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ISPS Faculty Public Policy Proposal Series

“The Connecticut Individual Healthcare Responsibility Fee”

February 5, 2018

ISPS18-04

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This series provide a forum for faculty to make concrete policy recommendations based on their academic expertise. The policy proposals reflect the views of the author and not ISPS or Yale University.

Executive Summary:

The paper proposes that all residents of the state of Connecticut take responsibility for their healthcare costs by contributing towards those costs if they are not already covered by public or private health insurance. Residents who choose not to participate will owe the same dollar amount (typically 9.66% of income) as a fee to the state to help cover the costs of care for the uninsured. This fee will deter uninsured residents from free-riding on Connecticut taxpayers. Because of ACA subsidies, lower income residents (those at 400% of the poverty level) already contribute 9.66% of income when they purchase through the state exchange. High income residents will be able to purchase insurance on the exchange at below this fraction of income. Middle-income residents, for whom the cost of insurance is above 9.66% of income, will instead contribute at that level to a Healthcare Savings Account out of which they can pay healthcare costs in current and future years. The proposal insures that all Connecticut residents have some access to healthcare and that all are paying an equitable share of costs.

The federal government has eliminated the penalty for not having health insurance. The paper models the impact on participation in AccessHealthCT in the event that the state does *not* adopt a plan to encourage participation. Data suggest that the most healthy 30% of participants would leave the exchange, likely causing more than a \$1000 increase in annual premiums for those that remain. By contrast, if a fee such as the one proposed is adopted, up to 60,000 additional residents could join AccessHealthCT. We estimate that this would drive down annual premiums by \$300 due to scale effects, and possibly as much as \$1000 due to the lower cost profile of the new enrollees.

Motivation

Connecticut, like many other states, maintains a high quality and widespread network of healthcare providers throughout the state. When a Connecticut resident is hurt or sick and does not have insurance, he or she is treated without regard to the ability to pay. However, when those individuals cannot pay, taxpayers inevitably shoulder the burden through taxes to the state or higher premiums that providers demand to continue operation.

A number of states are exploring the opportunity to implement requirements for individuals to enroll in public programs or purchase health insurance since the federal government chose to eliminate any penalty for lack of insurance coverage. The abrogation of the federal government from helping the ACA to function – while presenting challenges – provides an opening to states to control and improve their own marketplaces. In particular, economic research finds that the federal mandate was too small, and therefore states can be better off designing and enforcing their own.¹

¹ <https://www.aeaweb.org/articles?id=10.1257/aer.20130758>

The proposal here is designed to give general principles and omits many details that will have to be determined in order to make the policy function smoothly. For example, the state may have to authorize a form of HSA that has the necessary attributes. These operational details can be chosen in consultation with the staff at AccessHealthCT and others in state government for maximal effectiveness.

Advantages of an Individual Healthcare Responsibility Fee

Economic analysis shows that the arguments for a fee of this type are very strong. In particular, unlike taxes in general, a fee assessed when a resident does not have health insurance only has a positive impact. Most of the time the fee will cause the resident to purchase insurance and we know that people with health insurance benefit from it and enjoy better health.² Secondly, it will reduce the healthcare cost burden on fellow citizens and the state. If the resident pays the fee rather than buying insurance, these monies can be used to offset the costs of insurance for lower-income Connecticut residents as noted below.

A mandate or fee, however, can only truly be successful in the presence of a functioning exchange that provides those complying with reasonably priced, efficient insurance offerings. Accordingly, we view a well-run exchange as inseparable from the Individual Healthcare Responsibility Fee.

If AccessHealthCT serves the full population of those who otherwise do not have public or private insurance, this will have a number of follow-on benefits for the people of the state:

- 1) More enrollees will lead to economies of scale, more insurer entry, and more competition
- 2) More relatively healthy enrollees will lead to lower costs and therefore declining premiums
- 3) State residents will get the benefit of more insurer innovation in managing illness and coordinating care because insurers do not need to expend managerial time avoiding adverse selection
- 4) Scale, choice, and low costs will benefit entrepreneurs and small businesses in CT; a great exchange will provide stability to keep entrepreneurs and small businesses in CT
- 5) More insured residents will lower the state's cost of uncompensated care and provider costs of uncompensated care
- 6) More insured residents will be able to access health care at the right time, in the right setting improving health and efficiency of the health care system

By contrast, if Connecticut does not take steps to require participation in insurance markets, it will be allowing residents to free-ride on their fellow taxpayers. When free-riding is easy and free, many people will take the risk of being without health insurance, secure in the knowledge the state will pay for their care if there is a true emergency. The consequences of exit of healthy people from the exchange are:

² e.g. <http://www.nejm.org/doi/pdf/10.1056/NEJMs1706645>)

- 1) Higher average costs in the exchange leading to rising premiums
- 2) Not as many enrollees, not as many insurers participating, less competitive pressure on premiums
- 3) Higher premiums due to cost and competition driving out more people from the exchange and creating a vicious cycle

In short, the existence of the exchange would be imperiled. Entrepreneurs thinking that they could live with a family in Connecticut and build a business would feel insecure and move to a neighboring state with a stable exchange (e.g. Massachusetts) or to states with strong innovation economies and clear commitments to state level health policy and to maintaining their exchange (e.g. California).

