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Seven state options to reduce the number of uninsured (and stabilize insurance markets)

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The Patient Protection and Affordable Care Act (ACA) covered more than 20 million previously uninsured people in America. States can build on this progress by developing strategies to reach the remaining uninsured, 75 percent of whom already qualify for Medicaid or insurance offered by health insurance marketplaces. Following are seven innovative, practical options states could consider to broaden the circle of coverage while lowering unsubsidized premiums in the individual market:

1. Move towards implementing a Medicaid buy-in policy that lets consumers with incomes too high for Medicaid enroll in substantially more affordable insurance. The buy-in approach preferred by many advocates and officials would offer consumers with incomes too high for Medicaid the opportunity to use premium tax credits (PTCs) to obtain Medicaid-type coverage. With a waiver under ACA section 1332, such coverage might substantially lower enrollee premiums and deductibles, compared to what people now must pay in the exchange. Unfortunately, any policy—including a Medicaid buy-in approach—that substantially increases enrollment is likely to violate section 1332's deficit neutrality requirement, which forbids waivers that increase total federal spending.

Colin Baillio of Health Action New Mexico has developed a strategy to overcome this challenge by taking multiple steps, during the next few years, to increase enrollment into marketplace coverage funded by PTCs. As a result, the federal-cost "baseline" to which a buy-in waiver will be compared will have such high participation levels that only modest additional enrollment would result from a waiver. This could allow future federal approval for a buy-in proposal that offsets the cost of additional enrollees by lowering average federal costs per PTC beneficiary. The latter cost-offset could be supplied both by the buy-in policy itself and by other measures added to the waiver proposal, like reinsurance, described below.

2. Supplement federal financial assistance with extra help paying premiums and lowering deductibles. Unaffordability is the most significant factor inhibiting enrollment, according to much research. Federal PTCs and cost-sharing reductions have helped, but costs remain a significant obstacle preventing many uninsured from obtaining coverage. A few states use their own resources to supplement federal subsidies, making coverage more affordable for consumers with incomes up to 300 percent of

the federal poverty level (FPL). In Massachusetts, for example, those additional subsidies, and the resulting enrollment of young and healthy adults, played a major role helping the state obtain the country's lowest marketplace premiums, even while the state's overall health care costs were among the highest in the nation. Massachusetts used Medicaid waivers under Social Security Act section 1115 to claim federal funds that cover part of the cost of supplemental aid, but the federal government may not grant similar waivers to new states. Depending on the local political landscape, states without access to section 1115 dollars might consider using general-fund dollars for this purpose or taxing non-profit insurers and hospitals that have accumulated large surpluses, augmented by windfalls from recent federal tax cuts.

States could also explore targeted provider donations as a "win-win" financing strategy. This approach builds on successful hospital initiatives in several localities to pay the small amount of low-income consumers' premium costs that is not covered by PTCs. In each case, hospitals' resulting uncompensated care savings far exceeded their premium contributions. Both hospitals and consumers could benefit if these programs were scaled up to serve all eligible residents of a state, reducing or eliminating premium costs for the lowest-income uninsured who qualify for PTCs.

3. Implement the ACA's Basic Health Program (BHP) option, through which consumers with incomes below 200 percent FPL receive state-contracted coverage, rather than marketplace insurance. When New York used BHP to greatly lower premiums and end deductibles for people with incomes between 138 and 200 percent FPL, enrollment more than doubled for the affected income group, rising from 166,000 covered in 2015 to 436,000 in 2018. Fully 61 percent of New York's BHP members are under age 45, highlighting BHP's potential for improving risk pools and lowering premiums for unsubsidized consumers in the individual market.

4. Provide more hands-on assistance helping consumers enroll in and retain coverage. Consumer assistance with applications and renewals can greatly increase coverage. However, federal officials are gutting funding for this essential function in the federally facilitated marketplace. To preserve enrollment gains, states whose residents use that marketplace could furnish additional consumer assistance. Such efforts could be financed by charging fees to insurers serving the individual market or just the marketplace carriers. This model could benefit insurers by helping them gain customers. Moreover, unlike commissions for agents and brokers, insurance-company payment of state-imposed fees for enrollment assistance would not count against the Medical Loss Ratio requirements that limit insurers' administrative costs and profits to a specified percentage of premiums. Most states that operate their own exchanges already fund consumer assistance by charging fees to insurers that use the exchange; they could consider raising such fees if additional consumer assistance is needed.

