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United States Government Accountability Office
Washington, DC 20548

February 25, 2011

The Honorable E. Benjamin Nelson
Chairman
Subcommittee on the Legislative Branch
Committee on Appropriations
United States Senate

Subject: *Private Health Insurance Coverage: Expert Views on Approaches to
Encourage Voluntary Enrollment*

Dear Chairman Nelson:

To help expand health insurance coverage among the 50 million uninsured Americans, the Patient Protection and Affordable Care Act as amended (PPACA) mandates that individuals, subject to certain exceptions, obtain health insurance coverage or pay a financial penalty beginning in 2014—the “individual mandate”.¹ At the same time, PPACA generally requires insurers to accept all applicants, regardless of health status,² and prohibits insurers from excluding coverage based on any preexisting conditions.³ An individual mandate such as PPACA requires has been the subject of continued debate. Many health care policy experts have stressed the importance of a mandate in expanding health care coverage and keeping premiums affordable. For example, experts have noted that such a federal requirement may be necessary to prompt many individuals, such as younger, healthier individuals, to obtain coverage they otherwise would forego—particularly once they are guaranteed access to that coverage later when they may need it. They suggest that bringing these younger, healthier individuals into the insurance market is necessary to avoid adverse

¹Pub. L. No. 111-148, §§ 1501(b), 10106(b), 124 Stat. 119, 244, 909 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1029, 1032, 1034 (Mar. 30, 2010). Beginning in January 2014, individuals must maintain minimum essential coverage for themselves and their dependents, which includes employer-sponsored health plans, individual plans, and government-sponsored plans. Individuals must pay a penalty for each month they fail to comply with this mandate. Certain individuals, such as members of qualifying religious groups, are exempt from this mandate and other individuals, such as federal taxpayers whose household income is below the applicable filing threshold, are exempt from the penalty.

²For plan years beginning on or after January 1, 2014, PPACA requires health insurers offering group and individual coverage in a state to accept every employer and individual that applies for coverage in that state, subject to certain requirements. Pub. L. No. 111-148, § 1201(4), 124 Stat. 156.

³PPACA prohibits group health plans and insurers offering group and individual coverage from excluding coverage for any preexisting conditions. This prohibition is generally effective for plan years beginning on or after January 1, 2014 for adults and for plan years beginning on or after September 23, 2010 for individuals under age 19. Pub. L. No. 111-148, §§ 1201(2), 10103(e),(f), 124 Stat. 154, 895.

selection, whereby disproportionately less healthy individuals who need health care services enroll in coverage, leading to higher premiums that further discourage healthy individuals from enrolling.⁴ Some experts have argued that the individual mandate does not go far enough to ensure that all of the uninsured enroll, and that to do so would require heavier penalties that are fully enforced to be truly effective.⁵ Other experts suggest that, rather than requiring individuals to obtain health insurance coverage, a more appropriate role for the federal government would be to consider alternatives to encourage voluntary enrollment. Some of these experts also question the legality of a federal mandate.⁶ Since its enactment, the federal mandate has been subject to a number of court challenges to its constitutionality. Because of the possibility that legislative or judicial action could result in a change to, or elimination of, the mandate, you asked us to identify potential alternatives to encourage, rather than require individuals to obtain private health insurance coverage. For this report, we obtained the views of multiple experts on the range of approaches Congress could consider to encourage voluntary enrollment in private health insurance coverage.⁷

To obtain the views of experts, we interviewed 41 officials from 21 organizations that provide research and analysis on health care issues or otherwise are health care stakeholders. We identified these individuals and organizations based on a literature search of relevant published research or commentary, referrals from the Institute of Medicine of the National Academy of Sciences, referrals from those we interviewed, and internal GAO expertise. We selected the experts based on demonstrated subject matter expertise; representation of a range of perspectives (specifically including both proponents and opponents of the individual mandate); and representation from a wide range of institutions, including academia, business and consumer organizations, state government, health insurers, professional organizations, and policy research organizations. See enclosure I for the complete list of experts we interviewed and their organizational affiliation.

During each phone interview, we asked the experts to identify approaches that might encourage individuals to voluntarily enroll in health care coverage, regardless of any views the experts might hold on the importance of a mandate to expand health care coverage. We solicited comments on a list of approaches we circulated in advance, based on our preliminary research, as well as comments on approaches that arose during the discussions and those that arose during previous interviews with other

⁴For example, see J. Gruber, "Why We Need the Individual Mandate," Center for American Progress, Washington, DC, April 2010; and L. Blumberg and J. Holahan, "The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage," *New England Journal of Medicine*, 361:6-7, July 2009.

⁵For example, see A. C. Enthoven: "A Few Cautions About Exchanges," Kaiser Permanente Institute for Health Policy, California, January 2011; and "CBO Understates Major Impact Of Weakened Individual Mandate," Blue Cross Blue Shield Association, Chicago, IL, October 2009.

⁶For example, see R. E. Moffit, Ph.D: "Choice and Consequences: Transparent Alternatives to the Individual Insurance Mandate," *Harvard Health Policy Review*, Vol. 9, No. 1. Cambridge, MA, Spring 2008; and R. Barnett, N. Stewart, T. Gaziano: "Why the Personal Mandate to Buy Health Insurance Is Unprecedented and Unconstitutional," *The Heritage Foundation*, Legal Memorandum No. 49, Washington, DC, Dec 2009.

⁷Prior to PPACA, Congress has considered other legislation that included requirements for individuals to obtain health insurance. See, for example, the Health Equity and Access Reform Today Act of 1993, H.R. 3704, S. 1770, 103rd Cong. (1993). In addition, as of July 2007, Massachusetts required its residents, subject to certain exceptions, to obtain health insurance. Mass. Gen. Laws ch. 111M, § 2.

experts. At the conclusion of our interviews, we circulated to all the experts we interviewed a list of approaches compiled from all of our interviews, allowing each the opportunity to comment on any specific approach not discussed during their interview. We incorporated the experts' comments as appropriate.

We did not independently evaluate the potential effectiveness or the legal implications of the approaches individually or in combination.⁸ Moreover, we did not explore suggestions that primarily emphasized more generous subsidies or significant expansions of publicly funded insurance programs as a means of expanding coverage. The approaches identified in this report are not endorsed by GAO, nor necessarily by any particular experts we interviewed, or the organizations they represent.

We conducted our work from October 2010 to February 2011 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings in this product.

Background

Of the nearly 265 million individuals in the United States under age 65 in 2009, more than 156 million (59 percent) received health care coverage through employer-sponsored group market plans and nearly 17 million (6.3 percent) were covered by health plans purchased directly from an insurer in the individual market. Another 56 million (21 percent) were covered through public programs such as Medicaid—the government-sponsored health insurance program for certain low-income people—or other public programs.⁹ Most employees participate in employer-sponsored insurance where available, in part because employers typically subsidize a large share of employees' premiums and premium contributions are tax-deductible. Premiums for individual health insurance coverage usually depend on individuals' risk factors such as health status and age and thus may vary substantially, with individuals paying the full premium. In addition, a total of 50 million—one in five nonelderly Americans—were uninsured, with more than three-quarters of the uninsured from working

⁸In this report, we express no opinion on the merits of any lawsuits challenging the constitutionality of the individual mandate or other provisions of PPACA. In addition, we did not independently identify or analyze all PPACA provisions that may be implicated by the various approaches and instead address those provisions that were referenced by the experts.

