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HOW STATES CAN REFORM HEALTH CARE TODAY

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Printed in the United States of America.

ISBN: 979-8-9850916-2-5 (Paperback)
ISBN: 979-8-9850916-1-8 (PDF)
ISBN: 979-8-9850916-0-1 (epub)

21 22 23 24 25 10 9 8 7 6 5 4 3 2 1

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CHAPTER 3

Maximize Choice

Open Up Coverage Options

Charles Miller

KEY TAKEAWAYS

- Affordable Care Act plans do not meet the needs of many Americans because of one-size-fits-all requirements and unaffordable premiums.
- States can add more affordable and flexible options for their residents, including Farm Bureau plans and short-term plans.
- These options have a proven track record and do not disrupt the existing insurance market or increase costs for existing enrollees.

PROBLEM

Health insurance offered on the Health Insurance Marketplace exchanges under the Affordable Care Act (ACA) are failing to meet many families' needs, even as their cost to taxpayers explodes. Nearly 30 million Americans remain uninsured, but the lack of affordable options also impacts those who remain in jobs solely to keep their employer-sponsored insurance.

If current trends continue, America's economic strength will be negatively impacted by the increased drag of the cost of health care and health insurance as it results in less money in workers' paychecks, and fewer jobs as employers divert money away from new hiring to paying the benefits of current workers. Even worse is that as costs go up, patients put off medically

necessary care, and their health may suffer. Both those with insurance and those that are uninsured need more affordable options.

Who Are the Uninsured?

The uninsured in America come from all walks of life (see Figure 3.1). Of the nearly 29 million uninsured Americans in 2019,[1] only about 21 percent were below the federal poverty line (FPL), but a similar amount—about 17 percent—were earning more than 400 percent of the FPL (for a family of four, that is about $106,000 annually). The overwhelming majority (73 percent) live in households with at least one full-time worker.

As an illustration, in Texas there were nearly five million uninsured residents as of 2018 (see Figure 3.2). If Texas were to expand Medicaid, only about 16 percent of the uninsured would be newly eligible for coverage. By comparison, there are nearly 1.2 million uninsured Texans not eligible for any government assistance.[2] Even more already qualify for some form of government assistance, yet do not sign up because of concerns over cost or quality.

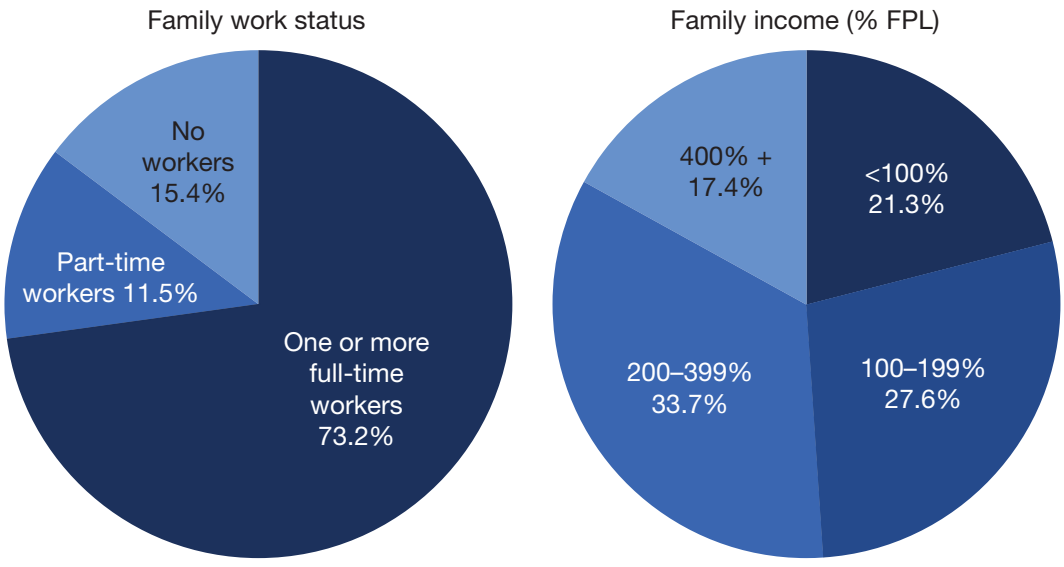

Figure 3.1 Uninsured by work status and income level.
Source: Graphic reproduced from Kaiser Family Foundation, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

