



Ending Federal Enforcement of the ACA's Individual Responsibility Requirement: How Should Maryland Respond?
Maryland Health Insurance Coverage Protection Commission
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OVERVIEW OF PRESENTATION:

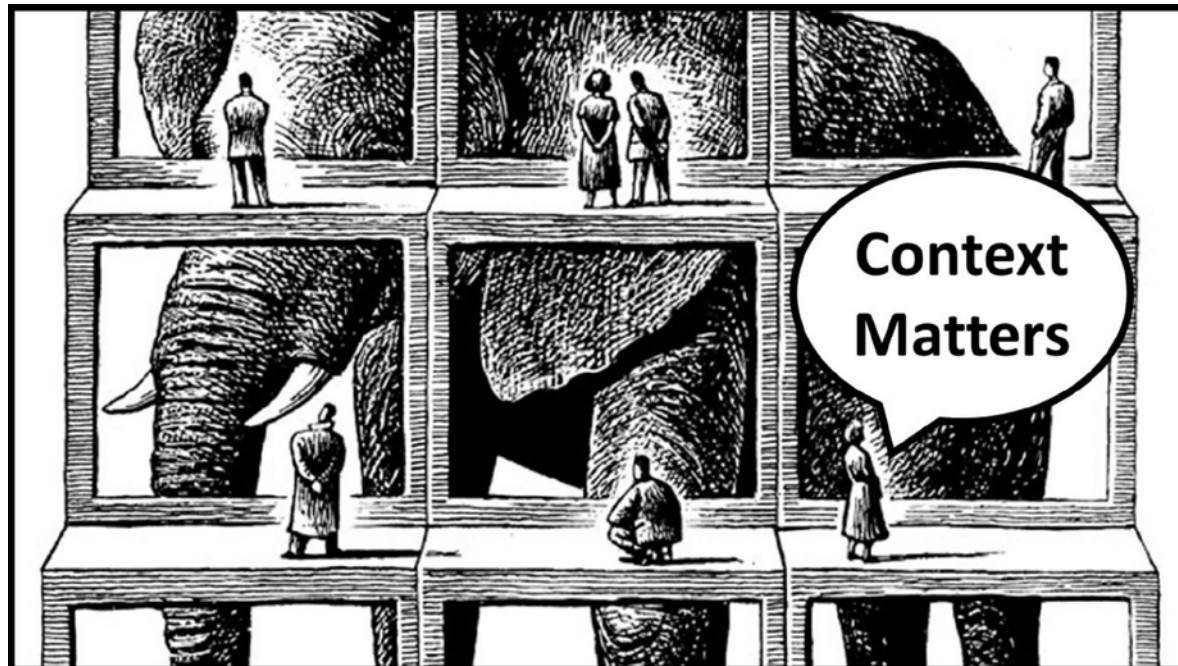
Context

Options

Focus on one option: the down-payment plan

Context

- ACA individual responsibility requirement (AKA “individual mandate”)
 - Everyone who can afford health insurance should obtain it
 - Accountability enforced through federal tax code
- Federal tax bill ended federal enforcement, effective:
 - Coverage beginning January 2019
 - Tax filing in 2020
- Should Maryland fill the gap left by the end of federal enforcement? If so, how?



Why enforce the ACA's individual responsibility requirement?

- Original rationale: needed to complement insurance reforms that protect people with preexisting conditions
- Without enforcement
 - Some young and healthy people will leave the individual market, raising risk levels and premiums
 - Fewer eligible people will enroll in Medicaid and CHIP
 - Some people may drop out of employer-sponsored insurance, and some firms may stop offering coverage



Impact in Maryland, if the state does not enforce the ACA's individual responsibility requirement:

- Premiums in MD's individual market rise by 16 percent
- 69,000 additional uninsured
 - 10,000 fewer people with employer-sponsored insurance
 - 43,000 fewer people with individual-market coverage
 - 16,000 fewer people with Medicaid and CHIP

Source: Urban Institute 2018.

