OHFB Market Reform & Exchange Design Work Group

# Issues regarding an Individual Health Insurance Requirement

## Background

The Oregon Health Fund Board's list of Design Assumptions includes:

> *All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available.*

This is driven by the Design Principle that:

> *The responsibility and accountability for the financing and delivery of health care is shared by all Oregonians."*

## Rationale

Some individuals – those who can afford coverage as well as those who cannot -- choose to forego insurance. When they become seriously sick or injured, however, they rely on hospitals which are required to provide emergency services to everyone regardless of coverage. The health care costs for these uninsured people are borne by those who have insurance, via the cost shift. Requiring all Oregonians to have health insurance is needed to minimize the cost shift.

In addition, a personal coverage requirement is needed if other market reforms are undertaken. In particular, this requirement is needed to avoid adverse selection if we were to adopt guaranteed issue in the individual market (i.e., the elimination of medical screening for eligibility). Without this requirement, the guaranteed issuance of individual coverage is not feasible.

## Issues

The following issues have emerged in the Work Group's discussion of market reform and exchange design. (Note: this is a *preliminary* list, and we expect to add to and modify it after further discussions.)

1. A benchmark benefit design must be defined for the purpose of determining that the individual health insurance requirement has been met. (The Work Group assumes that the Benefits Committee will develop this benchmark benefit design.)
    a. How comprehensive or limited should this benefit be? If it is more comprehensive than the benefit plans currently held by individual consumers, it would require them to "buy-up". This could be very disruptive to a large number of individuals who have been paying for coverage. If it is more limited, however, it might expose individuals to unaffordable out-of-pocket costs.
    b. How would the benchmark benefit design needed to meet the individual health insurance requirement be applied to employer-based coverage? If the benchmark benefit is more comprehensive than the benefit plans offered by some or most

employers, it would require individuals to purchase supplemental coverage or push their employers to offer more comprehensive coverage. This could be disruptive in the large segment of people who already have coverage, and monitoring and enforcement might be difficult. Some have suggested considering any employer-based coverage to meet the individual health insurance requirement.

2. To maximize the number of people who comply with the individual health insurance requirement, both participation incentives and non-participation penalties will be needed.
    a. The financial penalty for non-coverage should be significant, e.g., at least 50% (?) of the cost of the benchmark plan; it does not need to equal the cost of coverage, since the non-participating person will not be getting the benefits of coverage.
    b. Should the penalty be based on % of premium? If it is age-rated, the penalty would be relatively costly for older individuals. If it is flat dollar amount based on the average premium (or age 40-44), it would be a stiffer penalty for younger individuals (i.e., a higher percentage of their premiums).
    c. The penalty for non-coverage must be high enough to encourage current enrollees to retain their coverage.
    d. Due to administrative issues, there should not be a surcharge on insurance for delayed purchase (as in Medicare Part B)?
    e. We may want to consider other incentives, e.g., require evidence of coverage in order to get a driver's license or for school enrollment.
3. To minimize the problems of adverse risk selection in the insurance market, we should consider a rule that an individual enrolling from a period of non-coverage can only enroll during the next open enrollment period, and only into the benchmark plan.
    a. Should we also consider implementing a penalty for individuals entering coverage from a period of non-coverage?
4. We will need to develop rules regarding responsibility for minors and other dependents.
    a. How should penalties be applied if some members of a household are not covered while others have coverage?
5. Effective enforcement of the individual health insurance requirement is key.
    a. Which entities (Revenue, Employment, carriers, others?) should monitor compliance with the individual health insurance requirement? For non-subsidized people, it may make sense to use the tax system to monitor compliance. For example, insurers and TPAs (or employers) would report the names of covered persons to the state, which would compare the names to a master list compiled from Revenue, Employment, DMV, etc.) An alternative would be voluntary reporting on individual state income tax returns (with a requirement to file even if no tax is owed).
    b. Which entity administers penalties for non-participation? How and when are penalties applied? The Revenue Dept has an established process and can administer the penalty as they do other penalties. Rules would need to be established to direct the agency on how to apply. This may require statutes or administrative rules to support administration by the department.

6. Other issues:
    a. How to determine compliance?
    b. How often to determine compliance?
    c. What period counts for having insurance (at start or end of year, for 12 months)? Is continuous coverage required throughout the year? How should penalties be applied if a person has coverage for only part of the year? Should we consider pro-rated penalties? It may make sense for monitoring and enforcement rules to be consistent with the way that subsidy eligibility rules are applied (e.g., 3-month, 6-month, or 12-month eligibility).
    d. Exceptions
    e. Appeal process

**Possible Principles for Design and Enforcement of an Individual Health Insurance Requirement**

1. KIS – make it easy to administer, easy to comply, easy to verify coverage.
2. Fairness – people who can afford coverage should buy it, while lower-income people may need assistance to make coverage affordable.
3. Flat of the curve – we should recognize that getting 100% compliance is probably impossible and very expensive; 99% may be sufficient to meet the goals of reducing the cost shift and minimizing adverse selection.
4. Others?