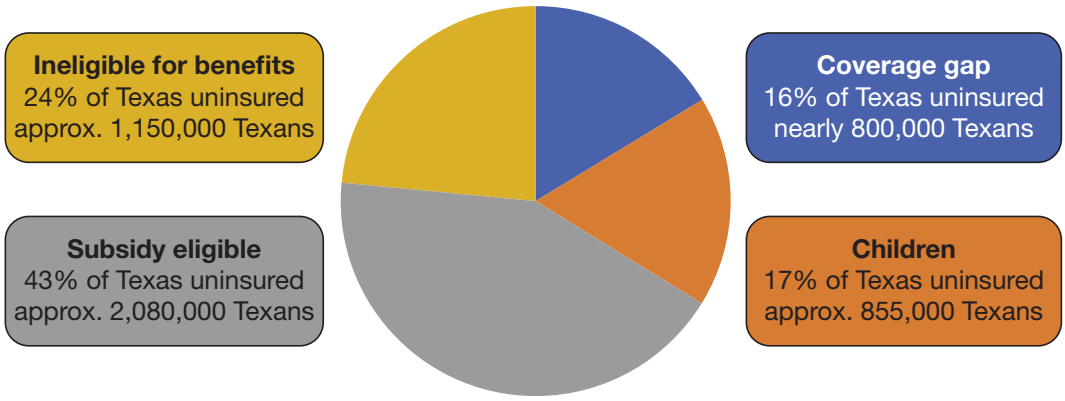

Figure 3.2 Breakdown of nearly five million uninsured Texans in 2018.

Health Insurance Is Increasingly Unaffordable

For those who are not eligible for any financial assistance, the cost of obtaining individual ACA coverage can be prohibitively expensive. As a result of the ACA, nationwide-average premiums for the individual market increased 105 percent from 2013 to 2017[3] and soared another 30 percent in 2018 before stabilizing since then.[4]

The average annual ACA premium was over $7,100 in 2020.[5] The average deductible for single individual coverage was $4,364,[6] and the out-of-pocket limit for ACA plans was $8,150.[7] This means that an average individual was looking at paying over $11,000 before their insurance started.

For those who are eligible for subsidies but have not chosen to sign up, the reasons could be a combination of both affordability and the quality of the insurance. Under the ACA, subsidies phase out as one's income increases and are smaller for younger individuals. For example, a Kaiser Family Foundation analysis estimates that the average monthly subsidy for a 27-year-old earning $51,000 a year would only be $9 a month, which when applied to an average silver-level plan premium of $370 per month is only mildly helpful in making the plan more affordable.[8] Because the premiums are so high, in many cases the amount of subsidy available—especially for younger and healthier Americans—is not enough to make ACA coverage a good value.

Price Is Not the Only Factor in Picking Coverage

The value of coverage is determined by both quality and price. Avalere found that 72 percent of the 2019 ACA market was comprised of "narrow network" plans, defined as health maintenance organizations (HMOs) and exclusive provider organizations (EPOs),[9] and that the percentage of narrow network plans has grown over time.[10] These narrow networks mean that patients often have a limited choice of providers, and the plans may not include a patient's current provider or health systems when seeking care.

Michael Cannon has explained that "Obamacare's preexisting conditions provisions are creating a race to the bottom because these provisions still penalize high-quality coverage for the sick, reward insurers who slash coverage for the sick, and leave patients unable to obtain adequate insurance."[11] Unable to charge actuarially sound premiums, the evidence suggests that insurers attempt to screen out the sickest patients by offering poor-quality coverage for certain expensive conditions.[12] For example, John Goodman found that not a single plan on the individual market in Texas included MD Anderson's cancer center in-network, and similarly, the world-renowned Mayo Clinic in Minnesota was not in-network in any plans offered in that state.[13]

The lack of good options for individual coverage may also contribute to job lock, where individuals remain in a job to maintain their health insurance benefits. This prevents people from doing what they otherwise think is best for their life, such as changing jobs, starting a business of their own, reducing hours to take care of family members, or even retiring early.[14]

In sum, the combination of high premiums and narrow network products has resulted in ACA exchange enrollment that is only about 40 percent of what was projected.[15] The overwhelming majority of exchange enrollees are lower income and qualify for enormous subsidies to purchase coverage. Middle-income households, particularly if the household is relatively young, have been priced out of the market through a combination of rising premiums and decreasing quality. These trends are leading to a growing population that is uninsured or seeking alternative coverage options.