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Options for Maryland Enforcement of Individual Responsibility

Approach	Advantages	Disadvantages
A. Replace federal tax-based enforcement with state tax-based enforcement	<ol style="list-style-type: none"> 1. Prevents coverage losses and premium increases from federal law 2. Replicates past policy, federal and from other states 3. Penalty money for other uses 	<ol style="list-style-type: none"> 1. Political challenges: least popular element of the ACA 2. Administrative costs to Comptroller
B. Same as A, but increase penalty amount	<ol style="list-style-type: none"> 1. Prevents coverage losses and premium increases from federal law 2. Incentivizes additional enrollment, lowering premiums 3. More penalty money for other uses than A 	<ol style="list-style-type: none"> 1. Political challenges grow more acute 2. Administrative costs to Comptroller
C. Same as A, but use state tax return to authorize data-sharing and enrollment, with tax-based special enrollment period	<ol style="list-style-type: none"> 1. Prevents coverage losses and premium increases from federal law 2. Some additional enrollment, some additional premium reduction 3. Penalty money for other uses 	<ol style="list-style-type: none"> 1. Political challenges remain, but potentially less acute 2. Higher administrative costs to Comptroller 3. Administrative costs to Exchange
D. Same as C, but let consumers turn penalty payments into down payments to buy insurance; when people are offered zero-premium plans, move towards auto-enrollment	<ol style="list-style-type: none"> 1. Prevents coverage losses and premium increases from federal law 2. Substantial additional enrollment, significant additional premium reduction and market stability 3. More public acceptance 	<ol style="list-style-type: none"> 1. Higher administrative costs to Comptroller and Exchange 2. Administrative costs to carriers 3. Moving towards auto-enrollment could leave some newly insured people unhappy with the coverage they receive 4. Less penalty money for other uses

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Key elements of down-payment plan

Use tax filing to enroll the uninsured into coverage, whenever possible. Don't just use tax filing for punishment.

Additional exemptions from the personal-responsibility requirement, recognizing

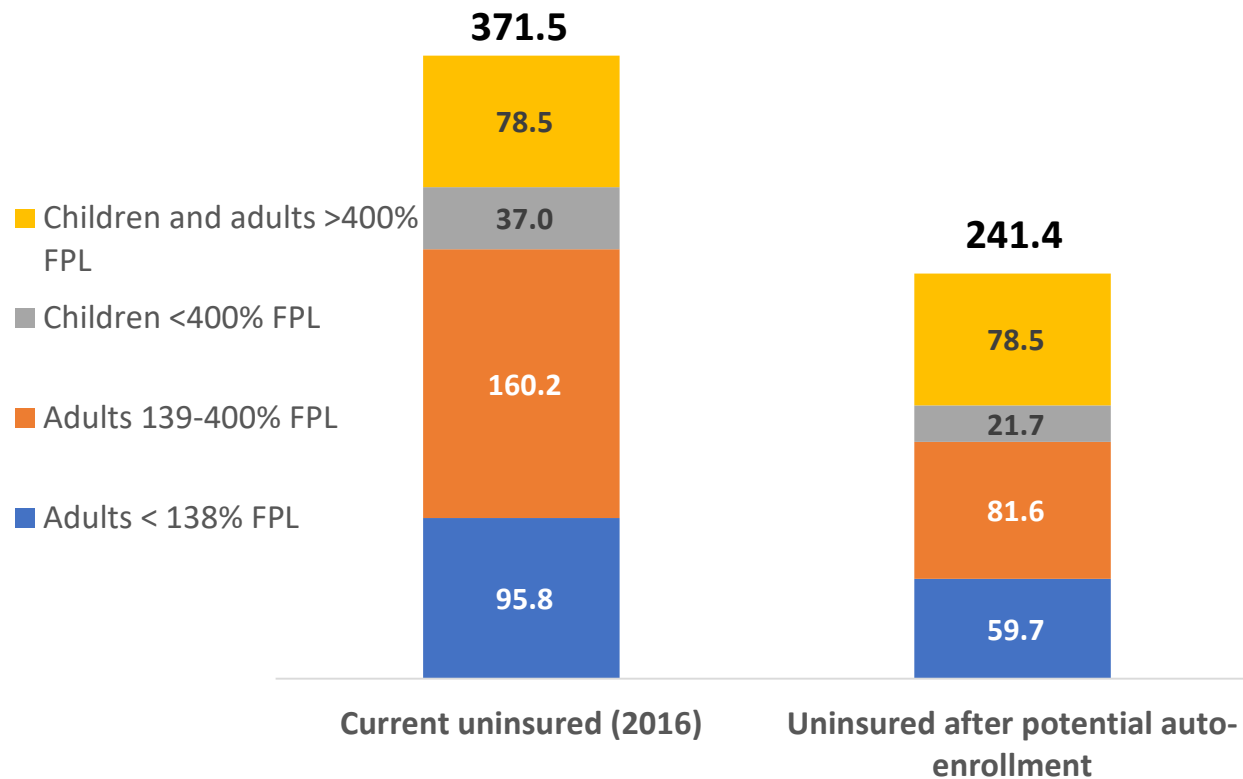
- Religious convictions that prohibit health-care use
- The tight budgets of low-wage, working families

