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EVENT SUMMARY

Penn Health Policy Forum

Health Reform and the Future of the Individual Insurance Market: Weighing the Evidence

March 7, 2017

Steve Parente, University of Minnesota

When I look at the ACA, I see a republican law with Medicaid expansion bolted in. The new proposed bill still has advanced or refundable tax credits—a republican idea.

The most important aspect of the proposed bill is that it offers some money to stabilize the 2018 individual market--which could very well collapse or have far less participation. The hope here is that money is available to states to develop risk pools or reinsurance. Problem with the way ACA did reinsurance was that it did not cover the upper bound of expenses, but covered a "donut" about $40,000 to $250,000. Very expensive cases still affected underwriting.

We have less than five months to give insurers the signal not to leave, or to come back.

Scott Harrington, University of Pennsylvania

Replacement plan tax credits will grow at CPI +1%, and if we see the same trajectory of health care cost growth, the tax credit will be increasingly stingy. The hot button issue is targeting the tax credits to income level; overall, it will lower support to those at the lowest income group.

However, there are perverse effects in the present plan, where a couple each making $16 an hour gets thousand in subsidies, which disappear when they each make $17. The individual market is not attractive to this couple at this level, and it is an implicit tax on making more money.

Replacement plan age-adjusted credits are not tailored to region and will be worth less in markets with high health care costs. But that may not be the full picture, as high cost markets are often high income markets. And maybe it's not best to have a system that provides federal support for higher cost markets. The credits might not be simple, but are far simpler than the ACA.

I like that there's extra money in the bill that would let states decide how to subsidize risk and reduce risk for others. We may see some proposals that have legs. The elephant in the room is the federal budget, which still has to be dealt with.

Bradley Herring, Johns Hopkins University

Under the ACA, there was some adverse selection, but not enough to cause a death spiral. Some people paint a picture of a death spiral because of the rise in premiums from 2016 to 2017, but that was caused more by the sunsetting of the reinsurance program.

I was expecting a Republican health reform proposal that would go back to the prior world of experience rating every year, and high risk pools. But that didn't happen, because of the limitations of the budget reconciliation process.

Will the end of the individual mandate result in adverse selection? What is the practical impact of a 30% surcharge on people who do not keep continuous coverage? We don't know yet, but CBO and Urban Institute are churning the numbers.

I'd like to see a limit on the tax exclusion for employer health insurance, but it is an idea only health economists seem to love.

Patrick Finn, McKinsey and Company

We can break out coverage into four categories:

1) routine care (low costs)
2) discretionary/elective care
3) management of chronic conditions
4) catastrophic (traditionally insurable) costs (roughly 28% of costs)

The ACA essential benefits cover all of this, and we've paired it with high deductibles to drive price-conscious care. What should we do now?

We could remove coverage for routine and discretionary care and make it more of a retail market. It could be funded by HSAs, and competition could drive prices down.

We could take the management of chronic care and takes steps toward value-based reimbursement. Plan designs could be more generous for compliance with recommended care, and less generous for noncompliance. Insurance would continue to cover catastrophic care.

These steps could cut 40% out of claims costs, making insurance more affordable and promoting cost-conscious care.

Daniel Polsky, University of Pennsylvania

Moving from subsidies to tax credits does not address issues of affordability particularly for those in higher need. Premiums may go down for the young and healthy, but older individuals may not be able to afford coverage. The question is, how do these set of incentives change the number of uninsured, and what type of insurance can they afford?

I have concerns about the continuous coverage provision. Low-income groups sometimes are forced to make difficult budget decisions. Even with the surcharge, it might make more sense for low income healthy people to stay out; the sicker ones will choose to pay the surcharge, making the whole risk pool sicker.

Teresa Miller, Pennsylvania Health Commissioner

What things look like in Pennsylvania: 1.1 million people covered through Medicaid expansion or individual market. The uninsured rate is the lowest we have ever seen. 175,000 have access to substance abuse treatment. To put that in perspective…that population would be the third largest city in Pennsylvania.

Two national carriers left our market, and we were looking at potentially half our counties without a carrier. We approved increases of 33% (higher than the rates they requested) to keep them in. The five carriers we have left are all losing money. What we heard when we talked to carriers is, "We need predictability and stability." I think it's safe to say we don't have that now. The carriers need to know what the rules are, and that they stay the same. That's a fair criticism.

We've seen high risk pools and they didn't work. I'm hopeful we can learn from the past and not repeat things.

Dan Mendelson, Avalere Health

Replacement plan is a viable approach that could pass under reconciliation. For example, the individual mandate is not repealed, but the penalty is brought down to $0.

There will be a Medicaid change that will benefit red states…it just kind of works that way. Surprising that Republican states expressing concern.

Medicaid might be the more profound change on the table. When you cap per capita costs in the out years, there are significant savings…any version of per capita caps are very adverse for providers, particularly for hospitals.

Will we continue the war that the ACA became, or will work together to improve the bill? The real victims are the real poor who need a stable system.

There isn't enough money to make this budget neutral right now, but there will have to be by the time it passes. Where is the money going to come from? It's not a matter of squeezing from benefits, but it could come from limiting tax exclusion for employer sponsored insurance, from a provider tax, maybe deciding that a tanning tax is not worthy of repeal.

Dave Grande, University of Pennsylvania

The question for the replacement plan is, "What's the goal here" It seems to me that the goal is to spend less money. So the question is how much the government is investing, and who is getting these resources.

We need to look at both how many people are getting help, but also who is getting help. Do people with the greatest need get help? Do people at greatest risk [populations that don't make enough money and populations with serious chronic disease and predictable high cost] get help?

We may be moving to a more traditional insurance model, but moving away from other goals to get people the help they need.

Steve Parente, University of Minnesota

If plans could say what they would like to see, they would say reinsurance like it is offered in the large group market (not like it is in the ACA). Call it stop-loss insurance: $100,000, after which some agency would cover the rest. This is insurance for insurance and not inexpensive--it would cost about $800 a year. But that's not far off from the money in the state innovation grants in the legislation.

Those grants could be used for other things. It could be used to offer a rider with a secondary prevention benefit for chronic disease patients…perhaps 5% more in premiums to make services free.

Key thing is that private industry has to respond. We need to say, 'We know you got burned, but we're making it better.'

The tax exclusion for employer sponsored insurance could come up in the Senate, or in tax reform. In a thought experiment, we get rid of tax exclusion, but instead of putting it toward health care, put it toward lowering marginal tax rates across the board. That could increase productivity by up to .5% GDP.