PROPOSAL—ALLOWING MORE OPTIONS HELPS CONSUMERS

States should permit additional coverage options for their residents. These options, such as Farm Bureau plans and short-term health insurance plans (STPs), are permitted by the federal government and do not have to comply with all the regulatory barriers that have led to unattractive products in the individual market. These options help millions of Americans who have been left behind by the ACA.

By authorizing alternative health benefit plans, states can allow many consumers to access less costly coverage, with greater choice over what services to insure. Some consumers may not wish to insure relatively small expenses such as primary care visits, or want access to direct primary care or more team-based care models. These alternative health benefit plans allow such innovation and customization. Alternative benefit plans offer many consumers better value because they are not bound by ACA rules that create perverse incentives and that have led to a sicker risk pool and high premiums and deductibles for coverage.

Farm Bureau Style Plans

A Farm Bureau style plan is a type of alternative health benefit plan that is offered by a dues-paying member-based nonprofit professional or trade association. Tennessee's Farm Bureau has been offering coverage since the 1940s, and in 1993, the state exempted Farm Bureau plans from state insurance regulation.[16] Over the past several years, Indiana, Iowa, Kansas, South Dakota, and Texas have authorized their Farm Bureaus to sell coverage that is not subject to state insurance regulation. The ACA only regulates plans that are defined as health insurance by the state and regulated as such by state insurance commissioners. Therefore, Farm Bureau plans, which are not considered insurance by the state and regulated by the state as such, are exempt from federal health insurance regulation, including the ACA. Of note is that the reinsurers of the coverage remain subject to regulation.

These plans utilize underwriting at the time of issuance, although nine out of ten applicants are offered coverage. After the initial underwriting, the plans are guaranteed renewable without premium increases if the individual gets sick, and the coverage can be kept as long as the individual remains a member of the association. In general, network access is extremely broad.

In Tennessee, the plans are popular with both consumers and regulators,[17] with the Farm Bureau plans retaining 98 percent of members.[18] The prices are far better than for ACA plans. Thirty-seven-year-old Jason Lindsey would have paid at least $1,500 per month for a plan to cover his wife and two kids with an $11,300 family deductible under the ACA. Through the Farm Bureau, his family is covered for $480 per month. Jason's experience is similar to those of thousands of other families in Tennessee. Average savings for a family of four have been over $800 per month for these plans.[19]

It is not just in Tennessee either. The Indiana Farm Bureau, which began offering plans in 2020, released the results of a survey of members in May 2021. Seventy-five percent of respondents said the health plan is less expensive than their previous coverage, with average savings of over $350 per month. Ninety-six percent of respondents said they would recommend their Farm Bureau plan to others.[20] By comparison, a 2018 survey by America's Health Insurance Plans (AHIP) found that only 71 percent of respondents were satisfied with their employer-sponsored health insurance.[21]

Short-Term Plans

Short-term plans are exempt from the ACA's requirements, so they can cover all ACA benefits or just some of them. The Trump administration reversed Obama administration restrictions on short-term plans in 2018. This had the effect of permitting states to have more control over the length of the plans, allowing individuals to purchase them for initial coverage up to one year, renewable up to a total of three years. About half the states allow this full flexibility, and about half have shorter timelines or prohibit the sale of STPs. Moreover, insurers can combine short-term plans with separate option contracts that would allow an individual to obtain the equivalent of "guaranteed renewability" through STPs.

The wide networks, unique benefits, and cost savings make such plans especially valuable for individuals who think they might only need insurance for a short period of time, such as individuals who are between jobs, starting new companies, taking time off from school, or looking to retire early and "bridge" to Medicare.[22] Despite critics' concerns about short-term plans, recent work has shown that trends in the ACA individual market are better in states that fully permit short-term plans than in those that restrict them.[23]

Short-term plans can make smart financial sense and be the difference between having coverage or having no coverage at all. For example, Mike

Pirner had emergency gallbladder surgery two months after buying a short-term plan for about $150 per month. The total costs associated with the procedure were near $100,000, but Mike only had to pay his $2,500 deductible, which was also his out-of-pocket maximum.

