RIPEC

RIPEC Policy Brief

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Adopting a State-Based Individual Shared Responsibility Payment

This RIPEC Policy Brief considers whether adopting a state-based individual shared responsibility payment in Rhode Island is a sensible policy choice that will contribute to the stability of the individual health insurance market.

Introduction

In the Spring of 2018, the Office of the Health Insurance Commissioner (OHIC) and HealthSource RI (HSRI) convened the Market Stability Workgroup to consider what actions, if any, should be taken by the state to mitigate the potential negative consequences for Rhode Island of federal changes to the Affordable Care Act (ACA). The group is charged with providing recommendations to the state that would be consistent with a set of three Guiding Principles:

1. Sustain a balanced risk pool;
2. Maintain a market that is attractive to carriers, consumers and providers; and
3. Protect coverage gains achieved under the ACA

Among the final set of recommendations that emerged from the Market Stability Workgroup, the group endorses the following state actions:

1. Adopt a state-based individual shared responsibility payment (SRP, or individual mandate penalty) to mitigate the impact of the federal health insurance mandate penalty repeal
2. Apply for a 1332 Waiver to implement a reinsurance program
3. Fund the state's share of the reinsurance program using revenues collected from the SRP

There has been a tendency to focus on the SRP primarily as a funding source for the reinsurance program, but RIPEC believes it is critical that we consider the policy merits of each component – the SRP and the reinsurance program – separately. In other words, the decision regarding whether or not to adopt a state-based SRP should be separate from the question of whether and how to fund a reinsurance program.

With that in mind, is a state-based SRP a good policy choice for Rhode Island? RIPEC believes it may be, for both theoretical and empirical reasons.

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Theoretical Argument for Supporting a State-Based SRP

The SRP was one of the three key, interconnecting coverage reforms included in the ACA. To increase and maintain sustained, affordable, and comprehensive coverage, the ACA included the following reforms:

1. Community rating that does not exclude pre-existing conditions
2. Mandatory coverage so individuals do not self-select coverage only when they are sick and need it
    a. The SRP – a meaningful penalty for those that do not obtain coverage to motivate the healthy individuals to obtain and keep insurance in order to balance the risk pool
3. Income-based subsidies to ensure coverage is affordable and accessible to all

The SRP was also designed to address the "free rider" problem in health care. People get injured or sick regardless of whether they have insurance coverage, and hospitals are required to treat people regardless of the ability to pay. If someone is unable to pay for their health care, those costs are passed on to the rest of the system, ultimately driving up provider costs and, eventually, driving up the cost of premiums.

Now that the Congress has repealed the SRP at the federal level through the Tax Cuts and Jobs Act, there is concern that healthier people will choose to exit the market, degrading the risk pool and ultimately driving up the cost of premiums. Families and individuals with incomes above 400 percent of the federal poverty level (FPL) are considered especially at risk of leaving, because they are ineligible for subsidies on the Exchange, and therefore must pay for the full cost of their insurance. While subsidized individuals and families are shielded from rate increases (because the federal subsidies rise as premiums increase), those above 400 percent FPL will bear the full cost of any rate increases – so as rates go up, more healthy people are expected to exit the market, thereby further driving up premiums, causing more people to exit, and so on.

Finally, there is concern that as more people drop coverage, uncompensated care will increase, which drives up the cost of the health care system as a whole.

Theoretically, then, adopting a state-based SRP to replace the federal penalty would support maintaining a balanced risk pool (and put downward pressure on any premium rate increases) by once again creating an incentive for healthy people to obtain and retain insurance coverage, and would mitigate any increases in uncompensated care.

Empirical Arguments for Supporting a State-Based SRP

Before determining whether adopting a state-based individual SRP is the right policy choice for Rhode Island, we should examine the empirical evidence. That is, does the available data demonstrate that the SRP has been effective in incentivizing healthier people to obtain and retain coverage?

