

ISSUE BRIEF

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Freeing States from the Obamacare Insurance Mandates

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Contrary to its title, the Affordable Care Act (Obamacare) has made health insurance *less* affordable for millions of Americans by driving up their premiums. One of the main factors responsible for significant premium increases is the set of new federal mandates that Obamacare imposed on individual market and small-employer group health insurance policies.

There has been considerable focus on how legislation to repeal and replace Obamacare could affect the 20 million individuals receiving subsidized coverage through the exchanges and the Medicaid expansion. However, much less attention has been paid to another group of 25 million individuals who also have a significant personal stake in the outcome.

That group of 25 million consists of the 10 million people with individual-market coverage who do not qualify for Obamacare subsidies (about 80 percent of the pre-Obamacare individual market of 12 million), plus at least another 15 million with coverage through small group plans (who also get no subsidies). Some of those 25 million are still covered by pre-Obamacare plans (which they risk losing), with the rest in plans that are subject to Obamacare's costly insurance market provisions.

These are the individuals that most need relief from Obamacare's soaring premiums. Any repeal-and-replace legislation needs to include provisions that enable them once again to buy health insurance that is not burdened by the additional cost of federal benefit mandates or distorted by Obamacare's age rating restrictions. This is why one of the top priorities for health reform has been to restore to states the authority to regulate insurance markets, which Obamacare removed from them by layering on new federal insurance mandates. States should be freed from Obamacare's benefit mandates, the minimum actuarial value requirement, and age-rating restrictions.

Obamacare's Benefit Mandates

Obamacare requires health plans to cover a set of "essential health benefits," as well as a set of "preventive services" for which plans are prohibited from charging enrollees any co-payments.¹ Prior to implementation of the law, many states contracted for actuarial studies to determine the effects of those and other provisions on premiums in their health insurance markets. Our review of those studies finds that the Obamacare benefit mandates increased premiums by an average of 9 percent.

However, variations from the mean are significant. For instance, a Milliman study calculated that the average premium increase attributable to expanding coverage to meet the law's essential health benefits requirements could range from 3 percent to 17 percent, given differences in the extent of coverage provided by pre-Obamacare individual market plans.²

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State law is another factor. States that before Obamacare imposed more benefit mandates experienced below-average premium increases, as their existing coverage requirements were closer to the new federal requirements. Conversely, states with fewer benefit mandates before Obamacare experienced larger-than-average premium increases, as there was a bigger gap between the new federal requirements and those in prior state law.

In effect, Obamacare's essential health benefits provision increased health insurance costs in even the previously most overregulated states, and its impact was greatest in the states with less regulation. However, in no state were the new federal benefit requirements less than the state requirements in place before Obamacare.

Furthermore, Obamacare's prohibition on plans charging enrollees copayments for certain preventive services was likely responsible for an additional 1 percent to 2 percent increase in premiums. In the impact analysis that accompanied its 2010 regulation implementing the preventive services mandate, the Department of Health and Human Services (HHS) estimated that imposition of the preventive services mandate would increase premiums by about 1.5 percent.³ Because most health plans already covered most or all of the specified preventive services, the increase in premiums was mainly the result of costs being shifted from out-of-pocket payments to premiums, plus some additional utilization of covered services.

Obamacare's Minimum Actuarial Value Requirement

The minimum actuarial value requirement effectively establishes a floor for what plans must

pay toward the cost of covered services.⁴ The law standardizes plans into four "metal" tiers (labeled Bronze, Silver, Gold and Platinum) according to actuarial value. It specifies that the actuarial values must be 60 percent for Bronze plans, 70 percent for Silver plans, 80 percent for Gold plans, and 90 percent for Platinum plans. Thus, plans may no longer have an actuarial value below 60 percent. Our review of the actuarial studies finds that this minimum actuarial value requirement increased the cost of the least expensive plans by an average of 8 percent.

The studies also found that the affected plans typically had actuarial values in the range of 50 percent to 60 percent. That is noteworthy because, in response to complaints about Obamacare increasing premiums, even some supporters of Obamacare suggested amending the law to create a new class of "Copper" plans with an actuarial value of 50 percent.

Obamacare's Age Rating Restrictions

Obamacare limits age variation of premiums for adults to a maximum ratio of three to one.⁵ In other words, for the same plan, an insurer is not permitted to charge a 64-year-old a rate that is more than three times the rate it charges a 21-year-old. Yet the natural age variation in medical costs among adults is about five to one.⁶ Thus, the effect of this mandated "rate compression" is to force insurers to artificially underprice coverage for older adults and artificially overprice coverage for younger adults. Our review of the actuarial studies finds that the Obamacare three-to-one limitation increased premiums for younger adults by around one-third.⁷

Furthermore, while younger adults tend to be in better health, they also tend to earn less than older