If Mike had been on a standard ACA plan, he would have paid an $8,550 deductible, assuming the surgery was at a facility that was covered by his plan. Prior to purchasing a short-term plan, he had researched ACA plans and found the cost of the plans most similar to his short-term plan was above $500 per month. The annual combined out-of-pocket costs plus the premium for an ACA plan would be near $15,000—compared to about $4,000 for his short-term plan. "An Obamacare plan was simply not an option," he says, "For a time, I considered having no insurance at all, until I realized short-term plans made sense for my situation.[24]

OVERCOMING OPPOSITION

In 2021, the Texas legislature enacted legislation authorizing Texas Mutual and the Texas Farm Bureau to offer health benefits without those benefits being subject to insurance regulation. In general, opponents—special-interest groups and existing health plans—made three criticisms that serve as a helpful preview of what you should expect to see as arguments against giving residents more coverage options:

1. Allowing these plans would remove protections for people with pre-existing conditions (see Figure 3.3).
2. These plans would "cherry-pick" the healthiest people from ACA plans, making ACA plans more expensive.
3. These plans are unregulated "junk plans" that do not protect people.

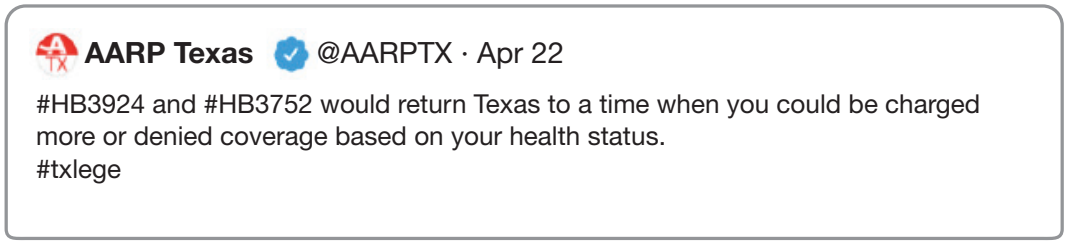

Figure 3.3 Example of opposition messaging to bills authorizing alternative benefit plans.

Myth—These plans will harm people with preexisting conditions / Truth—People with preexisting conditions will continue to have exactly the same access to ACA plans

Individuals with preexisting conditions will continue to be able to purchase ACA-compliant plans just as before, with guaranteed issue and community rating provisions. Alternative health benefit plans do not remove those rules and do nothing to impact anyone's access to ACA plans. Moreover, for the vast majority of people who purchase ACA plans, their share of the premiums would be unaffected since the subsidy structure limits the amount a household has to pay to a certain amount of premium—regardless of the total premium size.

Myth—Alternative health plans will "cherry-pick" the healthy members away from ACA plans, making ACA plans more expensive / Truth—There are very few "cherries" left to pick, and even if there were a large number, the vast majority of ACA enrollees are subsidized, so their net premiums would not increase

The current makeup of the ACA market makes it highly unlikely that this concern has merit. In short, there are not many "cherries"—low-risk individuals who are not heavily subsidized—left in the ACA for alternative health plans to "pick." For the most part, these individuals never signed up for the ACA in large numbers.

The makeup of the uninsured compared to the makeup of those who enrolled in ACA plans is illustrative (see Figure 3.4). In Texas, for example, early enrollees in the ACA exchanges were disproportionately old compared to the uninsured population. While 18–34-year-olds represented 43 percent of the Texas uninsured population, they only represented 29 percent of ACA enrollees.[25] Meanwhile, those over 55 represented only 10 percent of uninsured Texans but 22 percent of ACA enrollees. As of the December 2020 open enrollment period, those figures had become even more skewed, with 18–34-year-olds representing about 25 percent of enrollees, while those over 55 comprising 27 percent.[26]

Since their rocky start, the ACA exchanges have stabilized.[27] At this point, almost all enrollees are getting a subsidy[28] and therefore are unlikely to leave the exchange, since the subsidies are only available for exchange plans.

Both Farm Bureau and short-term plans mainly benefit those who are not currently purchasing ACA plans. In Iowa, an estimated 83 percent of Farm Bureau plan enrollees would have been uninsured in the absence of the