⁹The enrollment for each source of coverage exceeds the total of the nonelderly population because some people have multiple sources of coverage. See Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey," *EBRI Issue Brief*, no. 347 (September 2010). Individuals 65 and older are generally eligible for Medicare, the federal program that serves elderly and certain disabled individuals.

families,¹⁰ and the vast majority in low- or moderate-income families.¹¹ Research indicates that uninsured individuals may forego some health care, and they may not be able to pay for care that they do receive. Uncompensated care costs for the uninsured amounted to about \$57 billion in 2008.¹²

PPACA contains a number of provisions that are designed to expand access to private health insurance, many of which take effect in 2014. For example, in addition to the individual mandate, PPACA requires the establishment of American Health Benefit Exchanges in each state by January 1, 2014, through which eligible individuals and small employers can compare and select insurance coverage amongst participating health plans.¹³ Upon enrolling in plans offered through the Exchanges, certain individuals may qualify for premium tax credits and cost sharing reductions.¹⁴ PPACA requires the Exchanges to perform several functions, including: awarding grants to third parties to facilitate enrollment into available plans, establishing telephone hotlines to respond to requests for assistance, and maintaining Web sites to provide comparative information on health plans for consumers.¹⁵ In addition, the Exchanges must provide for initial open enrollment periods, followed by annual open enrollment periods in subsequent years, as defined by the Secretary of Health and Human Services.¹⁶

PPACA also imposes certain requirements on employers and other insurers offering private health insurance. For example, beginning in January 2014, employers with more than 200 full-time employees that offer health coverage must automatically enroll new full-time employees into a plan—referred to as “autoenrollment”—providing these employees the opportunity to disenroll from the plan—or opt out—if they so choose.¹⁷ In addition to requiring insurers to accept applicants regardless of health status, PPACA allows insurers offering individual or small group coverage, beginning in January of 2014, to impose varying premiums based only on certain

¹⁰The majority of uninsured workers are not offered health insurance by their employer, or may not be eligible for coverage often because they have not worked for their employer for a sufficient amount of time or they do not work enough hours. See The Kaiser Commission on Medicaid and the Uninsured: *The Uninsured: A Primer- Key Facts About Americans Without Health Insurance*, December 2010 (Menlo Park, Calif. and Washington D.C). The high cost of insurance is also a key barrier for some uninsured workers—the employee’s share of the average annual cost of employer-sponsored family coverage was nearly \$4,000 in 2010. See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2010 Annual Survey*, (Menlo Park, Calif., and Chicago, Ill.: 2010).

¹¹Adults and particularly young adults ages 19 to 29 are especially likely to be uninsured.

¹²See The Kaiser Commission on Medicaid and the Uninsured: *The Uninsured: A Primer- Key Facts About Americans Without Health Insurance*, December 2010.(Menlo Park, Calif. and Washington D.C).

¹³Pub. L. No. 111-148, § 1311(b), 124 Stat. 173. In this report, we refer to American Health Benefit Exchanges as “the Exchanges.” The Exchanges facilitate the purchase of individual coverage and provide for the establishment of Small Business Health Options Programs to assist small employers in facilitating enrollment of their employees into qualified health plans in their state.

¹⁴Pub. L. No. 111-148, §§ 1401-1402, 10105, 10108(h), 124 Stat. 213, 906, 914, as amended by, Pub. L. No. 111-152, §§ 1001, 1004, 124 Stat. 1030, 1034.

¹⁵Pub. L. No. 111-148, § 1311(d)(4), 124 Stat. 176.

¹⁶Pub. L. No. 111-148, § 1311(c)(6), 124 Stat. 175. The Exchanges must also provide for special enrollment periods in certain circumstances.

¹⁷Pub. L. No. 111-148, § 1511, 124 Stat. 252.

factors, including age.¹⁸ Insurers may vary premiums based on age by no more than a 3 to 1 ratio for adults (meaning that the rates for the oldest person in the pool would be no more than three times higher than for the youngest person). Starting January 1, 2011, PPACA requires insurers offering group or individual coverage to expend a significant percentage of their premium revenues on reimbursement for clinical services provided to their enrollees and activities that improve health care quality—also referred to as the medical loss ratio requirement.¹⁹ See enclosure II for further background information on the issues discussed in this report.

Results in Brief

The experts we interviewed discussed several specific approaches to encourage voluntary health insurance enrollment during our interviews. The approaches are summarized below, generally presented in the order of frequency with which they were proposed by the experts for consideration. These approaches are not endorsed by GAO, nor necessarily by any particular experts we interviewed, or the organizations they represent.

- Modify open enrollment periods and impose late enrollment penalties.
- Expand employers' roles in autoenrolling and facilitating employees' health insurance enrollment.
- Conduct a public education and outreach campaign.
- Provide broad access to personalized assistance for health coverage enrollment.
- Impose a tax to pay for uncompensated care.
- Allow greater variation in premium rates based on enrollee age.
- Condition the receipt of certain government services upon proof of health insurance coverage.
- Use health insurance agents and brokers differently.
- Require or encourage credit rating agencies to use health insurance status as a factor in determining credit ratings.

In discussing these approaches, four key themes emerged. First, experts emphasized that most people would prefer to purchase health insurance coverage; however, to the extent that high cost is a barrier, the use of financial incentives is key. Second, they stated that regardless of the particular approach taken to increase voluntary enrollment in the absence of an individual mandate, the availability of affordable, high-quality health care plans with a basic set of benefits, and full coverage of

¹⁸Pub. L. No. 111-148, §§ 1201(4), 10103(a), 124 Stat. 155, 892. If a state permits insurers that offer large group coverage to participate in an Exchange, then these premium rate limitations also apply to those insurers (with the exception of self-insured plans).

¹⁹Pub. L. No. 111-148, § 1001(5), 10101(f), 124 Stat. 136, 885. Insurers offering large group coverage must spend at least 85 percent and insurers offering individual and small group coverage must spend at least 80 percent of premium revenues on these qualifying health care expenses, subject to possible increases in required percentages by states. If insurers fail to meet these targets, they must provide an annual rebate to each enrollee on a pro rata basis.

preventive care services is essential to encouraging voluntary enrollment in the coverage. Third, experts said that strong marketing and public education from trusted, community-based sources informing people about their health care choices, their costs, and the consequences of not enrolling in a timely manner are important. And fourth, they said convenient access to the health insurance system through multiple access points staffed by knowledgeable individuals would further facilitate enrollment.

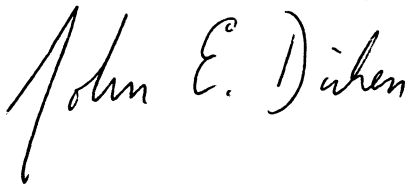
Experts expressed important cautions in interpreting their comments on these approaches. Not all the experts concurred that any particular approach merited consideration, and those who proposed an approach for consideration did not necessarily suggest its impact would be significant or comparable to that of an individual mandate. Experts noted that various approaches would have different impacts on encouraging voluntary enrollment, and that a combination of multiple approaches holds more potential to encourage voluntary enrollment than any single approach. For example, a marketing and public education campaign may be combined with other approaches, and would be important to the successful implementation of any effort to encourage enrollment in health insurance. Furthermore, they emphasized that independent research is required to fully evaluate the potential effectiveness and legal or other implications associated with any approach or combination of approaches.

Enclosure III contains the full discussion of each approach, including an overview of how each would work and key associated challenges and trade-offs.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to relevant congressional committees and other interested members. The report will also be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Individuals making key contributions to this report include Randy DiRosa, Assistant Director; Iola D'Souza; Laurie Pachter; Pauline Seretakakis; Hemi Tewarson; and Stephen Ulrich.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive, flowing style.

