

Testimony



Common Sense Solutions to Improve the Affordable Care Act: Simple Changes Can Go a Long Way

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Chairman Pitts, Ranking Member Green, and members of the Subcommittee, I thank you for the opportunity to testify today regarding various proposed changes to the Affordable Care Act (ACA). These changes represent efforts to provide equity, improve transparency, and reduce burdensome requirements that are unnecessarily driving up the cost of health insurance. Further, several of these changes will have the added bonus of assisting in federal deficit reduction.

Making targeted changes to the ACA certainly does not imply that these are the only changes that should be made to the law or that making these changes will suffice to solve all of the issues created by the law. I have testified on many occasions before this Committee and others about the numerous problems with this law, however that is not my purpose today. The changes being discussed today are not groundbreaking ideas that will fundamentally alter the health care system; rather they are common sense improvements that should have broad, bipartisan support. In a less politicized environment, these and other changes would be bipartisan initiatives passing with little fanfare.

Introduction

The ACA was signed into law in 2010 with the goal of providing accessible, affordable health insurance coverage for all. Unfortunately, as I have testified [over](#) and [over](#), these goals have yet to be met for many individuals.[\[1\]](#)[\[2\]](#) Today, the Subcommittee is attempting to provide some relief through a handful of proposals that deserve bipartisan consideration.

Grace Periods

Under the ACA, individuals purchasing insurance coverage on the Exchanges were given a 90-day grace period during which insurers were required to continue offering coverage despite an individual not paying their premiums. This is very generous relative to the laws states had implemented for coverage prior to the ACA, and gives individuals buying coverage on the Exchange an advantage over those purchasing off the Exchange – an uneven playing field for consumers. As of 2012, all states but two had a minimum grace period requirement of 30 or 31 days for plans offered in the individual market.[\[3\]](#) The generosity of the grace period for plans purchased on the Exchange could easily allow individuals to take financial advantage, at the expense of other paying consumers and taxpayers. With a 90-day grace period, individuals may receive coverage for twelve months while only paying for nine months' worth of coverage.

A study by McKinsey found that 21 percent of 2015 Exchange plan enrollees stopped paying for coverage at some point during the year. In 2016, half of those individuals (49 percent) repurchased the same plan they had stopped paying for the year before; two-thirds of these individuals had also stopped paying for coverage at some point in the 2014 plan year. Insurers and providers both must account for the possibility of not being paid in full and therefore increase their prices, passing the cost onto consumers who do pay their obligations and the taxpayers subsidizing the coverage through the premium tax credit subsidies.

Aligning grace periods for policyholders in the individual market on and off the Exchange within a state will create equity among consumers. Further, reducing the 90-day grace period could significantly reduce the risk of losses for insurers and providers, which in turn will provide greater stability in the market and reduce the additional cost that unfairly burdens other consumers and taxpayers.

Special Enrollment Periods

Between specific statutory language, and subsequent regulatory guidance, the ACA provides for a combined 34 circumstances under which an individual may be eligible to enroll in an Exchange plan under a Special Enrollment Period (SEP). This is extremely generous. Medicare allows just seven of these instances, while the Health Insurance Portability and Accountability Act (HIPAA) requires only three be provided.

I have previously testified about the importance of adequately and efficiently [verifying an individual's eligibility for premium assistance](#) under the ACA; verifying an individual's eligibility to enroll during a SEP is equally important.^[4]

Many insurers have complained that the plethora of categories rendering people eligible for SEPs—and the seemingly lax verification protocols—allow individuals to take advantage of the system, undermining and destabilizing the market. Insurers found that in 2014 individuals who enrolled during a SEP had much higher medical claims—10 percent, on average, though some as much as [55 percent higher](#)—than those who enrolled during the open enrollment period preceding the coverage period.^[5] Too much flexibility for SEPs may allow individuals to wait until they are sick to enroll in coverage, undermining the insurance market, and ultimately resulting in higher premiums the following year to compensate. In fact, SEP enrollees were found to be 40 percent more likely to have a lapse in coverage than those that enrolled during the open enrollment period.^[6]