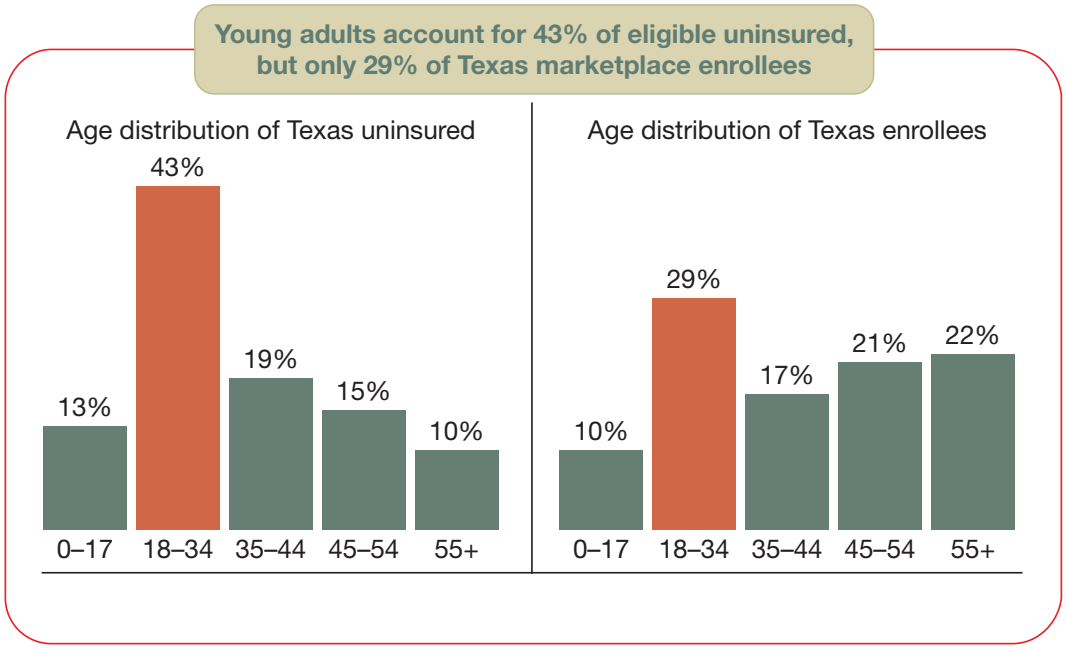

Figure 3.4 Comparison of age distribution of eligible uninsured population in Texas (2013) and average ACA enrollment population in Texas (2014–2016 OEPs).
Source: Graphic reproduced from Robiel Abraha, Shao-Chee Sim, and Elena Marks, "A Closer Look at ACA Marketplace Enrollment in Texas, October 2013–February 2016: Key Highlight and Future Implications," Episcopal Health Foundation, October 31, 2016, https://www.episcopalhealth.org/research-report/closer-look-aca-marketplace-enrollment-texas-oct-2013-feb-2016-key-highlights-and-future-implications/.

Farm Bureau plan.[29] Most current ACA enrollees are likely to be either sick enough or have a low enough income (and thus high enough subsidies) to make the ACA a good value. Neither group is a "cherry" ripe for picking for alternative health plans.

Similarly, critics of short-term plans asserted that the short-term plans expanded by the Trump administration would lead to adverse selection in the individual market. However, contrary to those concerns, average exchange premiums declined after the expansion of STPs, decreasing more in states that fully permitted the expansion compared to states that restricted them. Benchmark plan premiums in states that fully permitted STPs decreased 7.9 percent between 2018 and 2021, compared to only a 3.2 percent decrease in states that restricted them.[30] As Brian Blase summarized his study's findings, "Actual experience shows that states that fully permit short-term plans have experienced improvements in their individual markets compared to states that

restrict short-term plans on every dimension—enrollment, choice of plans, and premiums."[31]

Even if the critics are correct that cherry-picking would raise gross premiums, few enrollees would experience any change in cost. Assuming that these plans would trigger additional adverse selection in the ACA market, that point is only true for *gross* premiums. Enrollees eligible for subsidies will not see any increase in their *net* premiums. As of the December 2020 open enrollment period, 85 percent of ACA enrollees nationwide were subsidized and thus insensitive to price changes.[32] In many states—including Wyoming, Utah, Texas, South Dakota, Oklahoma, Nebraska, North Carolina, Mississippi, Florida, and Alabama—subsidized enrollment exceeded 90 percent of total enrollment. Even if authorizing alternative health benefit plans would increase *gross* premiums for the ACA plans, these subsidized enrollees would see no difference in their *net* premiums.

Myth—The enhanced federal subsidies in the American Rescue Plan Act make alternative plans unnecessary / Truth—The enhanced subsidies are only scheduled to be temporary, are financially inefficient, and are ineffective at reducing the number of uninsured

The American Rescue Plan Act temporarily increased the amount of subsidies that individuals are eligible for as well as removing the "benefit cliff" that capped eligibility for subsidies at 400 percent of the federal poverty line. This temporary boost is for 2021 and 2022, although President Biden and many congressional Democrats have proposed to extend it further. The Congressional Budget Office projected that the enhanced subsidies would only lead to a reduction in the uninsured of about 1.3 million nationwide, at a cost to the federal government of about $35 billion over two years. That works out to a cost of nearly $27,000 per additional insured.[33] Thus, there would still be many uninsured who could benefit from alternative plans, including the hypothetical single 27-year-old earning $51,000 discussed earlier, who would qualify for just a $9 per month subsidy, leaving a remaining monthly premium of $361 for a benchmark plan.

