BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Moving Forward: A Health Insurance Market for 2017 and Beyond

For more than 80 years, the private health insurance market has provided Americans with healthcare coverage that has continuously evolved to meet consumer needs. Yet today we are at a crossroads. Although we've made great strides in expanding access to health insurance, it is still too expensive for many working, middle-income Americans who do not get coverage through their employers. Moreover, in one-third of U.S. counties today, people who buy coverage on their own have only one choice among health insurers.

Moving forward there may be differences on the best approach, but fundamentally there is agreement that Americans are best served by a competitive, private health insurance market that offers consumers the choices they want at a price they can afford. Further, that healthcare coverage must be accessible to as many Americans as possible, just with more choices and better prices.

As we move forward, it is important to put in place a smooth transition between what we have today and a competitive private health insurance market. This can be done in three key steps:

1. Address immediate priorities to preserve the private health insurance market

By January 1, millions of people nationwide will have purchased coverage in the individual market and will be receiving the care they need. It is critical to avoid disrupting their access to care by taking actions in the short term that would result in:

- ***Even fewer health insurance options*** for consumers, as insurers facing financial uncertainty are forced to exit the individual market. Already 40 percent of rural counties have only one option;
- ***Significant premium increases*** in 2018, making coverage even more unaffordable for millions of working Americans;
- ***Reduced access to care*** for many middle-income Americans as out-of-pocket costs go up, and coverage choices go down; and
- ***Disruption to the already fragile individual market*** that must serve as a solid foundation for any private sector replacement plan.

First, it is important to do no harm by maintaining two critical programs in 2017 -

- The majority of Americans who purchase coverage on the Exchanges get help with out-of-pocket costs like deductibles and co-pays. These are millions of working, middle-income families making up to $60,750 for a family of four who cannot afford to pay deductibles that average around $7,500 for a silver plan today. Any administrative actions to change the cost-sharing reductions must go hand-in-hand with immediate funding to maintain access to care.

- The temporary reinsurance program was put in place to ease the transition of closing state high-risk pools and bringing people with significant medical needs into the private, individual market. Insurers were required to reduce their premiums upfront in 2016 and pay medical claims in full because the reinsurance program would pick up the cost in 2017. Rescinding these funds would cause premiums to increase for millions of Americans and cause insurers to exit the individual market entirely.

2. Issue Executive Orders and take administrative actions early in 2017

There are a number of regulatory actions the Administration can take immediately to smooth the transition to a competitive private health insurance market in 2017 and 2018, in a manner that is not disruptive to consumers. Any regulatory changes impacting health insurance plans sold to consumers in 2018 should be finalized by April 2017 in order to allow time for insurers to develop their products and rates, obtain state approval, and tell consumers about their coverage options. Existing regulatory timelines and approval processes must be streamlined and modified in order to give consumers choices among more affordable insurance products as quickly as possible, without sacrificing a successful implementation process.

These changes include:

- **Return regulatory authority for insurance to the states.**
  - Return authority to states for health insurance rate review, benefit design and review, and provider network adequacy.
  - Support state flexibility for waivers to improve the individual market.
  - Limit requirements that add costs and disrupt the employer health insurance market; instead, allow states to determine how best to regulate the small group market, including setting the rating rules.

- **Close coverage loopholes that lead to higher costs for consumers.**
  - Limit the number of special enrollment periods (SEPs) to those that are necessary for life-changes; require all individuals to show proof of eligibility before coverage becomes effective.
  - Expand existing guidance to prohibit steering of individuals eligible for Medicare or Medicaid into private health insurance by health care providers.
  - Allow insurers to ensure Medicare-eligible beneficiaries are enrolled in Medicare.
  - Require people to pay their outstanding debts before reenrolling in coverage.
  - Shorten the open enrollment period so that it does not span calendar years (i.e., ends on Dec 15, 2017) so people maintain a full year of continuous coverage.

- **Allow people to keep their choice of health plan.**
  - Allow states to continue “grandmothered” individual and small group policies for two more years. These pre-ACA policies are set to expire in 2017.
  - Allow “grandfathered” policies to continue regardless of whether their deductibles and benefits have changed.
  - Allow cost-sharing reductions to continue through Dec 31, 2018 and make contracted payments to health insurers to avoid disruptions in coverage for millions of Americans.

- **Cut back regulations and fees that add costs without value.**
  - Eliminate taxes and fees that hurt middle-income Americans (health insurance tax, 3.5% federal exchange user fee, device tax).
  - Allow insurers to offer innovative plans and eliminate standardized health plans.
  - Eliminate the federal SHOP and the requirement that all insurance companies that sell policies on the Exchange must also participate in SHOP.
  - Minimize federal reporting requirements that add costs without value (e.g., summary of benefits and coverage).
  - Reduce the scope of Section 1557 non-discrimination rules.