Key principles in the Connecticut Individual Healthcare Responsibility Fee:

- 1) Insurance is affordable at every income level. Affordability refers to all the payments required by the plan, both premium and out of pocket; these payments are limited to 9.66% of income under the definition of “affordable” in the federal Affordable Care Act. We adopt this definition.
- 2) The goal is to set a fee that is the same level as a resident’s contribution to health insurance through the exchange. Thus, every resident will prefer purchasing affordable insurance (which has a benefit) to paying the fee (none).
- 3) Every resident must be responsible for organizing his or her insurance as long as it is affordable by either: signing up for Medicaid, for ACA subsidies through the exchange, through insurance from an employer, or through an unsubsidized plan on the exchange. Without such responsibility, that person is a walking liability to the Connecticut taxpayer and budget. When insurance is not affordable, i.e. the premiums required by the plan exceed 9.66% of income, a resident is required to contribute 9.66% of income to a Healthcare Spending Account run through the exchange which the resident can use to pay for medical care.
- 4) EHBs: Throughout this report we refer to “insurance” as Connecticut-defined EHBs. A resident who purchases substandard insurance outside the state would not meet the definition of insurance and would be subject to the fee.
- 5) If an enrollee cannot reasonably pay the deductible, then the insurance is not affordable and thus the state will discourage or even limit low income enrollees from purchasing plans with significant deductibles. Enrollees may prove affordability of a deductible by funding an HSA to that level. In this way, very high deductible plans can be consistent with the responsibility requirement.

Proposal

Any resident of the state of Connecticut lacking insurance for EHBs for more than 90 days must pay a fee equal to 9.66% of income (MAGI) up to a cap of \$10,000 unless the AccessHealthCT silver plan is not affordable in which case the resident may alternatively contribute those funds to a Flexible Spending Account.³

Affordability is defined to be health insurance premiums (covering 80% of expected costs) that are equal to or less than 9.66% of income. Each resident without insurance will enter AccessHealthCT which will retrieve income and demographics. The exchange will enroll anyone eligible in Medicaid and CHIP. The exchange will then calculate the cost of the lowest-cost silver plan and compare that to the enrollee's income. If the cost/income is 9.66% or below, the household must either purchase insurance or pay a fee of the same amount to the state. If the cost/income is above 9.66% of income, the resident will see the same set of plans as other shoppers, but will also see the option of enrolling in an AccessHealthCT-run Healthcare Spending Account (HSA). This account will be funded by the enrollee through automatic deductions totaling 9.66% of income and the funds will carry over in the account from year to year.

An additional benefit of the HSA is that AccessHealthCT will arrange with one (or more) of the insurers on the exchange to open its network to these HSA-only households. Those households will not receive any cost sharing from the insurer (because they have not purchased insurance) but they will gain access to the network and negotiated prices of that insurer. Because the insurer is effectively adding buying power to its insured group, it will be able to achieve lower provider prices, thereby benefiting other enrollees on the exchange. Residents without insurance will thus be contributing to the cost of their own healthcare, and will have a source of funds readily available for first-dollar medical expenditures which they can make at reasonable prices negotiated by a large insurer. Enrollees in an HSA are of course free to purchase healthcare from any other provider if they so prefer.

Affordability analysis

In an ideal world, the state and federal governments would provide enough subsidies so that all residents could afford to purchase health insurance. However, at present, the law does not provide subsidies past 400% of the poverty level. This is close to \$100,000 for a family of four. If a family plan costs \$15-20,000 then many families just past the cutoff will not find insurance to be affordable under our definition. This is the reason for the HSA option in the plan.