The Centers for Medicare and Medicaid Services (CMS) evidently [agrees with this observation](#), as evidenced by the recent issuance of an interim final rule tightening restrictions for SEPs. Indeed, the fact that the rule was issued without first seeking public comment implies that the agency believed such changes were either of such import that delay would be especially harmful and/or that such provisions were unlikely to receive significant opposition. However, the rule only affected eligibility for individuals seeking to enroll under the “permanent move” allowance. Given that there are 33 other allowances, more needs to be done. Requiring a formal process for eligibility verification, and requiring proper documentation supporting such claims, will go a long way in reducing the number of individuals unjustly taking advantage of the current system. Further, individuals should not be granted coverage unless and until their eligibility has been verified, with the caveat that coverage be retroactive to the day the application and all necessary documentation was submitted should the individual indeed be determined eligible. Finally, requiring the Secretary to report to Congress on the number of individuals who attempt to enroll during a SEP but are unable to do so, and specifying whether enrollment was not permitted because the individual did not provide the necessary documentation or because the documentation was invalid, will enable policymakers to make more informed decisions in the future should it be determined that adjustments to such policies are needed.

Age Rating Restrictions

One of several provisions included in the ACA in order to constrain premium variation among individuals was a cap on the permissible variation of premium rates due to age by a ratio of 3:1, such that premiums for the elderly could not be more than three times greater than those for the youngest bracket of individuals in the adult population. Prior to the ACA, this ratio averaged 5:1. This difference was justified by the fact that this was roughly the average difference in spending among 64-year-old patients compared with 21-year-olds, according to the Congressional Budget Office (CBO).[7] The stricter requirement imposed by the ACA artificially inflates premiums for younger individuals, forcing them to subsidize the coverage of older—and typically sicker—individuals. This result is likely responsible for much of the low enrollment among the younger adult population, despite these individuals having the highest uninsured rate among all age groups.[8] In 2016, 3.5 million adults aged 18-34 enrolled in Exchange plans, representing only 28 percent of all enrollees, despite representing 36 percent of the potential enrollee population.[9]•[10]

As the American Action Forum has previously [reported](#), repealing the age variation limit should allow for premiums to decline and remove at least some of the financial disincentive preventing the younger population from enrolling in Exchange plans.[11] Increased enrollment rates among the “[young invincibles](#)” would contribute to greater market stability, and help prevent a “death spiral.”[12] The administration has been trying to make progress with this segment of the population, but, despite 2.3 million young adults gaining insurance by enrolling in their parents’ plans, the uninsured rate for these individuals continues to be 2.4 percentage points higher than the average for the total non-elderly population.[13] Loosening this restriction would greatly assist with that effort.

Accountability for Terminated State Exchange Grants

In order to facilitate the establishment of State Exchanges, states were provided grants under the ACA to assist with the costs of doing so; such grants totaled \$5.5 billion. However, very few states actually succeeded in setting up a state-based Exchange, and many of those that did eventually relinquished control to the Federal government, placing the burden of continued maintenance and upgrades of the system used by 38 states on the Federal government.[14] Of the \$900 million provided to states that failed to accomplish the task for which the money was provided, only \$21.5 million (23.8 percent) has been “returned” to the federal government. More specifically, this money was simply “de-obligated.” Taxpayers deserve to know their dollars are being spent wisely, efficiently, and for the purposes for which they are intended. The federal government should be doing more to ensure that the states that have failed to meet their obligations are held accountable and return those funds in a timely manner. This is a matter of good governance, transparency, and fiscal responsibility. With more than \$19 trillion in national debt, every dollar counts.