John E. Dicken
Director, Health Care

Enclosures – 3

Experts Interviewed by GAO about Approaches to Encourage Voluntary Health Insurance Enrollment

Organization	Name	Title
America's Health Insurance Plans	Gary Bacher	Senior Vice President
	Donna Horoschak	Senior Vice President, Product Policy
	Betsy Pelovitz	Vice President, Product Policy
American Academy of Actuaries	Cathy Murphy-Barron	Chairperson of the Federal Health Committee
	David Shea	Former Chairperson of the Federal Health Committee
	Cori Uccello	Academy Senior Health Fellow
	Tom Wildsmith	Vice President of the Health Practice Council
American Enterprise Institute for Public Policy Research	Joseph Antos	Wilson H. Taylor Scholar in Health Care and Retirement Policy
	Thomas P. Miller	Resident Fellow
American Federation of Labor and Congress of Industrial Organizations	Gerald M. Shea	Assistant to the President for Government Affairs
Assurant Health	Don Hamm	President and Chief Executive Officer
Blackstone Group	Dr. Robert Galvin	Chief Executive Officer, Equity Healthcare
Blue Cross Blue Shield Association	Alissa Fox	Senior Vice President
	Justine Handelmeyer	Vice President
	Kris Haltmeyer	Executive Director
	Robert Imes	Director
CDBykerk Consulting, LLC	Cecil D. Bykerk	President
Columbia University	Dr. John W. Rowe	Professor of Health Policy and Management, Mailman School of Public Health
Consumers Union	Lynn Quincy	Senior Health Policy Analyst
Council of State Governments	Chris Whatley	Director, Washington Office and Deputy Executive Director
	Ellen Andrews	Health Policy Consultant
	Nell Etheredge	Legislative Analyst
Employee Benefit Research Institute	Dr. Paul Fronstin	Senior Research Associate
Harvard University	Dr. David Cutler	Otto Eckstein Professor of Applied Economics/Professor of Economics
The Henry J. Kaiser Family Foundation	Diane Rowland	Executive Vice-President and Executive Director, Kaiser Commission on Medicaid and the Uninsured
	Gary Claxton	Vice President and Director of the Health Care Marketplace Project
The Heritage Foundation	Dr. Stuart Butler	Director of the Center for Policy Innovation
	Ed Haislmaier	Senior Health Research Fellow
The Lewin Group	John Sheils	Senior Vice-President and Principal

Enclosure I

Organization	Name	Title
Mercer	Susan Connolly	Senior Consultant, Health Benefits Practice, Intellectual Capital
	Chris Covill	Head of Voluntary Benefits Consulting Group
	Sharon Cunninghis	US Health and Benefits Consulting Business Leader
	Stephanie Poe	Americas Head, Public Relations
	Tracy Watts	Senior Health Care Consultant
Massachusetts Institute of Technology	Dr. Jonathan Gruber	Professor of Economics
National Business Group on Health	Helen Darling	President
The Urban Institute	Dr. Robert Reischauer	President
	Dr. Linda Blumberg	Senior Fellow
	Stan Dorn	Senior Fellow
	Dr. John Holahan	Senior Fellow
U.S. Chamber of Commerce	James Gelfand	Director of Health Policy

Source: GAO.

Health Insurance Coverage and Select Provisions of the Patient Protection and Affordable Care Act As Amended (PPACA)

More than 156 million (59 percent) of the individuals in the United States under age 65 received health care coverage through employer-sponsored group market plans in 2009.¹ Employers are not required to offer health insurance, but most large employers provide coverage either by purchasing plans from insurers or by self-funding their own plans, and most eligible employees tend to participate in these employer-sponsored plans.² Small employers (often defined as 50 or fewer employees) are less likely to provide coverage than large employers, and when they do, they generally purchase that coverage from insurers in the small group market.³ Workers employed by small employers, and these workers' families, are more than twice as likely to be uninsured as individuals in households with a worker at a large employer. Large and small employers typically subsidize a large share of employees' health insurance premiums,⁴ and employer and employee contributions for workers' health coverage are generally excluded, without limit, from workers' taxable income.⁵

Private group health insurance coverage is regulated at both the federal and state levels. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to ensure access, portability, and renewability within the group insurance markets. One of HIPAA's provisions prohibits insurers from imposing exclusion periods based on preexisting health conditions when individuals are moving between different group health plans, such

¹P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey," *EBRI Issue Brief*, no. 347 (December 2010).

²In 2010, almost all (99 percent) large employers offered health insurance and over 80 percent of employees who were offered employer-sponsored coverage and were eligible for that coverage elected to participate. See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2010 Annual Survey*, (Menlo Park, Calif., and Chicago, Ill.: 2010).

³Small employers employ nearly 30 percent of the private sector workforce. In 2010, 68 percent of small employers, and 59 percent of the smallest employers (between 3 and 9 employees) offered their employees health insurance. See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2010 Annual Survey*, (Menlo Park, Calif., and Chicago, Ill.: 2010).

⁴In 2010, large employers contributed about 82 percent of the average annual premium (\$5,050) for single coverage and about 74 percent of the average annual premium (\$14,038) for family coverage. While small employers contributed a similar share for single coverage, they contributed only 65 percent of the average annual premium for family coverage. Thus workers employed by small employers paid over 27 percent more for family coverage than workers employed by large employers. See Kaiser Family Foundation and HRET 2010 Annual Survey.

⁵Employers can offer a "premium conversion" arrangement, which allows workers to pay their share of the premium for employment-based coverage with pretax dollars. In addition, workers whose employers sponsor flexible spending accounts are able to pay out-of-pocket expenses with pretax dollars.

Enclosure II

as when they change jobs.⁶ Another HIPAA provision prohibits insurers from imposing varying premiums for similarly situated group plan enrollees on the basis of health status or medical history.⁷ States also impose various requirements on insurers. For example, states may require insurers in the small group markets to limit the variation allowed in premiums based on health status and other risk factors.⁸

An additional 16.7 million (6.3 percent) Americans under age 65 in 2009 were covered by health plans purchased directly from an insurer in the individual market. These plans are generally purchased by self-employed individuals, early retirees, or workers who were either not offered, or decided not to participate in, employer-sponsored health insurance. Unlike the employer-sponsored group market where premiums generally are based on the risk characteristics of the entire group, premiums for individual market coverage are generally based on each individual's expected health care costs depending on risk factors such as health status and age. Also, individual plans tend to have higher administrative costs, and unlike employer-sponsored coverage, individual plan premiums are not subsidized by an employer and are generally not tax-deductible.⁹ As a result, the cost of individual market coverage is typically greater and more varied than employee contributions to employer-sponsored coverage. HIPAA provides certain guaranteed access to coverage for eligible individuals moving from group to individual coverage, but this protection does not apply to individuals moving between individual market plans.¹⁰ At the state

⁶Group health plans and health insurance issuers offering group coverage may only impose preexisting condition exclusion periods when: (i) the individual received treatment for the condition during the six-month period prior to the individual's enrollment date, (ii) the exclusion is for not more than one year after enrollment (or 18 months for late enrollees), and (iii) the period of exclusion is reduced by the number of days of the individual's prior creditable coverage. In addition, preexisting condition exclusions cannot be applied for pregnancy, genetic conditions and certain children. See 29 U.S.C. 1181 (2006) and 42 U.S.C. § 300gg (2006). PPACA expands upon this requirement by prohibiting group health plans and insurers offering group and individual coverage from excluding coverage for any preexisting conditions. This prohibition is generally effective for plan years beginning on or after January 1, 2014 for adults and for plan years beginning on or after September 23, 2010 for individuals under age 19. Pub. L. No. 111-148, §§ 1201(2), 10103(e),(f), 124 Stat. 154, 895.

⁷See 29 U.S.C. § 1182(b) (2006) and 42 U.S.C. § 300gg-1(b) (2006).