The enhanced federal subsidies decrease the number of market enrollees who are not receiving a subsidy. This only makes the response to the cherry-picking critique even stronger, since having more subsidized enrollees further decreases the number of enrollees who might hypothetically be impacted by the cherry-picking effect.

Ultimately, there is little harm to the ACA market by permitting alternative coverage options, even less so with the enhanced subsidies, but restricting these options would inflict great harm to the individuals who could have benefited from them.

Myth—Alternative plans create an unlevel playing field for insurers with different rules / Truth—If it is not fair, it is because alternative benefit plans are not eligible for massive federal subsidies

Alternative health benefit plans are not generally competing against ACA plans for the same customers, but to the extent there is an unfair playing field, it is because ACA plans are eligible for generous subsidies, while alternative benefit plans have to demonstrate their full value to consumers in order to get them to purchase these plans and keep them as members.

Myth—Alternative benefit plans are unregulated, "junk" plans / Truth—The Farm Bureau is a trusted, member-driven, long-run-oriented, well-known entity, with no history of bad faith actions in other states, and states remain free to regulate STPs as they see fit

Despite that five states have already authorized Farm Bureau plans, opponents have been unable to find a single individual who had a coverage complaint.[34] The lack of controversy over Farm Bureau plans may be partially because of the nature of the Farm Bureau. The Farm Bureau is a member-run, nonprofit organization whose purpose is to create products of benefit to its membership. This structure and the desire of the Farm Bureau to maintain a sterling reputation is a key consumer protection. As *Stat News* describes it, the Farm Bureau "doesn't kick any of its members out once they get sick. They can always renew their coverage, even if they develop a costly condition. . . . The benefits themselves are pretty robust too."[35] Their reporters spent two weeks talking with consumer advocates, health insurance brokers, and other state officials and could not find anyone who complained about the coverage.

In addition, organizations that are authorized to offer alternative health benefit plans depend on the legislature for this authorization and know that if they engage in deceptive or unfair practices, the legislature can rescind this authorization. Tennessee Farm Bureau's general counsel has alluded to the ultimate reason that states should not be concerned about allowing the company to start offering plans: "The legislature has an opportunity every year to say no, we don't want this setup to continue, and yet every year

since 1993 they've allowed this to continue because we're trusted, because we're doing what we told them we would do. It's not a loophole. It's not an accident."[36]

Unlike Farm Bureau plans, short-term plans may be fully regulated by the state. While imposing ACA-style regulations such as community rating and benefit mandates would weaken this market and harm consumers, states should consider improvements, including a guaranteed renewable option with the coverage so people can be permanently protected from going through underwriting in the future. States should also consider prohibiting "post-claims underwriting," in which the insurer sells the customer a plan without engaging in underwriting at the front end, only performing the underwriting after a claim is submitted. States should also be clear that inappropriate rescissions, whereby a policy is retroactively canceled based on minor or immaterial inaccuracies on the application, will not be tolerated.

CONCLUSION

For tens of millions of Americans, the ACA has failed to live up to its promise of providing affordable health insurance. They have seen premiums skyrocket, deductibles increase, networks narrow, and the price of care escalate. They want new options to pick from.

Because alternative benefit plans do not have to comply with the ACA's requirements, they can provide an attractive option to individuals who have been harmed by the ACA's one-size-fits-all nature. Legislatures that make these options available to their residents will take a firm step toward reducing the uninsured rate by meeting the diverse needs of their residents while not disrupting the existing insurance marketplace.

ABOUT THE AUTHOR

Charles Miller is a senior policy advisor for Texas 2036, a non-profit public policy organization committed to implementing data-driven policies that ensure Texas remains the best state to work and live by its bicentennial in 2036. Charles joined Texas 2036 after serving as a budget and policy advisor for Governor Greg Abbott, where he advised on a broad range of issues, including health care, insurance, workforce development, elections, information resources, cybersecurity, first amendment issues, and civil law. Previously, Charles practiced

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