5. Use state income-tax filing to give the eligible uninsured new opportunities to seek coverage. States have many options for leveraging state income tax filing to facilitate enrollment in health insurance, taking advantage of very high tax-filing rates among uninsured consumers who qualify for Medicaid, the Children's Health Insurance Program (CHIP),

and marketplace plans. For example, states could create special enrollment periods (SEPs) allowing marketplace sign-ups at tax time, when consumers have left behind the financial anxieties of November-December open enrollment periods, which federal regulations require to coincide with holiday shopping. Uninsured taxpayers could opt to have data from their return shared with state health agencies, which would enroll them into Medicaid or marketplace plans that are available at zero additional premium cost, beyond PTCs. Nationally, the majority of PTC-eligible uninsured (54%) qualify for marketplace plans with premiums that cost no more than the uninsured consumer's PTC.

Tax-time enrollment could be particularly significant in states that pass legislation to use their tax systems to enforce the ACA's individual coverage requirements. When consumers pay a penalty for last year's uninsurance, they could immediately learn from that experience and enroll in coverage that averts future penalties. A less punitive approach is proposed in Maryland legislation, which would let uninsured consumers convert their penalties into down payments that help buy health insurance. Nationally, 70 percent of the PTC-eligible uninsured, or 5.8 million people, are offered insurance that costs no more than their PTC, plus applicable penalties for lacking insurance. Enrolling consumers almost by default into such coverage, which would be free to taxpayers in a state implementing the Maryland proposal, could greatly reduce the number of PTC-eligible uninsured while improving the individual-market risk pool and lowering unsubsidized premiums.

6. Enact state-based individual mandates while structuring them to strengthen both individual and group markets. Massachusetts has had its own mandate law since 2006, and New Jersey, the District of Columbia, Vermont, and Washington State passed new mandate bills in 2018, after Congress eliminated enforcement of the federal mandate. When a state replaces the disappearing federal enforcement of the ACA's individual mandate with a state mandate law, it encourages participation in health insurance by young and healthy adults. If all states took that step, individual-market premiums would drop by 11.8 percent, and 3.9 million uninsured would receive coverage in 2019, rising to 7.5 million in 2022.

States with mandate laws can also achieve other important goals by setting standards that employer-sponsored insurance (ESI) must meet for beneficiaries to comply with individual coverage requirements. For example, although federal law bars states from directly regulating employee benefits, state individual mandate legislation could be structured to rein in ESI deductibles and other out-of-pocket costs, which have skyrocketed in recent years. In Massachusetts, residents can avoid state tax penalties only if they enroll in coverage that meets the state's definition of "minimum creditable coverage," which excludes ESI with very high deductibles. While state and federal employer mandates have required large and medium-sized companies to offer their workers coverage, many labor and health economists believe that employers' main motivation for offering ESI is to recruit and retain valuable employees. Massachusetts' approach to its individual mandate gives companies a strong incentive to meet those goals by offering insurance that meets state mandate requirements.

7. Lower premiums by using public reinsurance dollars to pay individual market claims.
Reinsurance programs in Minnesota and Maryland, which immediately cut premiums by 20 percent and 30 percent, respectively, illustrate this approach's potential gains. Reinsurance lowers costs for people who buy unsubsidized coverage, many of whom are asked to pay completely unaffordable amounts today. In deciding whether to move forward with this approach to help residents who are ineligible for PTCs, states may want to consider (a) potential increases in premium payments that would result for low- and moderate-income PTC beneficiaries who now choose the lowest-cost silver plan or a bronze plan; and (b) whether reinsurance should be held in reserve to help establish federal deficit neutrality for future 1332 waivers that take major steps to improve coverage and care for people of all income levels.

One innovative idea, originally suggested by Michael Miller of Community Catalyst, would focus reinsurance exclusively on gold-level coverage, which typically has individual deductibles below $1,500—far less than average deductibles of $4,000 and $6,000 in silver and bronze plans, respectively. If focusing all reinsurance dollars on gold plans lowered their premiums by 40%, or twice the reduction achieved by Minnesota's market-wide reinsurance, gold plans would become less costly than silver plans in every state and less costly than bronze in 41 states. PTC beneficiaries would not be harmed, and those with incomes above 200 percent FPL would gain access to far more valuable plans. A wholesale shift to coverage with more reasonable deductibles could result, improving access to health care while buttressing public support for post-ACA insurance markets.

Conclusion

This is only a partial list of strategies worth considering to increase the number of people with insurance and to lower unsubsidized premiums in the individual market. To decide among these and other priorities for action in 2019, state advocates and officials will likely need to consider potential limits on available resources, the income and age distribution of the state's uninsured residents, local market conditions, and how each state's evolving political landscape shapes the parameters of the possible.

Families USA looks forward to partnering with state advocates and officials across the country as they consider their options for addressing these and other health policy priorities. Stay tuned to familiesusa.org for additional information, and please feel free to reach out to us directly.