⁸More stringent state regulation of the variation in premiums imposed by insurers can make coverage more affordable for small employers with high-risk employees, but may also increase the cost of insurance for healthier groups. For example, in those states, a small employer with older workers, including some in poor health, would pay the same premium as an employer of the same size and geographic location with younger, healthier workers. In contrast, in a state with less stringent regulation, a small employer with older and less healthy workers could pay significantly more than an employer of the same size and geographic location with younger, healthier employees.

⁹Total qualified health care expenses (including premiums) are deductible if they exceed 7.5 percent of adjusted gross income. Self-employed individuals may also be able to deduct 100 percent of health insurance premiums.

¹⁰Insurers offering individual plans may not deny coverage to, or impose any preexisting condition exclusion on individuals who (i) have had at least 18 months of prior creditable coverage, defined as a group health plan, government plan, or church plan, with no break of more than 63 days, (ii) have exhausted any available continuation of coverage, (iii) are not eligible for other group or government coverage; and (iv) did not lose group coverage because of the nonpayment of premiums or fraud. See 42 U.S.C. § 300gg-41 (2006). As referenced above, in addition to prohibiting insurers from excluding coverage based on any preexisting conditions, PPACA also expands upon this prohibition by requiring insurers offering group or individual coverage to accept every individual and employer that applies for coverage in that state, subject to certain requirements, for plan years beginning on or after January 1, 2014. Pub. L. No. 111-148, § 1201(4), 124 Stat. 156.

Enclosure II

level, insurance in the individual market may be less regulated than in the group market. To varying degrees, many states permit health insurers to use medical underwriting—a process used to assess an applicants' health status and other factors to determine the basis for applicable premiums, the extent of coverage they provide, or whether to provide coverage at all.¹¹

In 2009, a total of 50 million—one in five—nonelderly Americans were uninsured. More than three-quarters of the uninsured were from working families,¹² and the vast majority were in low- or moderate-income families. Adults also made up more than their share of the uninsured—especially young adults ages 19 to 29.¹³ Research indicates that uninsured individuals may forego some health care, and they may not be able to pay for care that they do receive. Uncompensated care costs for the uninsured amounted to about \$57 billion in 2008. About 75 percent of this was paid by federal, state, and local funds for care of the uninsured.¹⁴

PPACA¹⁵ makes several changes to the regulatory structure governing private health insurance markets. For example, beginning in January 2014, PPACA generally requires that individuals obtain health insurance or pay a penalty for each month of noncompliance. Individuals are required to maintain certain minimum essential coverage for themselves and their dependents, which includes employer-sponsored plans, individual plans, and government-sponsored plans.¹⁶ Prior to PPACA, Congress

¹¹For example, health insurers may temporarily or permanently exclude coverage for specific medical conditions, or impose a 'preexisting condition exclusion' which for a fixed period limits coverage of services for any medical condition the purchaser has at the time coverage takes effect; or they may charge higher premium rates to purchasers perceived to be high risk. In 2008, 29 percent of individuals age 60 to 64 who applied for individual insurance policies were denied coverage based on their health status. See The Kaiser Commission on Medicaid and the Uninsured: *The Uninsured: A Primer- Key Facts About Americans Without Health Insurance*, December 2010 (Menlo Park, Calif. and Washington D.C).

¹²Workers usually enroll in employer-sponsored coverage if it is available and they are eligible; however, the majority of uninsured workers are not offered health insurance by their employer, or may not be eligible for coverage often because they have not worked for their employer for a sufficient amount of time or they do not work enough hours. The high cost of insurance is also a key barrier—the employee's share of the average annual cost of employer-sponsored family coverage was about \$4,000 in 2010. See The Kaiser Commission on Medicaid and the Uninsured: *The Uninsured: A Primer- Key Facts About Americans Without Health Insurance*, December 2010. (Menlo Park, California and Washington D.C).

¹³Young adults had the highest uninsured rate (32 percent) of any age group. More than half of uninsured young adults were in families with at least one full-time worker, but their low incomes made it more difficult for them to afford coverage. (The median income of uninsured young adults in 2008 was \$15,000.) See The Kaiser Commission on Medicaid and the Uninsured.

¹⁴See The Kaiser Commission on Medicaid and the Uninsured: *The Uninsured: A Primer- Key Facts About Americans Without Health Insurance*, December 2010. (Menlo Park, California and Washington D.C).

¹⁵Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

¹⁶Some individuals are exempt from the mandate, such as members of qualifying religious groups, while others are exempt from the penalty, such as federal taxpayers whose household income is below the applicable filing threshold. Pub. L. No. 111-148, §§ 1501(b), 10106(b), 124 Stat. 244, 909, as amended by Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1032, 1034.

Enclosure II

has considered other legislation that included requirements for individuals to obtain health insurance.¹⁷

PPACA requires the establishment of American Health Benefit Exchanges by January 1, 2014, to provide eligible individuals and small employers access to a selection of private health plans.^{18,19} When enrolling in a health plan through the Exchanges, certain individuals may qualify for premium tax credits and cost sharing reductions.²⁰ PPACA requires the Exchanges to perform several functions, including the following:

- Provide for an initial open enrollment period and annual open enrollment periods for subsequent years, as defined by HHS.²¹
- Establish navigator programs, through which grants are awarded to third parties for specified activities including: facilitating enrollment in the health plans, conducting public education to raise awareness of the availability of the health plans, distributing information about the plans and opportunities for premium tax credits and cost sharing reductions, and providing information to consumers in culturally and linguistically appropriate ways.²²
- Establish telephone hotlines to respond to requests for assistance and maintain Web sites with standard comparative information on health plans.²³

PPACA imposes requirements on certain employers. Beginning in January 2014, employers with more than 200 full-time employees (FTEs) that offer health coverage must automatically enroll new FTEs into a plan they currently offer. Employers must provide adequate notice and the opportunity for an employee to opt out if they so

¹⁷See, for example, the Health Equity and Access Reform Today Act of 1993, H.R. 3704, S. 1770, 103rd Cong. (1993). In addition, as of July 2007, Massachusetts required its residents, subject to certain exceptions, to obtain health insurance. Mass. Gen. Laws ch. 111M, § 2.

¹⁸Pub. L. No. 111-148, § 1311(b), 124 Stat. 173. In this report, we refer to American Health Benefit Exchanges as “the Exchanges.” The Exchanges facilitate the purchase of individual coverage and provide for the establishment of Small Business Health Options Programs to assist small employers in facilitating enrollment of their employees into qualified health plans in their state.

¹⁹In order to participate in the Exchanges, health plans generally must offer essential benefit packages, as defined by the Secretary, with at least one of four levels of coverage—bronze, silver, gold, or platinum. Bronze plans provide the lowest level of coverage. Pub. L. No. 111-148, §§ 1302, 1311(b), 124 Stat. 163, 173.

²⁰Pub. L. No. 111-148, §§ 1401-1402, 10105, 10108(h), 124 Stat. 213, 906, 914, as amended by, Pub. L. No. 111-152, §§ 1001, 1004, 124 Stat. 1030, 1034.

²¹Pub. L. No. 111-148, § 1311(c)(6), 124 Stat. 175. The Exchanges must also provide for special enrollment periods in certain circumstances.

²²Under PPACA, the Secretary of Health and Human Services also must establish procedures under which states may allow agents and brokers to enroll individuals and employers in health plans offered through the Exchanges and assist individuals to apply for premium tax credits and cost sharing reductions. Pub. L. No. 111-148, § 1312(e), 10104(i)(2), 124 Stat. 183, 901.

²³Pub. L. No. 111-148, § 1311(d)(4), 124 Stat. 176.