Enrollment incentives and auto-enrollment replaces mandate penalties, whenever possible

- If tax return data shows Medicaid eligibility, enroll the uninsured into Medicaid
- Let consumers convert penalty payments into “down-payments,” to help buy insurance
- Go as far as possible towards auto-enrolling uninsured consumers into Exchange plans if federal premium tax credits (PTCs), plus their down payments, cover full premiums
 - ❖ Paradigm borrowed from private-sector 401(k) accounts: auto-enrollment has become the industry standard, raising six-month 401(k) participation levels from 33% to 90% <http://www.nber.org/reporter/fall05/laibson.html>
- If someone is auto-enrolled into a high-deductible bronze plan, give them one final chance to “buy up” to a high-actuarial value (AV) silver plan or a gold plan, both of which offer much lower deductibles
 - ❖ Paradigm borrowed from private-sector marketing, post-purchase decisions

Impact on Maryland uninsured

Estimated number of Maryland uninsured, currently and after implementation of down-payment plan (thousands)



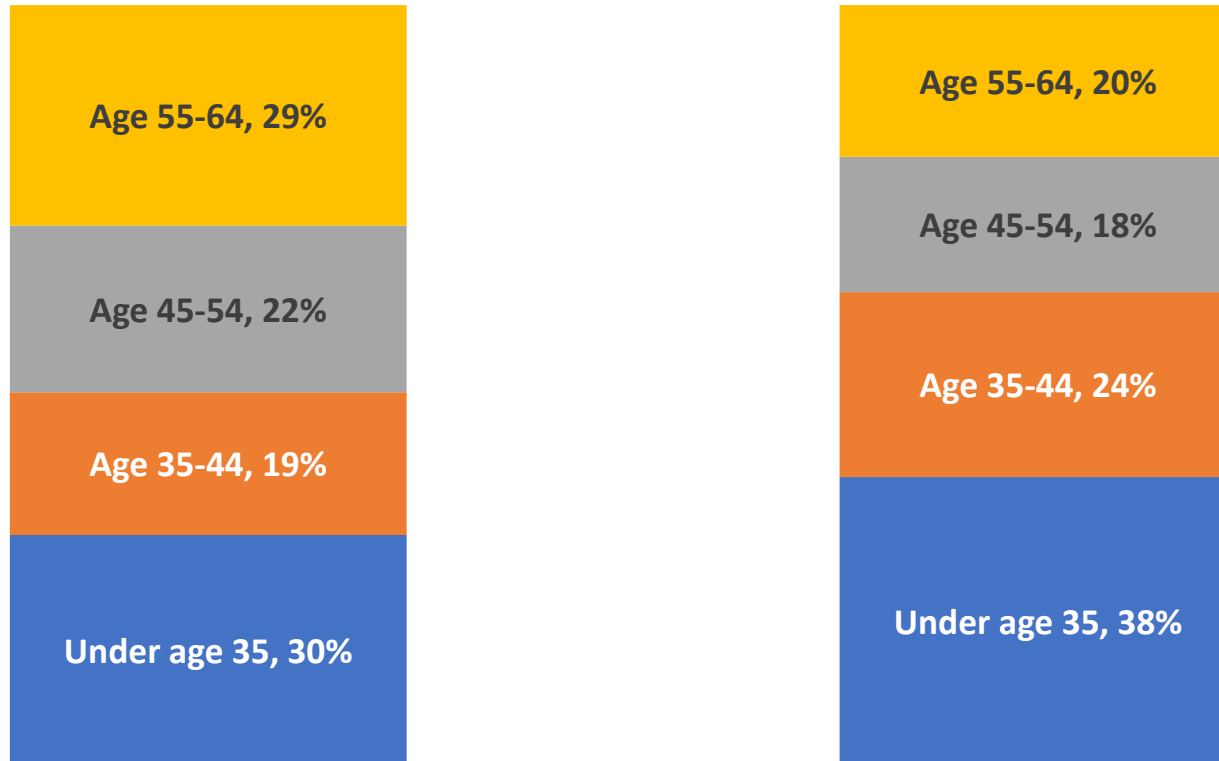
Newly covered

- 14,300 children with Medicaid/CHIP
- 36,100 adults with Medicaid/CHIP
- 78,700 adults with exchange coverage

Source: Families USA analysis of 2016 ACS data and 2019 MHBE premiums. Notes: "FPL" = federal poverty level.



Age distribution of adults under age 65



October 2018 Exchange enrollment

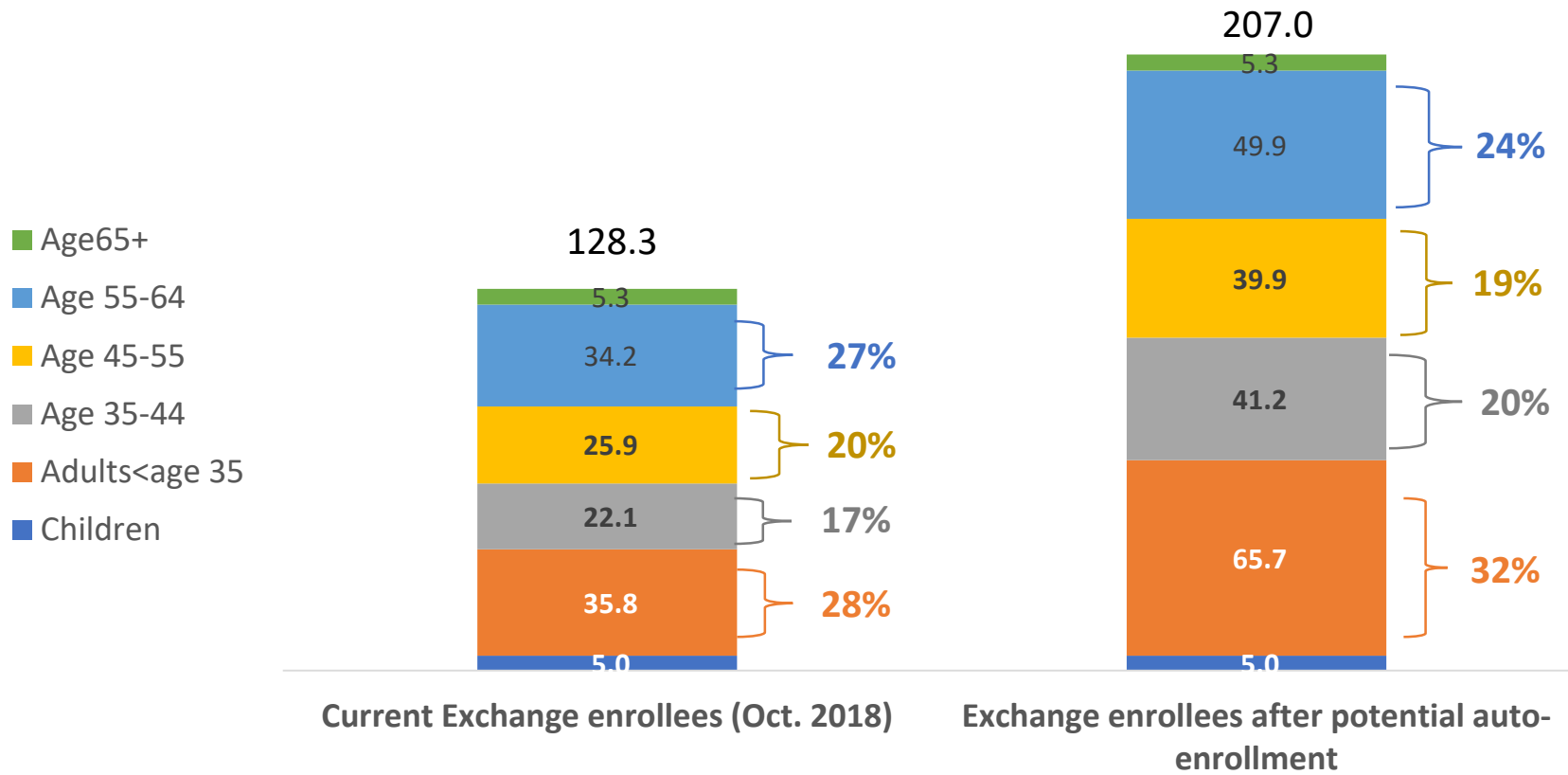
Potential auto-enrollees into zero-additional-premium plans