While full insurance is clearly better than a \$10,000 healthcare budget in an HSA, it is a reality that in Connecticut today middle-income residents who don't qualify for subsidies are currently being offered *no* structure to help them access healthcare services in an affordable way. An HSA option, funded by the enrollee, will give some guaranteed, first-dollar, level of healthcare access, and this is better for enrollees than zero healthcare access. Moreover, those enrollees will be

³ This proposal does not change current state laws allowing residents to apply for exemptions.

participating in the exchange going forward and will automatically get subsidies should their income fall to the requisite level, or be offered insurance plans rather than the HSA should income rise enough. If the state or the federal government should decide to increase subsidies beyond 400% of the poverty level in some future year, these households will be participating in the exchange and will benefit. The justification for setting the contribution at 9.66% of income is equality with the contribution level required in the last tier of subsidized enrollees. There are three groups of consumers to consider (the income levels below are only approximate, as affordability is determined by household size as well as income):

Incomes from \$0 to \$100,000 (approximately 400% of poverty): Either the household has insurance through some other source, or the household goes to AccessHealthCT and pays a fraction no higher than 9.66% of income towards premiums and receives federal subsidies. Under this proposal, if such a household fails to purchase insurance, it is charged a fee equal to the same dollar contribution it would have paid in the exchange to be used by the state for uncompensated care.

Incomes from \$100,000-\$250,000 (households not eligible for subsidies): In this range health insurance may or may not be affordable. For example, a single young person earning \$200,000 will find health insurance to be affordable while a family of 4 earning \$105,000 will typically not. When health insurance is not affordable, the AccessHealthCT software will offer an additional “plan” to the resident which is the HSA only. AccessHealthCT will set up the plan and arrange payments so that the enrollee is contributing 9.66% of income annually to the HSA. The enrollee may use these funds for medical expenses. If the resident does not choose either to buy insurance or to enroll in the HSA, then the resident will pay a fee of 9.66% of income to the state to be used for uncompensated care.

Incomes from \$251,000 upwards: In this range households are likely to find health insurance to be affordable. For example, a family of four could pay \$25,000 in costs which is a little less than 10% of \$251,000. When a resident without another source of insurance enters the exchange and finds that a silver plan costs less than 9.66% of income, that resident must either purchase insurance or pay a fixed fee of \$10,000 to the state to be used for uncompensated care.

Analysis of Mandates

We recommend the state of Connecticut implement this fee through legislation modeled after the Federal language under the ACA as this is simple and consistent with other aspects of the law.

Connecticut will likely want to place a cap on the total amount even a wealthy person could be assessed, such as the \$10,000 suggested above. We feel \$10,000 is a significant sum of money even for a family earning more than \$250,000 and would likely induce purchase of insurance. The state may choose what do with the fees collected. Several options follow:

- a) The fee may be used ONE TIME ONLY by the taxpayer to pay for insurance for the remainder of the calendar year in which they pay their taxes (and any balance placed in a HSA for use in the next year). In subsequent years, the same taxpayer would have to wait

for an open enrollment period in which to buy insurance, but the state could allow the use of the fee for that purpose.

- b) Funds collected can be used for a supplemental state program that reduces out of pocket costs for those just above 400% of the poverty level
- c) Funds collected go to pay for uncompensated care
- d) Funds are contributed to a high-risk pool

We recommend allowing residents to use the fee to purchase insurance (a) with any unclaimed funds going to reduce the cliff at 400% by expanding subsidies to residents just past the cutoff (b).

We also recommend that AccessHealthCT user interface begin the insurance plan choice process with questions about financial risk and financial savings. Enrollees should focus on the amount they can spend in a healthcare crisis out of all source: their savings, flexible spending accounts, and borrowed from family and friends. After this sum is established, AccessHealthCT can recommend to them plans with that level of deductible or lower. Purchase of a recommended plan will result in enrollees experiencing true insurance, namely a smoothing of financial expenditures over time, instead of the common problem of having “insurance” but being exposed to costs of many thousands of dollars in the event of getting sick.

Alternatively, the state could restrict the characteristics of plans sold to low income people. For example, a resident would not be allowed to purchase a plan with a deductible larger than 2% of income. Restrictions on large deductibles will allow residents to use their health insurance, obtain access to healthcare, reduce distress, and reduce medical bankruptcies.⁴ Of course, if a deductible is thousands of dollars smaller in a particular plan, its co-insurance or premiums must be high enough to offset that amount; the same out of pocket costs are being spread more smoothly over time rather than occurring only when the enrollee uses healthcare.

However, we can allow for large deductibles as follows. Residents who do not want to have conventional insurance may purchase a high-deductible or catastrophic plan, *provided* they can prove the ability to pay the deductible. If they cannot pay the deductible, they are effectively relying on fellow taxpayers to pay their healthcare costs in the event of an accident/incident. We recommend requiring insurers who sell catastrophic plans to confirm the enrollee has the entire amount of the deductible available in a healthcare spending account (HSA) prior to purchase. For example, a resident with \$20,000 in her HSA is permitted to purchase a plan with up to a \$20,000 deductible.