Enclosure II

choose.²⁴ An employer with at least 50 FTEs that does not provide coverage to employees and their dependents for any month generally is subject to an assessable payment if one or more of its full-time employees signs up for a plan through an Exchange and is eligible for a premium tax credit or cost sharing reduction.²⁵ An employer with at least 50 FTEs that offers coverage to employees and their dependents may also be subject to an assessable payment, subject to certain exceptions, if one or more of its FTEs enrolls in a health plan through an Exchange and is eligible for premium tax credits or cost sharing reductions due to the nature of the coverage offered by the employer.²⁶ As of March 1, 2013, employers also must provide current employees (and new employees at the time of hiring) with specific information including about the existence of an Exchange, the services it provides, and the manner in which the employees may contact the Exchange for assistance.²⁷

PPACA regulates certain features of health coverage offered by insurers in both individual and small group markets. For example, as addressed above, PPACA requires insurers to accept all applicants, regardless of any preexisting medical conditions, thus establishing guaranteed issuance of coverage for individuals and employers. PPACA allows insurers offering individual or small group coverage beginning in January 2014, to impose varying premiums based only on certain factors, including age, but will limit the age-based variation to no more than a 3 to 1 ratio for adults across age rating bands established by the Secretary of HHS.²⁸ Starting January 1, 2011, PPACA requires that insurers offering coverage spend at least 85 percent for the large group market and 80 percent for the small group and individual markets of premium revenues on reimbursement for clinical services and health care quality improvement activities.²⁹

²⁴Pub. L. No. 111-148, § 1511, 124 Stat. 252. Automatic enrollment is subject to any waiting period authorized by law.

²⁵Pub. L. No. 111-148, § 1513(a), 124 Stat. 253.

²⁶Pub. L. No. 111-148, § 1513(a), 10108(i), 124 Stat. 253, 914, as amended by, Pub. L. No. 111-152, § 1003, 124 Stat. 1033. Access to employer-sponsored coverage does not disqualify individuals from participating in Exchange plans or for premium tax credits or cost sharing reductions for these plans. For example, when an employer's coverage imposes premiums exceeding 9.5 percent of the household income of the employee, or the coverage pays less than 60 percent of covered expenses, that individual may qualify for premium tax credits.

²⁷Pub. L. No. 111-148, § 1512, 10108(i), 124 Stat. 252, 914.

²⁸Pub. L. No. 111-148, § 1201(4), 10103(a), 124 Stat. 155, 892 (to be codified at 42 U.S.C. § 300gg). If a state permits insurers that offer large group coverage to participate in their Exchange, then these premium rate limitations also apply to those insurers (with the exception of self-insured plans).

²⁹Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 136, 885. States have the option to increase these percentages.

Expert Views on Approaches to Encourage Voluntary Enrollment in Private Health Insurance Coverage

The experts we interviewed discussed several specific approaches to encourage voluntary private health insurance enrollment during our interviews. The specific approaches are summarized below, followed by more detail on how each would work and key associated challenges and trade-offs discussed by experts in the remainder of this enclosure. They are generally presented in the order of frequency with which they were proposed by the experts for consideration. These approaches are not endorsed by GAO, nor necessarily by any particular experts we interviewed, or the organizations they represent.

- Modify open enrollment periods and impose late enrollment penalties.
- Expand employers' roles in autoenrolling and facilitating employees' health insurance enrollment.
- Conduct a public education and outreach campaign.
- Provide broad access to personalized assistance for health coverage enrollment.
- Impose a tax to pay for uncompensated care.
- Allow greater variation in premium rates based on enrollee age.
- Condition the receipt of certain government services upon proof of health insurance coverage.
- Use health insurance agents and brokers differently.
- Require or encourage credit rating agencies to use health insurance status as a factor in determining credit ratings.

In discussing these approaches, four key themes emerged. First, experts emphasized that most people would prefer to purchase health insurance coverage; however, to the extent that high cost is a barrier, the use of financial incentives is key. Second, they stated that regardless of the particular approach taken to increase voluntary enrollment in the absence of an individual mandate, the availability of affordable, high-quality health care plans with a basic set of benefits, and full coverage of preventive care services is essential to encouraging voluntary enrollment in the coverage. Third, experts said that strong marketing and public education from trusted, community-based sources informing people about their health care choices, their costs, and the consequences of not enrolling in a timely manner are important. And fourth, they said convenient access to the health insurance system through multiple access points staffed by knowledgeable individuals would further facilitate enrollment.

Experts expressed important cautions in interpreting their comments on these approaches. Not all the experts concurred that any particular approach merited consideration, and those who proposed an approach for consideration did not necessarily suggest its impact would be significant or comparable to that of an

individual mandate. Experts noted that various approaches would have different impacts on encouraging voluntary enrollment, and that a combination of multiple approaches holds more potential to encourage voluntary enrollment than any single approach. For example, a marketing and public education campaign may be combined with other approaches, and would be important to the successful implementation of any effort to encourage enrollment in health insurance. Furthermore, they emphasized that independent research is required to evaluate the potential effectiveness and legal or other implications associated with any approach or combination of approaches.

Modify Open Enrollment Periods and Impose Late Enrollment Penalties

Expert Views on Alternative Approach

In the absence of a mandate, open enrollment periods could be enhanced beyond the annual periods provided for under the Patient Protection and Affordable Care Act, as amended (PPACA) by incorporating different open enrollment period frequencies and coupling them with various penalties for late enrollees who do not enroll when first eligible.^{1,2} Limiting access to coverage to only such periods is intended to reduce the likelihood that individuals would otherwise wait until they need health care to enroll.

Open enrollment periods could vary in their frequency. Generally, the less frequent they are, the less likely individuals will risk remaining uninsured until the next such period. While PPACA provides for annual periods, these could be extended to every 18 months, every 2 years, or less frequently—some suggesting as infrequent as every 5 years. Or the open enrollment period could be a one-time event in 2014 with subsequent special open enrollment periods only for individuals experiencing qualifying life events that change eligibility for coverage, such as giving birth or attaining adulthood, divorce, or changing jobs.³ Any open enrollment period frequency would need to provide for portability between health plans for those who have remained continuously covered.

A range of penalties could be applied that generally either increase the cost or restrict access to coverage for late enrollees.⁴

- **Increase costs:** Late enrollees could enroll during subsequent open enrollment periods, or possibly between open enrollment periods, but incur financial penalties. Such penalties could take the form of requiring retroactive payments of

¹As referenced in encl. II, the American Health Benefit Exchanges (the Exchanges) must provide for an initial open enrollment period in 2014, followed by annual open enrollment periods in subsequent years, as defined by the Secretary of Health and Human Services. The Exchanges must also provide for special enrollment periods in certain circumstances.

²For individuals 65 and older, Medicare Part B covers physician and outpatient services, and Medicare Part D covers prescription drugs. Under these programs, beneficiaries who do not enroll when they are first eligible may have to pay late enrollment penalties in the form of higher premiums.

³A broad definition of qualifying life events would be required to assure all scenarios are covered and to assure portability continues to exist between health plans for those continuously covered.

⁴The types of penalties could also be combined—for example, a waiting period combined with a small financial penalty.

Enclosure III

missed premiums from the date of the last open enrollment period,⁵ or a flat or gradually escalating premium penalty depending upon the length of time without coverage.⁶ To encourage individuals to maintain their coverage once enrolled, the premium penalties could decline after a period of continued coverage, until they are eventually eliminated. Other financial penalties could include higher cost-sharing for the individual, such as copayments, coinsurance, or deductibles. Another financial penalty could be to reduce or deny subsidies for otherwise eligible late enrollees. Another variation would be to provide a premium discount to all individuals who enroll when first eligible, but withhold the discount from late enrollees.