Source: Families USA analysis of 2016 ACS data, 2019 MHBE premiums, and MHBE reports of 2018 enrollment. Note: MHBE adult enrollment estimates, but not auto-enrollment estimates, include 18-year-olds.



Impact on total Exchange enrollment and age mix

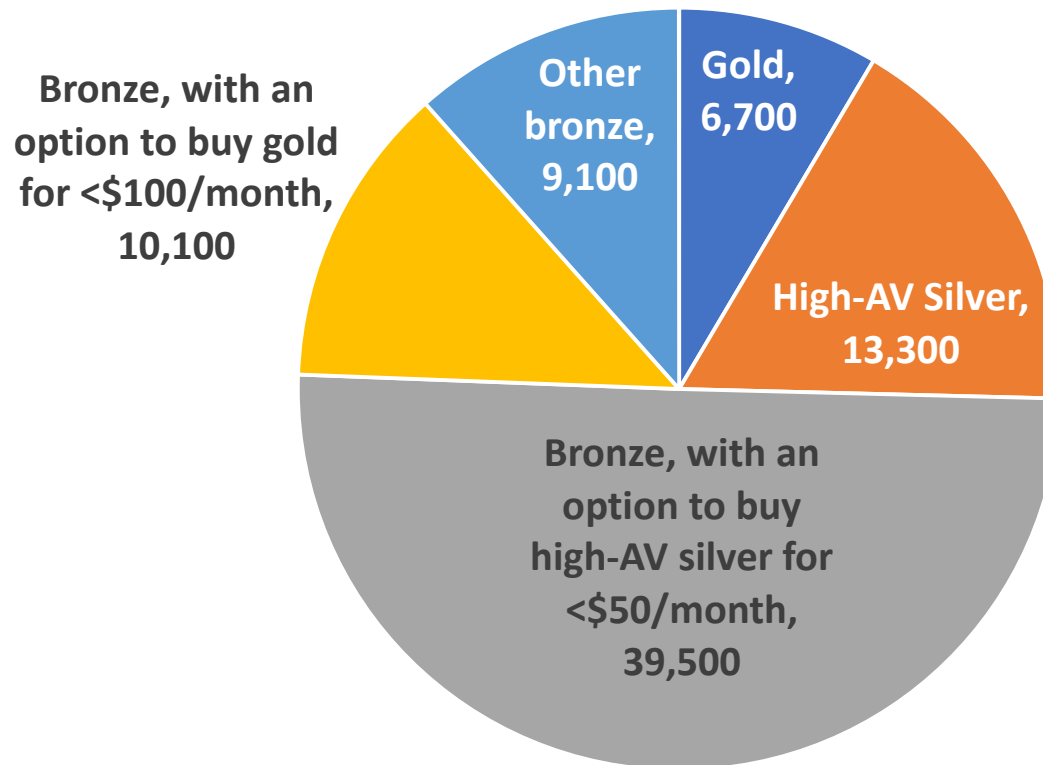
Estimated number and age distribution of Marylanders in Exchange plans, currently and under down-payment bill (thousands)



Source: Families USA analysis of 2016 ACS data, 2019 MHBE premiums, and MHBE reports of 2018 enrollment. Note: MHBE adult enrollment estimates, but not auto-enrollment estimates, include 18-year-olds.



