Dedicated Insurance and Minimal Essential Coverage

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Background

The Patient Protection and Affordable Care Act imposes a tax penalty on individuals who do not maintain "minimum essential coverage" in 26 USC 5000A. A dedicated insurer is a state-authorized entity which provides insurance to a single designated individual. For a plan issued by a dedicated insurer to provide minimum coverage, it needs to comply with the applicable federal law and regulations.

Dedicated Insurance and Congress's Intent

Part I of Subtitle F of Title I of the Affordable Care Act is intended to do just what its title suggests – promote individual responsibility within the context of promoting quality, affordable health care for all Americans. In contrast, it is not intended to allow large insurers to extort money from individuals under the guise of the tax code.

By demonstrating fiscal responsibility to the State, dedicated insurers provide a reasonable mechanism for people to meet their healthcare responsibility requirements. In particular, the associated savings will help prevent medical bankruptcies and reduce uncompensated care. Just as employers with a single employee can provide essential coverage under the direction of the Secretary of Labor, coverage providers need not insure a large number of individuals to comply with the law.

Regulatory Compliance

Most federal health insurance regulation has been influenced by the Affordable Care Act, which modifies the Public Health Service Act. Other provisions of federal law were enacted through the Health Insurance Portability and Accountability Act. There have been a modest number of acts amending these statutes consistent with their high-level goals. Regulations authorized through those acts are generally promulgated through the department of Health and Human Services, which has the authority to regulate health insurance issuers. Issuers are defined in 42 USC 300gg-91:

The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance…

A corporate dedicated insurer is clearly an insurance company and meets the requirements to be an issuer. While not all plan sponsors meet this definition, if a plan is treated as insurance under state law, it is generally treated as insurance under federal law. For this reason, we can assume a natural person issuing coverage will be considered an insurance organization with respect to their insurance activities.

In general, the Affordable Care Act regulations may be divided into five major categories: scope of coverage, health status non-discrimination, informational requirements, information technology, and risk transfer. Each area is worth considering in detail.

Scope of Coverage
Plans issued by dedicated insurers can easily comply with the essential health benefit requirements of ACA section 1302(a), preventive health coverage under 2713, and actuarial value requirements as verified by the HHS calculator. The designated insurable individual can simply choose to forgo those services viewed as undesirable. The drafting of a plan documenting this coverage is similar to the drafting of a summary plan document required by ERISA plans serving very small employers and may be based on a simple statement offering full coverage of those health benefits enumerated in the law.

Health Status Nondiscrimination
Within the affordable care act, there are a number of provisions intended to prevent insurers from discriminating against patients based on health status. It is fairly obvious that dedicated insurers can comply with most provisions, however the guaranteed issue provision is worth considering in detail. In general, the guaranteed issue provision in 42 USC 300gg-1 requires insurers that accept applications issue coverage to all applicants. However, this provision does not apply to dedicated insurers for a number of reasons. The guaranteed issue provision states:

Subject to subsections (b) through (e), [1] each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

This is clarified further under regulations in 45 CFR §147.104:

Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or employer in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products. (b) Enrollment periods…

Direct Issuance
As with employer plans and student health plans, dedicated insurance is issued subject to an enrollment process without an associated application process. Since no application process exists, no individuals "apply" for dedicated insurance coverage. Given the unique nature of the insurer, it is unlikely that anyone other than the designated individual would even want to apply for such coverage. With respect to the regulation, dedicated insurance is not "approved for sale" as the coverage is not sold, and is not "approved" but authorized according to a lower standard of regulatory scrutiny. A dedicated insurer issues coverage, but does not generally "offer" coverage within the meaning of §147.104 or 300gg-1. As such, the guaranteed issue provisions do not apply to dedicated insurers.