- Restrict access to coverage: Late enrollees could enroll during subsequent open enrollment periods or possibly between such periods, but face restrictions on the extent of coverage available to them. For example, insurers could use medical underwriting⁷ to identify preexisting medical conditions that could be excluded from coverage for a period of time.⁸ Alternatively, insurers could limit access to plans offered in the Exchanges with more limited benefits, such as those at or below the level of the bronze plan.⁹ Another variation is to limit for late enrollees the ability to move up to more generous plans within the Exchanges or limit access to any plans within the Exchanges. Late enrollees could be eligible for a specified period only for high risk pool coverage, where premiums may be higher.¹⁰

Individuals who experienced a qualifying life event, such as becoming newly eligible for coverage by birth or attaining adulthood, divorce, or changing jobs, would not be considered late enrollees and thus not be subject to these penalties.

⁵For example, an individual who missed an annual open enrollment period from December 1 through December 31 and joined in the subsequent April would be required to pay retroactive premiums from January through March.

⁶For example, a 10 percent penalty might apply for the first year of late enrollment, a 15 percent penalty for the second year, and a 20 percent penalty for the third year, and so on.

⁷Medical underwriting is a process used by insurers to assess an applicants' health status and other factors to determine the basis of premiums, the extent of coverage provided, or whether to provide coverage at all.

⁸As referenced in encl. II, PPACA prohibits insurers offering group or individual coverage from excluding coverage based on any preexisting conditions and requires insurers to accept every individual and employer that applies for coverage in that state, subject to certain requirements.

⁹As referenced in encl. II, in order to participate in the Exchanges, health plans generally must offer essential benefit packages, as defined by the Secretary, with at least one of four levels of coverage, from lowest to highest—bronze, silver, gold, or platinum.

¹⁰Thirty-five states have established high risk pools that provide coverage of last resort for high risk individuals who do not have access to group insurance and have been denied individual market coverage because of their preexisting medical conditions. In addition, PPACA provided for the establishment of a temporary federal high risk pool program for individuals who have preexisting conditions and who have been uninsured for 6 months prior to applying for the program. This federal risk pool program will operate until 2014. Pub. L. No. 111-148, § 1101, 124 Stat. 141.

Expert Views on Key Challenges, Trade-Offs, or Other Issues

- Financial penalties increase costs and can impose further barriers to individuals for whom affordability is already a concern. Even with subsidies, plans may not be affordable for some, and penalties would compound this concern.¹¹ Under any circumstances, financial penalties should not become so expensive as to preclude late enrollees from ever obtaining coverage. For example, a gradually escalating premium penalty could be capped at some point so those who are unable to enroll when first eligible will not face prohibitively high premiums forever when they do attempt to enroll.¹² Incentives for timely enrollment may work better than penalties for late enrollment.
- Infrequent open enrollment periods—particularly with restricted access to coverage in between—may be perceived as punitive and may be contrary to the goal of coverage expansion. For example, a frequency of 2 years or less often, coupled with coverage exclusions for preexisting conditions for late enrollees, may provide a strong incentive to obtain coverage when first eligible, but also reinforces the uninsured status of individuals that PPACA addresses. That is, individuals not electing coverage during open enrollment could be locked out of the health insurance market for an extended period of time and remain uninsured.
- A waiver of financial penalties or coverage exclusions could be considered for certain low-income individuals.
- Open enrollment periods and penalties tend to be more effective in prompting individuals to enroll who are risk-averse or have access to highly subsidized insurance, such as individuals whose employers offer and subsidize coverage, or the Medicare population. Open enrollment periods and penalties may be less effective in prompting enrollment among young and healthy individuals who may not believe they will get sick and are thus less risk-averse, and those without access to subsidized coverage.

Expand Employers' Roles in Autoenrolling and Facilitating Employees' Health Insurance Enrollment

Expert Views on Alternative Approach

To help expand the number of employees with coverage in the absence of a mandate, the autoenrollment requirement for large employers under PPACA could be expanded to include smaller employers, potentially including those that do not offer coverage.¹³ In addition, employers that do not offer coverage to their employees could

¹¹ As referenced in encl. II, certain individuals may qualify for premium tax credits and cost sharing reductions when enrolling in a plan offered through an Exchange.

¹² Some experts suggested a cap of 150 percent of premium.

¹³ As referenced in encl. II, beginning in January 2014, PPACA requires employers with more than 200 full-time employees (FTEs) that offer health coverage to automatically enroll new FTEs into one of the plans they offer if they do not enroll themselves. Employers must provide adequate notice and the opportunity for employees to opt out if they so choose.

be required to play a role in facilitating their employees' access into plans offered in the exchanges, including deducting employee premium contributions from payroll.

- Expanded Autoenrollment with Opt-Out

The goal of this approach is to overcome individuals' inertia in choosing a plan by having employers automatically enroll them if they do not enroll themselves. As with current autoenrollment requirements under PPACA, employees could opt out of the plan to which they have been autoenrolled. With the default option of enrollment in coverage unless it is declined, however, participation rates may be higher than they otherwise would, particularly among the young and healthy who may be less motivated to actively enroll but who may retain the coverage once enrolled. Rather than limit this autoenrollment requirement to employers with more than 200 employees, the requirement could be expanded to smaller employers, possibly also including those who do not offer health insurance. Where employers do not offer coverage, their role would be to autoenroll employees into a plan through the Exchanges. Employees without existing coverage would be given a short window to select a plan offered by their employer, or receive information about the plans offered through the Exchanges if the employer did not offer coverage.¹⁴ Employees who do not voluntarily enroll by the deadline would then be automatically enrolled into the most basic, low-cost plan offered by the employer, or randomly assigned into the lowest level plan offered through the Exchanges.¹⁵ Employees could opt out or select a different plan within a specified time frame. After that time, employee premium contributions would be deducted from their paychecks and, if applicable, sent to the appropriate health plans in the Exchanges.

Autoenrollment leverages employers' experience in administering payroll deductions and benefits. Since employers know whether employees have enrolled in their coverage and have access to their payroll, two key problems in providing coverage for the uninsured—identification of the uninsured and collection of premiums—are mitigated.¹⁶ Also, autoenrollment may be more palatable than a mandate because employees incur no financial penalties for opting out.

- Employer Facilitation of Employee Coverage Through Exchanges

Under this approach, employers that do not offer health insurance coverage could facilitate their employees' voluntary enrollment into health plans offered through the Exchanges. As in autoenrollment, the workplace would be the venue to determine insurance status, educate employees about their health care choices,¹⁷ and assist in

¹⁴This period could coincide with an open enrollment period for existing employees. New employees could have a similar window at the time of hire.

¹⁵The coverage would be portable for individuals moving between employers and from group to individual coverage.

¹⁶Since more than two-thirds of the uninsured are working, low-income people, autoenrollment through employers would be effective in reaching this group.

¹⁷As referenced in encl. II, PPACA requires employers to provide employees with certain information about the Exchanges.

the enrollment process.¹⁸ Once employees have selected a plan, their premium contributions could be deducted from their paychecks and forwarded to the Exchange in their state. Employers may choose to contribute to premium costs on the basis of a defined contribution amount or a percentage of premium, or they may choose to contribute nothing. To provide incentives for employees to purchase plans through the Exchanges, pre-tax premium deductions could be permitted for this coverage, similar to the tax treatment of employer-sponsored coverage.