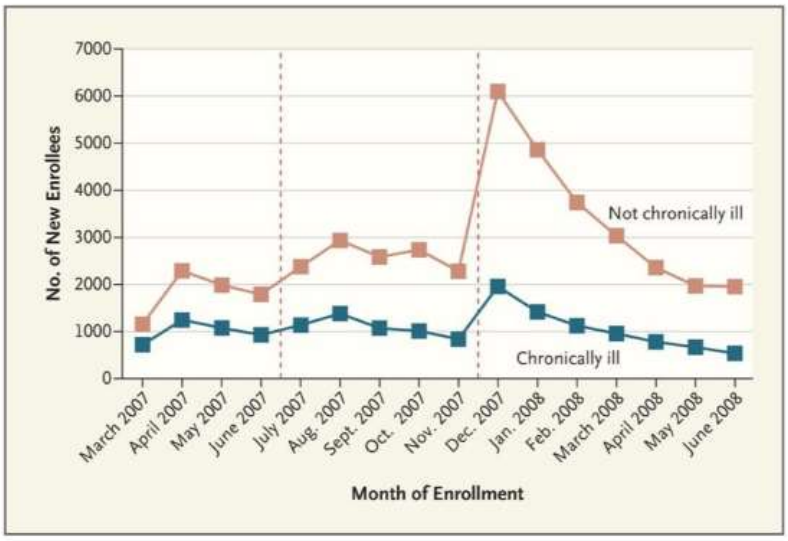
Most of the empirical research that attempts to isolate the impact of the SRP from the other provisions of the ACA finds that it has meaningfully decreased uninsured rates across the country, and therefore expects that the repeal of the SRP at the federal level will cause a substantial reduction in coverage.[1] Estimates of the precise impact of the SRP do vary – some research suggests the SRP had a very large impact on reducing uninsured rates, while other research estimates a more modest impact. While some do argue that the SRP is largely ineffective at increasing coverage, we have not found much empirical research to support this view.

The Massachusetts experience, examined by Chandra, Gruber, and McKnight in an article in the *New England Journal of Medicine*, is particularly useful in evaluating the impact of SRPs. Some have argued that incentives like subsidies for low- and middle-income Americans would work well enough on their own to make a mandate unnecessary, but the authors refute this notion by using Massachusetts as a historical model. For nearly a year prior to Massachusetts' SRP went into effect, the state began subsidizing insurance for individuals with incomes up to 300% FPL, and this allows for a useful before-and-after examination. Prior to the mandate going into effect, but after subsidies were introduced, Commonwealth Care's enrollees "were nearly 4 years older, were almost 50% more likely to be chronically ill, and had about 45% higher health care costs" than those who signed up after the mandate went into effect at the end of 2007. After the mandate went into effect, there were "enormous" gains in the number of healthy enrollees and a far small rise in enrollees with chronic illnesses.[2]

[1] See, for example:
Matthew Fiedler, "How Did the ACA's Individual Mandate Affect Insurance Coverage?: Evidence from Coverage Decisions by Higher-Income People," USC-Brookings Schaeffer Initiative for Health Policy, May 2018;
Mark Hall, "Stabilizing and Strengthening the Individual Health Insurance Market: A View from Ten States," USC-Brookings Schaeffer Initiative for Health Policy, July 2018;
Christine Eibner and Sarah A. Nowak, "The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors," Commonwealth Fund, July 2018;
Linda J. Blumberg, Matthew Buettgens, and John Holahan. "How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?," The Commonwealth Fund, July 2018; and
Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "The Importance of the Individual Mandate—Evidence from Massachusetts," *New England Journal of Medicine* vol. 364, no. 4, January 27, 2011.

[2] Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "The Importance of the Individual Mandate—Evidence from Massachusetts," *New England Journal of Medicine* vol. 364, no. 4, January 27, 2011.

Number of New Enrollees in Massachusetts Commonwealth Care by Chronic Illness Status



NOTE: The two vertical dashed lines represent the start of the mandate phase-in period (from July through November 2007) and the start of the period when the mandate became fully operational (from December 2007 onward).
SOURCE: Presentation to the Market Stability Workgroup, May 15, 2018, https://healthsourceri.com/wp-content/uploads/2018/06/MktStabWrkGroup-5-Presentation-051518-final.pdf.