State Law
Just as federal law prohibits purchase of plans through the exchange by incarcerated individuals, state law can limit which individuals can obtain coverage from other insurers outside of the exchange provided the limitations do not involve health status. Indeed, state law is preempted only "*to the extent that such standard or requirement prevents the application of a requirement*" of the PHS Act, which is the standard of preemption most deferential to state law. Under *Wyleth v Levine*, states are given deference with respect to which laws are viewed as preemptive. Dedicated insurers are not obligated to issue coverage contrary to federal or state law, and state law limits dedicated insures to providing coverage to only designated insurable individuals.

Financial Capacity

Dedicated insurers are exempt from guaranteed issue based on their lack of financial capacity to insure anyone other than the designated insurable individual based on the unique economic nature of the arrangement. The code at 42 USC 300gg-1 states:

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—
(A) it does not have the financial reserves necessary to underwrite additional coverage; and
(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals…

While there is a 180-day suspension associated with a denial of coverage under this provision, it is unlikely that a dedicated insurer will need to issue coverage more than once per calendar year.

Informational Requirements

There are a number of informational requirements embedded in the ACA. These include the explanation of coverage, health plan ID number assignment, consumer information reporting, and loss ratio reporting.

Explanation of Coverage

HHS provides very detailed guidance on how to create the uniform explanation of coverage document as required by 45 CFR 147 and ACA section 2715. Dedicated insurers can complete this using the template provided by HHS. Since plans are unlikely to change, this is effectively a one-time requirement.

Health Plan ID

Dedicated insurers should be able to obtain a health plan ID under 45 CFR 162 after providing contact information to HHS. HHS may need to revise its systems to accept information from non-corporate insurers; in the worst case dedicated insurers may need to use corporate form and assign some nominees to corporate roles.

Consumer Information Reporting

While HHS excludes information on plans not accepting enrollment from publication, HHS requires plans to report information specified in ACA section 1103 and 45 CFR 159. This information is administrative in nature and easy for a dedicated insurer to provide. For non-corporate entities, HHS may need to change account provisioning procedures for its submission system, or the dedicated insurer may need to assign a nominee to a particular corporate role such as CFO.

Medical Loss Ratio Reporting

Most insurers are required to keep administrative expenses below 20% within the individual market under ACA section 2718. Existing HHS regulations already provide that an insurer with under 1,000 covered lives is not credible and exempt from MLR rebates. However, MLR information must be reported to HHS under 45 CFR 158. In general, dedicated insurers will not charge a premium and not process claims, resulting a perfunctory report. As with other requirements, this may require revision to HHS processes or assignment of nominees.

Reporting of Coverage

Dedicated insurers will be able to report coverage as specified under ACA 1502 on IRS form 1094/1095.

Information Technology

Standard Transactions

Under section 1172 of HIPAA and 45 CFR 162, if a health insurer's trading partner requests that an insurer perform a common transaction electronically, that transaction must be performed according to a standard specified by federal regulation. Section 1104 of the ACA provides for operating rules and testing relating to these standards. Dedicated insurers are effectively exempt from the from the IT requirements because they will typically lack trading partners. As stated in the Final Rule on Health Insurance Reform: Standards for Electronic Transactions:

Use of a standard transaction does not create a relationship or liability that does not otherwise exist. A health plan would not be required by these rules to respond to such a request from a health care provider with whom it does not have a business arrangement.

It is anticipated that almost all designated insurable individuals will pay for service at the time such service is received. Payment would be rendered through the usual mechanisms traditionally insured consumers use to meet their copayment or coinsurance requirements including cash, check or credit/debit card. Since providers would need to process these payments in any event, rendering full payment in this manner is consistent with the goals of administrative simplification. Any other payment mechanism, no matter how well standardized, would add complexity as provider accounts and passwords would need to be provisioned.

In the unlikely event that a dedicated insurer choose to contract with trading partners, the relevant standards are available for purchase for under $1,000 and software could be developed under an open-source model for use by all dedicated insurers.

