individuals who consequently exit the market leaving behind older and sicker individuals. The replacement proposals uniformly expand the community rating range to 5:1, which is closer to the actual spread. While this approach may well reduce costs and lure younger individuals back into the market, costs for older adults will rise. The paper explains the net impact and tradeoffs in the following example:

> Widening the allowable age variation from a 3:1 ratio to a 5:1 ratio would more closely align premiums to underlying costs by age. One study estimates that such a change would reduce premiums for 21-year-olds by 22 percent ($70 per month), resulting in an increase in young adult enrollment.… However, premiums for 64-year-olds would increase by 29 percent ($274 per month), likely reducing older adult enrollment while also increasing federal costs for premium subsidies due to the higher premiums. Unsubsidized healthy older adults may be the most likely to drop coverage. On net, the study estimates that loosening the age bands would increase federal premium and cost-sharing subsidies by $11 billion in 2018 under the current ACA subsidy structure.

- ***Sale of insurance across state lines***

Another common feature of the replacement proposals calls for permitting the sale of insurance across state lines. The study cautions that allowing insurers to sell coverage across state lines "could create an unlevel (sic) playing field and threaten the viability of insurance markets in states with more restrictive rules," which in turn could "reduce the ability of individuals with pre-existing health conditions to obtain coverage" in those markets. States could, however, be encouraged to "pursue approaches tailored to their specific situations" through waivers or through other enhancements to state flexibility. These might include "the pursuit of different enrollment incentives, subsidy structures,

benefit coverage requirements, premium rating rules, etc."

- ***Incorporate expanded Medicaid population into the individual market***

The idea of incorporating the Medicaid expansion population into the individual market appears nowhere in any of the current replacement proposals, but it is addressed in the paper. Such an approach "would increase marketplace enrollment, potentially increasing marketplace stability." The paper cautions, however, that the impact on the risk profile and resulting premiums is unclear, noting that "having a lower income is often associated with having poorer health." The paper concludes that expanding traditional Medicaid might be the better approach. Politically, neither approach appears feasible.

Insurance Carriers—the Mediators of Actuarial Risk

Like the ACA, the replacement proposals place the health insurance carriers at the center of their regulatory scheme. While the ACA seeks to tightly constrain product design, mandating various coverage tiers, prescribing which constitute "essential health benefits" and imposing strict cost-sharing limits, the replacement plans do the opposite by endeavoring to provide carriers with flexibility to respond to market demands. The paper suggests that both approaches have weaknesses.

The paper rightly observes that, "like all businesses, insurers participating in the individual market have an obligation to protect their viability and solvency, requiring that they must earn a fair return that supports ongoing business activities." Premiums must be adequate to cover claims, administrative costs, taxes, and fees, and still provide a margin for profit or contribution to reserves and surplus. At bottom, carriers operate on a cost-plus model. Medical costs—principally hospitals, physicians, imaging and prescription drugs—are "what they are." Carriers merely facilitate their payments. Of course, how payments are determined and made is enormously complex. Prices are negotiated (but only at the margins), incentives applied, and networks built and nurtured, all to gain incremental competitive advantages in the marketplace.

But—and this is critical—while carriers react to rather than drive costs, their core mission is risk mediation. And in so doing, the quality of that risk makes all the difference. It is no accident that the paper's first principle for a sustainable individual health insurance market posits the need for "individual enrollment at sufficient levels and a *balanced* risk pool" (emphasis added). As the paper explains, an unbalanced risk pool invites adverse selection—i.e., covering too many sick people and not enough healthy people. As the system moves from balance to imbalance, the proportion of high-cost enrollees rises relative to that of healthy individuals, thereby driving up premiums. As costs increase, healthier individuals are the first to drop coverage (that they don't "need") leaving an even larger proportion of sicker, high-cost individuals. At some point, the imbalance becomes unsustainable, and the carriers exit the market entirely. One way to handicap the effectiveness of any replacement proposal, therefore, is to ask whether and how the proposal will foster a balanced risk pool.

Lessons for Policy Makers

Drawing from the sampling of the paper's findings and conclusions set out above, it is possible to make some rudimentary predictions about certain key and recurring features of the ACA replacement proposals. The ACA's individual mandate failed to provide sufficiently robust incentives to obtain and maintain coverage, and made it far too easy to move in and out of coverage. The go-to replacement

for the individual mandate, a continuous coverage requirement, is more porous than the individual mandate. Recognizing this, the replacement proposals revive access to state high-risk pools, about which the actuaries are less than enthusiastic. The reform proposals also rely heavily on market forces to drive individuals to the non-group market coverage of their choice, which may be from a carrier in another state. This latter, market-driven approach has been characterized by ACA proponents as “risk groups of one,” implying that the result will fragment rather than balance the non-group market. Opponents demur, claiming that market forces unfettered by regulation are best able to properly allocate aggregate risk.

In contrast to incentives to obtain and maintain coverage, the proposal to change the rules governing modified community rating to permit 5:1 (or greater) rather than 3:1 appears on its face to be risk-neutral. But it is not. This change *will* shift a portion of health care costs from younger, healthier individuals to older, sicker individuals. Nor is there is any reason to doubt the critics who assert that this will result in higher uninsured rates among older adults and increased federal costs for premium subsidies. Proponents nevertheless view the trade-off as necessary to lure young health individuals into the non-group market. Their claim is that, to ensure a viable individual market, we have no choice.

Lastly, there is Medicaid. While the paper offers the possibility of a wholesale merger of the Medicaid population into the individual market, this is nowhere suggested in any of the current replacement proposals. The proposals could, however, accomplish that result to a limited extent, since the contraction of Medicaid to its pre-ACA coverage levels will inevitably push a cohort of low-income individuals who are not otherwise Medicaid-eligible to seek coverage in the individual market, or go without coverage altogether.

Conclusion

Generally accepted actuarial principles are clear on this point: the proper management of risk is a non-negotiable prerequisite to the smooth functioning of the non-group market for health insurance. There is every reason to believe that the legislators and regulators who are driving the replacement process understand this. The ACA adopted a granular, rules-based approach; the proposals to replace the ACA seek to handle risk using a market-based approach. The replacement proposals thus are placing a large, unhedged bet on the free market’s ability to foster a stable and balanced risk pool. The stakes could not be higher.

Part 1 - Assessing New Normal

Part 2 - Explaining the Look-Back Measurement Method to Employees

Part 3 - Trump Plan "Healthcare Reform to Make America Great Again"

Part 4 - Ryan Plan, “A Better Way”

Part 5 - Rep. Tom Price Plan(s): Future of ACA Week 5

Part 7- The Future of the Affordable Care Act Week 7: The American Health Care Act

Part 8- An Employer’s Guide to the Collapse of the American Health Care Act

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