Number of uninsured receiving coverage at various metal-levels, with auto-enrollment into zero-additional-premium plans



Source: Families USA analysis of 2016 ACS data and 2019 MHBE premiums. Note: High-AV Silver plans are limited to consumers with incomes at or below 200% of FPL. They have lower deductibles than Gold plans.

Potential auto-enrollees into zero-additional-premium plans, by geographic area and metal level

	Gold	High-AV silver	Bronze, with access to high-AV silver for <\$50 a month	Bronze, with access to gold for <\$100 a month	Other bronze	Total
Two-carrier areas	-	8,500	39,500	10,100	9,100	67,200
One-carrier areas	6,700	4,800	-	-	-	11,500
Total	6,700	13,300	39,500	10,100	9,100	78,600

Source: Families USA analysis of 2016 ACS data and 2019 MHBE premiums.



Auto-enrollment

- Makes huge difference to participation levels
 - Louisiana Express Lane Eligibility: adding a SNAP opt-in box cut child health enrollment by 62%
- Used with health care
 - Medicare, Parts B and D
 - Medicaid auto-assignment
 - 1.8 million annual auto-renewals in healthcare.gov
- In this context, particularly important
 - People have access to essentially free coverage, not enrolled. Nationally:
 - ❖ 4.5 million uninsured--54% of PTC-eligible uninsured--are offered coverage that costs less than PTC
 - ❖ 5.8 million--70% of PTC-eligible uninsured--are offered coverage that costs less than PTC plus penalty
 - This is a low-risk group. Enrolling them improves risk pool, lowers premiums, stabilizes market
- Not fully automatic
 - Must consent to share tax data on tax return
 - Chance to select any plan during special enrollment period
 - ❖ Public education
 - ❖ Navigator help
 - Advance claims of PTCs: requires information updating and year-end tax filing
 - Can opt out or buy up after receiving information about the zero-premium plan
 - In some cases, exchange may need more information from consumer to determine eligibility
 - Immigrant protections
 - When a family has >1 way to spend down payment for zero-additional-premium coverage, contact the family to see preferred choice

Other factors

- Impact on jobs and Maryland economy: 71% increase in take-up of federal PTCs
 - 110,300 (October 2018) to
 - 188,900
- Protects markets in case reinsurance ends or gets cut back
- Administratively complex
 - Last session's fiscal note, with a more complex down payment bill, estimated administrative costs:
 - ❖ Year 1: \$4.9 million
 - ❖ Later years: \$2.8 million
 - Best estimate: more than \$30 million a year in penalty payments will not be used for insurance, available to cover administrative costs.
- The number with access to zero-additional-premium plans may change from year to year
 - One year's default enrollment will leave fewer uninsured the next year
 - If federal policy changes lower premium tax credit amounts, could be large drop
 - ❖ Trump administration guidance supportive of "silver loading," but that could change. New guidance for 2020 plan year will provide further information about administration posture.
 - ❖ Congress could restore CSR payments, ending silver loading
 - Unlikely that House Democrats would accept that change without significant offsetting increases to premium tax credits
 - New carriers in exchange could reduce the number of people with access to zero-additional-premium coverage
 - If reinsurance ends, the number with access to zero-premium plans could increase
 - Bottom line: likely to be a large impact, but the precise amount of new default enrollment will change from year to year

Conclusion

- Enforcing the individual responsibility to obtain coverage would help the market
- Going beyond “straight vanilla” mandate to the down payment plan would
 - Cover numerous low- and moderate-income uninsured in Maryland
 - Lower private health insurance costs in Maryland
 - Stabilize Maryland’s individual insurance market
 - Point the way to a better approach for other states and the nation
- Philosophy behind this approach to strengthening the individual market:

We’re all in this together.

Expanding the circle of coverage lowers costs for everyone.

- However: it will not be a walk in the park to achieve those gains

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