The existing research suggests the SRP may be especially important for preventing coverage losses among those making above 400% FPL. This population is not eligible for federal subsidies on the Exchange, and therefore bears the full cost of premiums and premium increases. As noted earlier, in the absence of the SRP, the concern is that some of the healthier people in this income range will drop coverage. For example, in one survey among non-elderly members of this income group, Matthew Fielder found a 24 percent reduction in the uninsured rate between 2014 and 2016; in another survey, he found a 39 percent reduction. He estimates that four-fifths of this reduction was caused by the mandate, while the remaining one-fifth of the credit should go to the publicity and increased awareness surrounding the ACA's rollout (along with other, unspecified factors).[3]

However, it is also worth noting that the SRP is important for stopping coverage losses among the subsidized and Medicaid population as well. The Congressional Budget Office estimated that repealing the federal SRP would save the federal government somewhere around $400 billion, despite the loss of revenue from the SRP. These projected savings largely come from lower Medicaid enrollment and reductions in the amount of federal subsidies. In other words, the CBO

[3] Matthew Fiedler, "How Did the ACA's Individual Mandate Affect Insurance Coverage?: Evidence from Coverage Decisions by Higher-Income People," USC-Brookings Schaeffer Initiative for Health Policy, May 2018; and Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "The Importance of the Individual Mandate—Evidence from Massachusetts," *New England Journal of Medicine* vol. 364, no. 4, January 27, 2011.

estimates that repealing the SRP will cause people to drop or not sign up for Medicaid or subsidized insurance, even though it is low-cost or free for the consumer.[4]

In light of these findings, it appears that adopting a state-based individual SRP is a rational policy choice for Rhode Island. Most of the extant literature and empirical evidence suggests the existence of the SRP is an effective incentive for healthy individuals to obtain and maintain health insurance coverage, thereby supporting a balanced risk pool and the maintenance of affordable premiums. Indeed, while the SRP is an effective incentive for all individuals, it appears especially effective at inducing those above 400 percent FPL to obtain coverage.

Using SRP Revenues to Support Reinsurance

RIPEC does not support adopting a state-based individual SRP for the sole purpose of providing a funding source for the state's share of a reinsurance program. However, if the state does move forward with adopting an SRP for its own sake, we do believe those revenues should be reinvested into the health care system. In particular, we believe it makes sense to use those revenues to fund the state's portion of a reinsurance program.

The purpose of the reinsurance program is to reduce or eliminate future increases in premiums in the state driven by a handful of very-high-cost individuals. While subsidized individuals and families who purchase coverage on the Exchange are shielded from any rate increases (because as their premiums increase, so does the value of the subsidies they receive), unsubsidized individuals and families (those above 400 percent FPL) will bear the full brunt of that increased cost. The concern is that as premiums rise, insurance will become increasingly unaffordable for those in the higher income brackets, eventually pushing some of the healthier consumers to drop their coverage. Once again, as healthy people exit, the risk pool worsens, further driving up the cost of premiums, causing more healthy people to leave, and so on. The benefits of reinsurance, then, fall mostly on those in the individual market making above the 400 percent FPL threshold.

The reinsurance program, then, can be thought of as a positive inducement, or "carrot" for those in the individual market above 400 percent FPL to purchase and retain health insurance, while a state-based SRP (which is particularly effective in driving this same population to obtain and keep coverage) can be thought as the "stick." In other words, the two policies complement one another, and together, they serve to sustain a balanced risk pool and therefore to protect coverage gains achieved under the ACA.

Given the complementarity of the two policies, RIPEC believes it is rational to use any revenues collected from a state-based SRP to support the state's share of a reinsurance program, with one

[4] Chris Deaton, "Repealing the Individual Mandate Would Save the Federal Government Money," *The Weekly Standard*, November 1, 2017.

important caveat. We strongly believe the SRP should be designed according to a set of principles, including fairness and effectiveness. That is, we do not believe the primary concern when designing the state-based SRP should be to maximize the revenues available for the reinsurance program; rather, the size of the reinsurance program should be tailored to the revenues raised by an optimal SRP program.