1. The essential health benefit mandates are at 42 USC § 18022 and are imposed on health insurance plans in the individual and small group markets by 42 USC § 300gg-6. The preventive services mandate is at 42 USC § 300gg-13.
2. James T. O'Connor, "Comprehensive Assessment of Obamacare Factors That Will Affect Individual Market Premiums in 2014," Milliman, April 25, 2013.
3. U.S. Department of the Treasury, Internal Revenue Service; U.S. Department of Labor, Employee Benefits Security Administration; and U.S. Department of Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," *Federal Register*, Vol. 75, No. 137 (July 19, 2010), pp. 41726-41760, esp. pp. 41737-41738, <http://www.gpo.gov/fdsys/pkg/FR-2010-07-19/pdf/2010-17242.pdf> (accessed April 21, 2017).
4. As specified in 42 USC § 18022 and imposed on individual and small group market plans by 42 USC § 300gg-6.
5. 42 USC § 300gg(a)(1)(A)(iii).
6. See Dale H. Yamamoto, "Health Care Costs—From Birth to Death," Health Care Cost Institute Independent Report Series, Report No. 2013-1, sponsored by Society of Actuaries, June 2013, http://www.healthcostinstitute.org/files/Age-Curve-Study_0.pdf (accessed April 21, 2017).
7. For a similar finding, see O'Connor, "Comprehensive Assessment of Obamacare Factors That Will Affect Individual Market Premiums in 2014," and Oliver Wyman, "Impact of Changing Age Rating Bands in 'America's Healthy Future Act of 2009,'" September 28, 2009, <http://www.oliverwyman.com/our-expertise/insights/2009/sep/impact-of-changing-age-rating-bands-in--acirc--euro-america-acir.html> (accessed April 21, 2017).

workers with more experience. That combination makes young adults more sensitive to changes in the price of health insurance and more likely to decline coverage if it becomes more expensive. Thus, imposing rating rules that artificially increase health insurance premiums for young adults is not only unfair, but also counterproductive because it increases the costs of coverage for those who are already most likely to be uninsured.

Unlike Obamacare's benefit mandates, which increase premiums for all policyholders with the same coverage, the law's age rating restrictions essentially redistribute premiums. So while Obamacare's age rating restrictions substantially increase premiums for younger adults, they do reduce premiums somewhat for pre-retirement-aged adults (50 to 64 years old). However, to the extent that Obamacare's rate compression makes premiums more attractive for older (pre-retirement adults) and less attractive for younger adults, it contributes to unfavorably skewing the risk mix of the market—forcing insurers to raise premiums further across the board.⁸

Freeing States from Obamacare's Insurance Regulations

States should be freed from Obamacare's costly insurance mandates. That can happen either through outright repeal⁹ or, as recently proposed, through a state-waiver approach.¹⁰ As for the latter, the basic idea is that Congress would enact a set of waiver provisions in the current context of the fiscal year 2017 budget reconciliation bill that a state could then use to "opt out" of Obamacare's more costly insurance mandates.

The waiver approach would accomplish the objective of giving states a way to regain their pre-Obamacare authority to set minimum coverage standards for health plans. That option is likely to be most attractive to states that under Obamacare experienced the biggest premium increases and greatest market dislocation—i.e., states that previously

imposed fewer benefit mandates or that now have few insurers willing to offer Obamacare-compliant coverage. As noted, the increase in premiums needed to "buy up" health insurance plans to meet Obamacare's new federal standards varied significantly among states depending on how a state's pre-Obamacare coverage requirements compared to the new federal requirements.

In addition to accommodating differences among states, a waiver approach encourages state experimentation in developing better solutions. Waivers in other programs at times have resulted in new approaches that produced significant positive results and were then adopted by other states—an example being the "cash and counseling" demonstration waivers for providing support services to disabled Medicaid beneficiaries. Thus, a waiver approach can provide the framework not only for flexibility, but also for experimentation and eventually even consensus-building. Were a majority of states to take advantage of the waivers, Congress would have additional impetus to repeal the regulations at the federal level altogether. As a general principle, flexibility, experimentation, and consensus-building are all attributes that it would be prudent for policymakers to encourage in the development of health policy reforms.

Rolling Back Costly Obamacare Mandates

Debate about repealing and replacing Obamacare has not focused adequately on the 25 million Americans in individual-market coverage and small group plans who get no subsidies and are most vulnerable to Obamacare's costly regulations. These are the individuals who most need relief from Obamacare's soaring premiums. Any repeal-and-replace legislation needs to include provisions that enable them once again to buy health insurance that is not burdened by the additional cost of federal benefit mandates or distorted by Obamacare's age rating restrictions.

A top priority for health reform has been to restore to states the authority to regulate insurance

8. For instance, insurers expected that 18 percent of exchange enrollees would be age 55–64, but that age cohort's actual share of exchange enrollment in 2015 and 2016 was 26 percent and 27 percent, respectively. Brain Blase, "Obamacare Enrollment Year 3 Summary—Increase in Mandate Penalty Has Not Improved Risk Pools," *Forbes*, March 16, 2016, <https://www.forbes.com/sites/theapothecary/2016/03/16/obamacare-enrollment-year-3-summary-increase-in-mandate-penalty-has-not-improved-risk-pools/2/#340fd508745d> (accessed April 21, 2017).

9. Edmund F. Haislmaier, "As Republicans Debate Health Bill, Let's Remember Why Americans Want Obamacare Repeal," *The Daily Signal*, March 21, 2017, <http://dailysignal.com/2017/03/21/as-republicans-debate-health-bill-lets-remember-why-americans-want-obamacare-repeal/>.

10. Yuval Levin, "The Waivers Question," *National Review*, April 5, 2017, <http://www.nationalreview.com/corner/446453/gop-health-debate-continues-yuval-levin> (accessed April 21, 2017).

markets, which Obamacare removed from them by layering on new insurance mandates. Whether by outright repeal or by waiver, states should be freed from Obamacare's benefit mandates, the minimum actuarial value requirement, and age-rating restrictions as soon as possible.

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