Conclusion

The Affordable Care Act, for the time being, is the law under which the country must operate. While we in this room today may differ on pursuing a full repeal of the law, repeal is clearly not achievable at this time. Therefore, we should focus on changes and improvements that provide consumers, providers, and taxpayers the most favorable outcomes possible. The evidence shows that there are clear failures in the law’s efforts to regulate the insurance market. Thus, changes that seek to roll back or correct these failed market reforms deserve bipartisan support. Consumers deserve to be freed from provisions that are unnecessarily inflating premium costs and creating inequities among health insurance purchasers. Taxpayers deserve transparency from their government and to have their money returned when improperly spent. And all parties need a clear set of rules, rather than vast amounts of regulation leading to a myriad of loopholes. Eliminating the burdensome and

restrictive regulations imposed by the ACA will reduce premium costs, making insurance both more affordable and more accessible.

PDF Version

Notes

- [1] Holtz-Eakin, Doug. “The Affordable Care Act after Five Years: Wasted Money and Broken Promises.” American Action Forum, 19 Mar. 2015. Web. 08 June 2016. <<http://www.americanactionforum.org/testimony/the-affordable-care-act-after-five-years-wasted-money-and-broken-promi/>>
- [2] Holtz-Eakin, Doug. “How the Affordable Care Act and the Employer Mandate Impacts Employers: An Overview.” American Action Forum, 23 July 2013. Web. 08 June 2016. <<http://www.americanactionforum.org/testimony/how-the-affordable-care-act-and-the-employer-mandate-impacts-employers-an-o/>>
- [3] State Laws Requiring Grace Periods for Premium Payments. Rep. Washington, D.C.: America’s Health Insurance Plans, 2012. Print.
- [4] Holtz-Eakin, Doug. “Subsidy Verification in the ACA: Complexity Creating Taxpayer Risk – AAF.” American Action Forum, 10 June 2014. Web. 08 June 2016. <<http://www.americanactionforum.org/testimony/subsidy-verification-in-the-aca-complexity-creating-taxpayer-risk/>>
- [5] Carlson, Chris, and Kurt Giesa. “Special Enrollment Periods and the Non-Group, ACA-Compliant Market.” (n.d.): n. pag. Oliver Wyman, 24 Feb. 2016. Web. 8 June 2016. <<https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf>>.
- [6] *Ibid.*
- [7] Burns, Alice, and Philip Ellis. “Private Health Insurance Premiums and Federal Policy.” Congressional Budget Office, Feb. 2016. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf>
- [8] Marken, Stephanie. “U.S. Uninsured Rate at 11.6% in Third Quarter.” Gallup.com. Gallup, 8 Oct. 2015. Web. 08 June 2016.
- [9] “HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT.” Office of the Assistant Secretary for Planning and Evaluation, 11 Mar. 2016. Web. 8 June 2016. <<https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>>.
- [10] “Exchange Enrollment: An Opportunity for Reform.” Council for Affordable Health Coverage, 7 June 2016. Web. 8 June 2016. <<http://cahc.net/wp-content/uploads/2016/06/CAHC-IssueBrief-FinalWeb-06161.pdf>>.
- [11] Holtz-Eakin, Doug. “Assessing Alternatives to the ACA’s Individual Mandate.” American Action Forum, 14 Apr. 2015. Web. 08 June 2016. <<http://www.americanactionforum.org/testimony/assessing-alternatives-to>>

the-acas-individual-mandate/>.

[12] Holtz-Eakin, Doug. “Premium Increases for “Young Invincibles” Under The ACA and The Impending Premium Spiral.” American Action Forum, 2 Oct. 2013. Web. 08 June 2016.
<<http://www.americanactionforum.org/research/premium-increases-for-young-invincibles-under-the-aca-and-the-impending/>>.

[13] “HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010–2016.” (n.d.): n. pag. Office of the Assistant Secretary for Planning and Evaluation, 3 Mar. 2016. Web. 8 June 2016.
<<https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>>.

[14] “HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT.” Office of the Assistant Secretary for Planning and Evaluation, 11 Mar. 2016. Web. 8 June 2016. <<https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>>.