Information Security

Standards adopted under section 1173 of HIPAA and 45 CFR 164 require that protected health information be kept secured. Section 264 provides for standards concerning privacy. In general, dedicated insurers can keep such information private through the same mechanisms that designated insured individuals keep their information private, such as file encryption. In the unlikely event of a breach, the designated insured can deem themself to have authorized the release.

Risk Adjustment Dedicated Environment

The ACA risk-adjustment process requires a dedicated environment, but the data requirements of the environment have fluctuated and as such HHS provided a safe-harbor provision for entities that make a good-faith effort to comply with the requirements in 2015. It is expected these requirments can be met with minimal cost by provisioning used hardware or a cloud-based virtual machine.

Risk Transfer

The Affordable Care Act specifies three risk transfer programs: the temporary reinsurance program, risk corridor program, and risk adjustment. The risk corridor program only applies to plans in the exchange and would exclude dedicated insurers.

Reinsurance

ACA section 1341 and 45 CFR 153 provide for a transitional reinsurance program whereby insurers receive 50% reimbursement for paid claims between $45,000 and $250,000 in 2015 and $90,000 and $250,000 in 2016. Participation in the program is dependent on inclusion in an insurers "*commercial book of business*" as specified in 45 CFR §153.400. A commercial book of business generally includes individual market policies.

In any event, participation in the program requires payment of a premium and fees of under $50/year and could be of use while the market for reinsurance develops products for dedicated insurers. As such, there is little downside to participation in the program.

Risk Adjustment

Under section 1343 of the ACA and 45 CFR 153, plans would participate in a risk adjustment program whereby payments are made to offset the difference between a plan's actuarial risk and the average actuarial risk of plans within the same market. This is intended to mitigate adverse selection whereby sicker patients would choose plans with the best customer service and healthier patients would choose the cheapest plan, leading to insolvency of customer-friendly insurers. Actuarial risk is computed based on demographic information, medical factors, and plan characteristics. The actual computation of adjustment payments uses simple mathematical formulas and tables, and can be automated with the use of spreadsheets or open-source software.

In principle, risk adjustment is compatible with dedicated insurance, as the savings of dedicated insurance comes from the difference between actual medical expenses and actuarially expected expenses rather than minimization of actuarial risk. The risk adjustment program would reward individuals with high actuarial risk for lowering costs, and as the savings would be taxable, the benefits could be shared with society as a whole.

Dedicated insurance plans differ somewhat from traditional plans. For example, a traditional plan in the Platinum metal tier would have greater induced demand actuarial risk than a Silver plan, as patients with higher expenses tend to enroll in plans with lower coinsurance requirements. However, the designated insured individual ultimately incurs the financial consequences of all medical expenses within dedicated plans, even if the plan has a high nominal actuarial value. This suggests that HHS may alter risk adjustment with respect to dedicated insurers.

Auditing

If dedicated insurers participate in risk adjustment under the current regulations specified in §153.630, they will be audited every year by an auditor selected by the insurer and then by an auditor contracted by HHS. Since there are few standards for auditors, the private auditor could be obtained through a crowd-sourcing website at low cost, or dedicated insurers could audit each other. The HHS audit would be conducted at HHS expense. Since the audits would be redundant, it is possible that HHS would apply an IRS-style random audit to dedicated insurers.

IRS Recognition

The IRS has confirmed that any dedicated insurer which can be regulated by HHS is within the individual market with respect to 26 USC 5000A, and able to offer minimum essential coverage, even if the plan is offered to only one individual. This is consistent with the treatment of very small ERISA plans in 42 USC 300gg-91:

(1) Individual market
(A) In general
The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.
(B) Treatment of very small groups
(i)In general Subject to clause (ii), such terms [2] includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Conclusion

Under our federal system, states have traditional had broad powers to regulate their insurance markets, many of which are explicitly reserved to the states under the PPACA. Dedicated insurers operating under simple rules prescribed by the state legislature and regulated by the state's insurance authority can help individuals obtain the healthcare they desire at an acceptable cost, while maintaining compliance with federal law.