Expert Views on Key Challenges, Trade-Offs, or Other Issues

- The cost and complexity of autoenrollment is likely to be greater for smaller employers and for employers who do not offer health coverage. Autoenrollment could involve significant costs particularly for small employers without personnel or administrative systems in place to help with the process. Employers that do not currently offer coverage will face new requirements relating to plan selection and enrollment, amending payroll and other systems to collect data and deduct premium contributions, and making payments to insurers. And because the deductions from worker paychecks will be significantly higher where the employer had not previously offered coverage—typically smaller employers—these employers may encounter negative reactions from employees surprised by large deductions from their paychecks. These challenges to smaller employers would need to be considered in determining the appropriate employer size for an expanded autoenrollment requirement, whether the requirement should be imposed on employers that do not offer coverage, and whether financial assistance should be provided to help small employers manage the associated costs.
- The nature of the opt-out process has important implications. The more required of employees, the less likely they are to opt out. For example, requiring employees to talk to an individual or go to a Web site to decline may yield fewer opt-outs than simply handing employees a form to check a “yes” or “no” box. Employees requesting to opt out could also be provided information about the consequences of doing so, such as their liability for the full costs of medical expenses or the obstacles to later obtaining coverage after initially declining it. Also, the window of time during which employees may opt out, presents trade-offs. Shorter periods could result in employees being autoenrolled who were caught unaware by the short time frame and did not intend to be enrolled. Longer periods could result in employers deducting premiums for employees who later decide to opt out.
- Health care coverage may be viewed as a private or sensitive topic, and both employees and employers—particularly small employers—may be reluctant to discuss coverage issues. For example, employees may not wish to reveal to their employer their existing coverage through Medicaid—the government-sponsored

¹⁸Alternatively employers could hire brokers and agents to educate and assist employees, although hiring brokers or agents to help employers in educating employees about their health plan choices is not without challenges. Employers may be reluctant to bring insurance agents into the workplace or to adequately compensate them, and appropriate compensation mechanisms need to be developed to ensure employees are steered into the most suitable plans rather than those that maximize revenue for the brokers.

Enclosure III

health insurance program for certain low-income people—or other public programs.

- Strong resistance from employees could subject employers to legal challenges for placing employees in plans they did not want or that they believe to be unsuitable, such as single coverage versus family coverage. Autoenrollment may be viewed by some as simply too intrusive.
- Autoenrollment is more effective when the cost of health insurance is not an issue. Individuals with low income will be more likely to opt out due to the cost of health insurance premiums. Even with premium tax credits or cost sharing reductions, the lowest level Exchange plan—the bronze plan—may be too expensive for some individuals with low income.
- Employer and employee contributions for employer-sponsored health coverage are generally excluded, without limit, from employees' taxable income. However, employee premium contributions for health coverage obtained individually through the Exchanges would not be excluded from taxable income.
- Some of the same challenges related to autoenrollment may also apply to the employer facilitation approach—particularly to small employers—including the cost and complexity of enrollment and health plan selection,¹⁹ amending payroll and other systems to collect data and deduct premium contributions, employee and employer discomfort and privacy concerns related to health care coverage discussions, and cost issues. As with autoenrollment, these challenges to smaller employers would need to be considered in determining the appropriate employer size for a facilitation requirement and whether financial assistance should be available to help small employers manage the associated costs.
- This approach would not address the large number of uninsured individuals who are unemployed.

Conduct a Public Education and Outreach Campaign

Expert Views on Alternative Approach

Voluntary enrollment could be enhanced by a coordinated campaign to inform citizens about the benefits of voluntarily enrolling in health care coverage, the choices and costs of various health plans, and the implications of not enrolling, beyond what is provided for under PPACA.²⁰ Such a campaign may be combined with other approaches, and would be important to the successful implementation of any effort to encourage enrollment in health insurance, whether or not an individual mandate were included. It should use simple, easily understood language to

¹⁹The federal government or the Exchanges could provide model communication materials for small employers.

²⁰As referenced in encl. II, PPACA requires the Exchanges to facilitate enrollment into plans by providing adequate information to consumers. For example, the Exchanges are required to establish a program through which third parties—which may include health insurance agents and brokers—may receive grants to conduct public education awareness activities, distribute information about the plans, and facilitate enrollment.

Enclosure III

communicate its message. It should involve targeted outreach to specific groups of the uninsured such as the young and healthy, working families, or low-income groups. To better reach these groups, the campaign could partner with trusted individuals or organizations, including those not typically associated with health care or health insurance.

The campaign could focus on the benefits of obtaining private health insurance, including how affordable insurance may be after subsidies, the cost of health care services without insurance, and full coverage for preventive care, which may draw people who are uninsured due to cost concerns. Some of the advertising used to promote Massachusetts' health care reform could be used as a model. For example, to communicate the message that having health insurance is beneficial in a simple and easily understandable way, state officials used an advertisement showing an image of a person falling off a ladder and the costs of treatment for a broken arm with and without insurance.

The campaign would need to be based on a clear understanding of the demographics of the uninsured, and include targeted outreach programs to specific groups. Massachusetts, for example, realizing that many of the uninsured in the state tended to be young, male, and employed individuals, partnered with Major League Baseball's Boston Red Sox to advertise messages about health reform during live games as well as during breaks of televised games. An outreach campaign should partner with a wide range of trusted sources such as community-based organizations, unions, employers, and media figures to reach other specific groups of people. Health care providers could reach uninsured people at the point of service. Targeted advertising through large employers with many uninsured workers could reach the working uninsured and advertising on Internet-based social media networks could reach younger individuals. A campaign could include personalized information on average or expected costs based on medical information individuals provide, or hospital bills could include information on what the charged services would have cost under a plan in the Exchange. Web-based tools could also be provided to allow people to compare the costs of various plans. Funding for the campaign could be distributed in small grants to a variety of local community and volunteer groups rather than to a few large groups, to better reach smaller communities.

Expert Views on Key Challenges, Trade-Offs, or Other Issues

An education campaign without some incentive to encourage enrollment may not significantly affect enrollment. Conducting an education and outreach campaign could significantly increase costs. In addition, the money spent does not directly affect individuals' incentives, coverage, or costs of insurance, and the effects of a campaign can be difficult to measure.

Provide Broad Access to Personalized Assistance for Health Coverage Enrollment

Expert Views on Alternative Approach

The Exchanges could expand voluntary enrollment by providing broad access to individual assistance to make it as simple and convenient to enroll as possible, beyond their responsibilities under PPACA.²¹ For example, access points at commonly visited locations such as pharmacies, libraries, schools, and grocery stores could be set up. Qualified, licensed employees staffing these access points could provide one-on-one support to assist with the enrollment process. These employees could be paid a flat fee for enrolling individuals in qualifying coverage.

Face-to-face interactions and personalized help are vital in ensuring high participation rates. Other partners and approaches could be used to increase individuals' access to enrollment support. For example, trusted entities that already work with relevant personal data, such as health care providers, tax preparation volunteers, and other community service providers, could be encouraged to facilitate patients' enrollment into appropriate plans based on face-to-face interviews. Various Web sites and Internet services could be another way to provide personalized help to individuals by providing applications and tools to assist with the selection of an appropriate plan.

Expert Views on Key Challenges, Trade-offs, or Other Issues

- Recruiting adequate staff capable of providing informed and useful support to insurance consumers seeking to enroll in coverage at multiple access points could be expensive and challenging, and state regulation of individuals who sell insurance products would need to be considered.
- Online tools may not be as effective as one-on-one support because some people may lack the requisite computer equipment or skills to successfully navigate Web sites.
- The money spent on these activities does not directly affect individuals' incentives, coverage, or costs of insurance.

Impose a Tax to Pay for Uncompensated Care

Expert Views on Alternative Approach

Rather than a penalty associated with a mandate, a tax could be imposed on all taxpayers to help cover the costs of emergency room and other uncompensated care incurred by people without health insurance. The tax could be rebated or waived upon proof of health insurance, and would be assessed on a sliding scale based on income. A variant on this approach could be to assess the tax only on those who

²¹As referenced in encl. II, PPACA requires the Exchanges to perform several functions including establishing telephone hotlines to respond to requests for assistance, maintaining Web sites with standard comparative information on health plans, and awarding grants to third parties, which may include health insurance agents or brokers, to facilitate enrollment.

