Stabilizing the Individual Market to Assure a Smooth Transition

Stability and predictability are critical to maintaining a well-functioning insurance market during the transition. Coverage options and rates were filed in May, 2016 for the 2017 plan year. Given the already difficult challenges of the individual market and continuing losses of many health plans on their individual business, significant changes in the basic parameters of coverage or funding for 2017 or 2018 would be extraordinarily destabilizing for insurers and consumers alike and likely lead to withdrawal from many markets.

Plans to repeal major elements of the ACA, with a transition period to be determined and replacement legislation to be developed at a later date raise a key question: Will this plan of action create such great uncertainty in the market that it will trigger large withdrawals even before a replacement bill is enacted, and put coverage for millions of people in jeopardy? Health plans and state regulatory agencies must soon make decisions on policies and rates for 2018 and need to know what operating rules and funding will be in place for that year. Consumers and caregivers also need clear expectations and information about available options; changes can be extremely disruptive if not communicated clearly and well in advance.

While there are multiple ways to alter the mechanisms for providing health coverage during a transition period, a guiding principle for reforms should be that individuals and families should not lose coverage. Early steps to adopt a "stabilization agenda" for the next several years could help to avoid large scale market withdrawal and loss of coverage. To stabilize the market in the short term and ensure a smooth transition period, legislation that repeals or modifies components of the ACA must include the following core elements:

- Adequate funding
- Stable risk pool
- Affordability

Adequate funding:

1. Continued funding of premium tax credits and cost-sharing reduction subsidies is key. Without this financial support, most individuals would not be able to afford health insurance and health plans would be unable to continue coverage. No step is more important in reducing market uncertainty than signaling that both subsidies will continue through a transition period.

2. Reinsurance is a well-established mechanism to protect against unanticipated losses and has worked effectively for exchange coverage and in other contexts. Reinsurance obligations for 2016 should be fully paid and the program should be extended for 2017 and beyond.

3. In addition, plans undertook coverage obligations in the understanding that no plans would gain excessive margins from exchange business nor suffer excessive losses; non-payment of the government's risk corridor obligations – again, a well-established mechanism used in Medicare Part D – cost plans millions or tens of millions of dollars. These obligations should be paid.

Stable risk pool:

1. Continuous coverage is critical – and plans have shown that individuals who maintain coverage show significant improvements in their risk profile in relatively short periods of time. Both expanded pre-enrollment verification of eligibility for special enrollment periods and further narrowing of special enrollment exemptions are warranted, as are steps to reduce gaming of grace periods, non-payment of premiums, and cancellations/re-enrollments.

2. If insurance reforms are maintained, as they should be, new steps to strengthen enrollment are necessary. Especially in the absence of a tax on individuals who do not enroll, health plans should be authorized to offer incentives for enrollment and those should be paired with penalties for enrollment after initial eligibility. These could be financial as in Medicare Part B (e.g., higher premium) and coverage-related, (e.g., late enrollee limited to bronze plan).

3. Risk adjustment allows health plans to offer affordable coverage to more complex patients and also serves to level the playing field among plans. Current risk adjustment methodology requires risk scores to be calculated based on a statewide risk pool rather than on the basis of each market area. This can adversely affect plans offering coverage in only a portion of the state. States should have the option of establishing a statewide v. market area risk pool for the individual market and for the small group market.

4. Health plans should have greater flexibility in designing coverage, but any changes in benefit packages and other coverage requirements should be designed with the expectation that health plans will continue to manage risk and accept all enrollees.

5. States should have the option to extend non-compliant plans during the transition.

Affordability:

1. Higher taxes likely have discouraged employers from offering coverage and are a significant factor in raising out-of-pocket costs. The premium or health insurance tax should be repealed permanently and the tax on high-cost plans ("Cadillac tax") should be revised to be more equitable or repealed.

2. If high-cost risk pools or other risk mitigation strategies chosen by states are included in reforms, adequate and broad-based funding to meet needs is essential. High-cost risk pools should not exclude patients for pre-existing conditions or impose waiting periods except as necessary to prevent gaming. Premiums should be at standard market levels.

3. Government policy should encourage and support innovations in benefit design to encourage value-based treatment, patient-centered care, and use of telehealth-based services and other technologies that increase access and efficiency and meet patient expectations.