3. Enact legislative changes to shore-up the private health insurance market, return regulatory authority for insurance to states and help middle-income Americans

It is important that healthcare be accessible to all Americans. But in order for premiums to be more affordable and health plan choices to be available, it is critical to build a system that balances the costs of caring for people with serious health conditions with powerful incentives for people to maintain continuous coverage and for young and healthy people to purchase health insurance.

Funding should be available to assist with the cost of caring for individuals with especially costly conditions; young people should be able to find value in their health care coverage; and people must not be allowed to purchase coverage when they get sick and then drop it after they receive care. Only this balance will keep premiums stable. The following incentives are necessary in the absence of an individual mandate:

- **Provide funding for high-risk individuals starting in 2018**. A funding mechanism to offset the cost of caring for those with serious health conditions is essential in order for premiums to be more affordable. While it may be preferred for states to establish and sustain this funding over time, adequate federal funding will be essential during the transition to new reforms and will allow states enough time to put in place mechanisms to help offset the costs of caring for those individuals with the highest medical costs.

- **Phase-in a fairer tax credits for younger consumers**. The current tax credit design provides much more generous subsidies to older consumers. To encourage younger people to buy coverage, Congress should adjust the required contribution under the tax credit formula by age to provide greater value to younger people.

- **Establish incentives to encourage people to maintain continuous coverage.** While special enrollment periods (SEPs) are important to ensure those experiencing a life-changing event (e.g., moving to a new service area or losing employer coverage) can enroll in coverage mid-year, the current rules allow some to enter and exit the market only when they need medical care, which drives up costs for everyone. Although CMS recently took steps to address this issue, more needs to be done. Congress can minimize the ability to misuse these consumer protections by requiring people to have prior coverage and showing proof of eligibility before enrolling through a SEP; and allowing states to set grace periods for non-payment of premiums. Other potential changes are now being modeled to promote continuous coverage. For example, Congress could allow states to establish a waiting period (e.g., 6 months similar to Medicare Part B) or premium surcharge for those who do not maintain continuous coverage.

- **Ensure patients are enrolled in the appropriate insurance program, and prohibit financially-interested parties from inappropriately steering patients from government programs into private coverage**. Health plans are seeing substantial increases in providers steering patients with serious conditions from Medicare and Medicaid to private individual coverage to boost their own reimbursement. This practice results in higher premiums for everyone else. While CMS recently issued a regulation that discourages this practice among dialysis providers, Congress should enact a broader prohibition on health care providers and nonprofit entities that are affiliated with or funded by healthcare providers from paying health insurance premiums.
- **Establish a 5:1 age band** to encourage more young consumers to participate in the insurance pool. The individual market today is heavily skewed toward older consumers, in part because younger people are required to pay substantially more than the expected value of their coverage.

- **Permanently repeal ACA taxes and fees,** including the health insurance tax and the authority for Exchanges to collect user fees.

- **Provide lower-cost products** by allowing for a longer transition of existing products (e.g., "grandmothered" products), greater actuarial value flexibility, and scaling back federal and state benefit mandates that limit plan flexibility and consumer choice.

- **Establish a health account to help people with out-of-pocket costs.** Congress should create a new "health account" to offer consumers financial help with their out-of-pocket costs if the cost sharing reduction program is not funded in the future.

Congress should also allow states to put in place reforms that work for them:

- **Return authority for the insurance market for small employers to the states.** The small group market is likely to collapse over time under the current, very restrictive federal rating rules. Returning regulatory authority for this market to the states would allow them to establish more flexible rules and give small employers a healthy and competitive health insurance market.

- **Use Section 1332 waivers to allow states to make insurance reforms.** Amend Section 1332 of the law to give states more flexibility to modify their insurance rules.

Looking Ahead

As we look ahead to creating a competitive private individual market that offers consumers robust choices at the best possible price, it is important to keep in mind a few principles that balance the urgency of providing consumers more affordable insurance products as quickly as possible, with a successful implementation process:

- **Give states adequate time to adopt changes.** States need a minimum of 2 to 3 years to enact legislation, issue regulations and implement new requirements. Some federal requirements and information technology functions may need to remain in effect while states implement new programs.

- **Focus on successful implementation.** Policymakers should learn from previous implementation challenges and focus on ensuring a successful transition to new rules and systems. Providing adequate time, being transparent with industry partners, and paying attention to operational requirements will help ensure a successful transition.

- **Allow time for insurers to develop new products for a reformed individual market**. It typically takes 18 to 24 months for health plans to develop and price new products. Adequate time must be provided for state approval of products and loading them into any new sales portals. Existing regulatory timelines and approval processes must be streamlined and modified in order to give consumers choices among more affordable insurance products as quickly as possible, without sacrificing a successful implementation process.

- **Ensure a gradual transition for consumers** who are currently receiving financial help. For example, moving to a flat tax credit overnight could result in substantial cost increases for certain consumers.