Enclosure III

receive uncompensated care. Individuals who receive uncompensated care could be identified by the health care provider by submissions to the Internal Revenue Service (IRS). The IRS could collect the tax from the uninsured individual and reimburse the provider. Under another variant, uninsured individuals could be denied the personal exemption allowed in the tax code. A third variant could be to impose a tax on those employers who do not offer health insurance if their employees incur uncompensated care costs, similar to the “Free Rider Surcharge” in Massachusetts.²²

Expert Views on Key Challenges, Trade-Offs, or Other Issues

- This approach may be considered by some to be a functional equivalent of a mandate.
- This approach will not work for people who do not file taxes, a group which may overlap with a large segment of the population that is uninsured and likely to incur uncompensated care.
- The same exemptions from the individual mandate penalty that exist under PPACA²³ would need to apply to an uncompensated care tax.
- If the tax were lower than the annual premium for the lowest cost plan—either an employer-sponsored or a bronze plan in an Exchange—people may choose to pay the tax if necessary and forego health insurance.

Allow Greater Variation in Premium Rates Based on Enrollee Age

Expert Views on Alternative Approach

To provide for lower premiums for the younger, often healthier individuals who are so important to bring into the insurance pool, PPACA premium rate variation requirements could be modified.²⁴ For example, as an alternative to premium rate variation based on age rating of 3 to 1, insurers could be allowed to provide for a premium rate variation based on age within a range of 5 to 1. Many states allow health plans to vary premiums based on age by 5 to 1 or more.²⁵

²²Under the “Free Rider Surcharge” in Massachusetts, businesses with 121 or more full-time equivalent employees who do not offer insurance may be required to pay a surcharge if their employees, or dependents of their employees, make significant use of the state’s Health Safety Net, formerly the Uncompensated Care Pool.

²³For example, uninsured federal taxpayers whose household income is below the applicable filing threshold are exempt from the financial penalties that may be imposed for failing to purchase health insurance.

²⁴As referenced in encl. II, PPACA permits insurers offering individual or small group coverage through the Exchanges to vary premiums based only on certain factors including age by no more than a 3 to 1 ratio.

²⁵“Impact of Changing Age Rating Bands in ‘America’s Health Future Act of 2009,’” Oliver Wyman, September 28, 2009.

Expert Views on Key Challenges, Trade-Offs or Other Issues

While allowing greater variation could result in lower premiums for younger enrollees, premiums could increase for older enrollees, potentially creating barriers to access for some of these individuals.

Condition the Receipt of Certain Government Services Upon Proof of Health Insurance Enrollment

Expert Views on Alternative Approach

A “government services mandate” could condition the receipt of certain services that the federal government currently provides—such as a college loan—on proof of health insurance coverage. Individuals attempting to obtain such services could be encouraged or required to have health insurance. A rational connection should exist between the conditioned service and health care. For example, a college student’s illness coupled with lack of health insurance could result in failure to complete college. Therefore it might be appropriate to require students availing themselves of federal college loans to have health insurance. The selected services should also relate specifically to uninsured populations. Insurance status would have to be continuously monitored to ensure coverage between the provision of services, for example before each disbursement of a college loan.

Expert Views on Key Challenges, Trade-Offs, or Other Issues

- A government services mandate may be considered a functional equivalent of a mandate.
- This approach would place significant administrative burdens on multiple public agencies to determine health insurance and potential exemption status.
- As an unintended consequence of this approach, people may forego services to avoid having to purchase health insurance.
- This approach could deprive an already vulnerable population of necessary services.
- Such an approach would provide an inducement only to those who receive the government services that are conditioned upon having health insurance.

Use Health Insurance Agents and Brokers Differently

Expert Views on Alternative Approach

Currently, insurers typically pay agents and brokers to sell health insurance through commissions based on the price of the product sold. This may motivate them to sell higher cost products or products that may not best meet the needs of individuals. Under PPACA’s medical loss ratio (MLR) requirements, insurers will be required to use a certain percentage of their premium revenues for reimbursement of clinical

Enclosure III

services and health care quality improvement activities,²⁶ limiting revenue available for administrative expenses—including compensation for agents and brokers—to 15 percent or less for insurers in the large group market and 20 percent or less for insurers in the individual and small group markets. Experts anticipate that these new MLR requirements may significantly reduce compensation available for agents and brokers.

Alternate ways could be developed to hire and compensate a workforce of agents and brokers and leverage their existing expertise to facilitate coverage through the Exchanges. Exchanges or small employers that do not offer insurance could hire agents and brokers to assist uninsured individuals or employees to select and enroll in appropriate plans.²⁷ Alternatively, the MLR requirement in PPACA could be amended to provide insurers with more flexibility to use premium revenue to compensate brokers for providing certain value-added services, such as identifying opportunities for explaining variations in plans through the Exchanges for individuals as well as opportunities for premium tax credits and cost sharing reductions. Also, agents and brokers could be paid a flat fee for enrolling previously uninsured individuals in qualifying coverage in the Exchanges, reducing any incentive to sell more expensive coverage that might not be appropriate for the consumer.

Expert Views on Key Challenges, Trade-Offs, or Other Issues

- Paying agents and brokers adds to the administrative costs and may be less cost effective than other means of encouraging enrollment.
- Developing appropriate compensation mechanisms is needed to provide incentives for the enrollment of individuals in the most appropriate plans.
- Allowing agents to identify individuals without insurance could compromise the privacy of the uninsured.
- Agents and brokers would need to have the cultural fluency relevant to uninsured populations.
- Changing the MLR requirement could result in less premium revenue available to spend on health care or could result in premium increases.

²⁶See encl. II for additional information on this requirement.

²⁷As referenced in encl. II, under PPACA, the Secretary of Health and Human Services must establish procedures under which states may allow agents and brokers to enroll individuals and employers in health plans offered through the Exchanges and assist individuals to apply for premium tax credits and cost sharing reductions. PPACA also provides that the Exchanges award grants to entities, which may include agents and brokers, to facilitate enrollment. Thus, agents and brokers may be a resource to address other approaches to encourage voluntary enrollment discussed in this document such as those relating to public education and outreach and providing access to personalized assistance.

Require or Encourage Credit Rating Agencies to Use Health Insurance Status As a Factor in Determining Credit Ratings

Expert Views on Alternative Approach

Credit rating agencies could be required or encouraged to use individuals' health insurance status in the determination of credit scores, encouraging individuals to obtain health insurance to improve their access to credit. Currently, health insurers do not report data to credit rating agencies. Lenders use credit scores to determine to whom they should issue loans, particularly for home or automotive purchases. A lack of health insurance could be used as a measure to help assess the risk of bankruptcy due to increased risk of catastrophic health costs. In addition, individuals looking to build a credit history could use the prompt payment of premiums as evidence of credit-worthiness.

Expert Views on Key Challenges, Trade-Offs, or Other Issues

- Credit rating agencies would need to first research the relationship between health insurance status and credit worthiness, and the implications of linking credit scores to health insurance status for low-income individuals.
- Credit rating agencies would need to consider how to treat enrollment in public programs like Medicare and Medicaid.
- The penalty in this case—a poor credit score—may be too abstract or uncertain to motivate individual behavior. Many uninsured and low-income individuals may not pay attention to their credit rating because they do not anticipate taking out home or automotive loans.
- Reporting systems of agencies that collect health insurance information and interface with credit reporting systems would require standardization.
- The penalty may disproportionately affect low-income individuals, who may already face challenges in access to credit.

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