We further recommend investing in a mechanism to alert the exchange to individuals losing coverage in the state and reach out to auto-enroll them unless they actively choose another path. It is important that the default plan into which a resident is enrolled is the best choice for them based on the information Access Health has about their usage. With the information being shared today only a rough calculation is possible. We recommend that Access Health work on modeling

⁴ New research is showing that deductibles do not make consumers better shoppers in terms of choosing lower cost providers or choosing higher-value care. If deductibles do not help appreciably with moral hazard, they have little useful function https://eml.berkeley.edu/~bhandel/wp/Utilization_BCHK_Web.pdf.

default choices in future so that it provides wise defaults for consumers who do not make active choices themselves. A model for such a mechanism is in Kolstad-Handel.⁵

Connecticut-specific modeling

The IRS reports that 60,000 Connecticut residents paid the federal penalty in 2016 rather than obtain health insurance. However, whatever funds were collected did not flow to the state.

Current enrollment on AccessHealthCT is about 110,000. If all the residents paying the federal fee were to instead purchase insurance on the exchange, enrollment would grow by approximately 50%. Economic research finds that a 10% increase in enrollment induces a \$300-400 / year drop in average cost. If growth were 50% and the drop-in costs were entirely passed through to consumers, premiums would fall by \$25-30 per month.⁶ However, the pass through of costs will likely be lower than 100% and will depend on the intensity of competition.

There are sophisticated economic models of insurance markets with an exchange we can use to calculate the impact on average costs. For example, assume that all 60,000 people who paid the fine to the IRS became enrolled (with subsidies if qualifying) on to the exchange in 2019. Further suppose that those enrollees were perfectly healthy. This is a reasonable assumption because those residents already chose not to enroll, likely because their healthcare costs were too low to make insurance a good deal. A simulation based on California data indicates that average costs would fall from \$3500 to \$2300, or by \$100 per person per month on the exchange. If the new enrollees were not perfectly healthy, but had a few hundred dollars a year in costs, then the drop-in costs would be accordingly smaller.

We can estimate what might happen in Connecticut by examining the outcome of the introduction of the individual mandate in Massachusetts. We think the Massachusetts results are applicable to Connecticut given that Connecticut will keep community rating and guaranteed issue when it implements an Individual Healthcare Responsibility Fee, and indeed the Massachusetts results turn out to be consistent with our calculations.⁷ The introduction of the individual mandate in Massachusetts i) increased enrollment by 26%, ii) reduced claims expenditures by 8%, and reduced premiums by as much as 23%. This change resulted from a penalty of \$1,250 which is lower than the fee we recommend assessing in case of noncompliance.

In Connecticut, if the mandate disappears or becomes a zero fee, many enrollees will leave the exchange. We can assume that the youngest people are the most likely to decide that insurance is not a good financial deal and pull out. About 30% of enrollees in AccessHealthCT are young (<44). This is a similar sized group to the result from Massachusetts above, so we can estimate

⁵ https://www.brookings.edu/wp-content/uploads/2016/06/smart_policies_on_health_insurance_choice_market_handel.pdf

⁶ Tebaldi, Pietro (2017) “Estimating Equilibrium in Health Insurance Exchanges: Price Competition and Subsidy Design under the ACA (under review)”

⁷ http://www.shadac.org/sites/default/files/publications/MA_Individual_Mandate_Brief_0.pdf

something like that effect will run in reverse. When 30% of people leave an exchange, average costs are predicted to rise by about \$1000 a year and premiums are likely to rise accordingly. However, if the sickest people stay on the exchange while the healthy leave, the effect could be larger.⁸

Lastly, but importantly, insurers prefer to operate in a state with an Individual Healthcare Responsibility Fee because it ensures them that the population on the exchange is representative of the state population as a whole. This enables issuers to accurately forecast costs and set premiums more aggressively. As quantified above, more enrollees, including those in HSA-only “plans,” will increase an insurer’s economies of scale which allows insurer costs to fall. These lower costs will be passed on to consumers if competition on the exchange stays vigorous. Scale and consistency also incentivizes insurers to invest in new, innovative products. Shifting the focus from managing/avoiding higher cost patients to providing value to populations through lower prices and better care is likely to generate improvement in Connecticut’s health care outcomes and costs.

⁸ A leading simulation in the literature from a paper by Handel, Kolstad, and Spinnewijn gives similar results. <http://www.nber.org/papers/w21759.pdf>