

NATIONAL
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INSURANCE

**Improving Coverage and Cost through
Health Insurance Reform**

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Before the election of Barack Obama in 2008, it was not uncommon for Democrats and Republicans to single out a similar roster of problems with the American health care system – high and rising costs and unmet needs. “Negative consensus” was how Paul Starr summarized the familiar litany a quarter century ago.¹ This common diagnosis of the systemic illness never gave way, however, to a shared agenda of a feasible remedy – even when there were overlapping ideas, such as the bipartisan use of subsidized insurance exchanges in Massachusetts and in the Affordable Care Act (ACA).

The political polarization that greeted the introduction, enactment, and implementation of the ACA after its passage in 2010 confirmed the futility of relying solely on a negative consensus to produce a shared agenda of reform. Following the ACA’s launch, the dire circumstances of America’s negative consensus eased considerably, as health-care cost inflation and gaps in coverage declined sharply, according to independent sources and abundant evidence.

The new President and Congress are committed to repealing the ACA. The key question facing policymakers is how to replace it. Although the negative consensus did not translate into agreement on reform, the new leadership is now coming to terms with the reality introduced over the past seven years of stronger coverage and lower health inflation. In the process, lawmakers must wrestle with a daunting question: How can they change the ACA without reversing progress that the law has achieved on coverage and cost control?

This section is directed at addressing this question. It focuses on policy changes that may enjoy support and prove feasible.

Background

The “negative consensus” prior to the Affordable Care Act

The ACA was passed after decades of proposals by both parties to mitigate a stubborn set of problems related to gaps in coverage and high and rising health care costs. Strikingly similar speeches from across the aisle lamented the gaps in affordable insurance coverage for working families and children, along with the catastrophic impacts of high health inflation on America’s economic competitiveness and workers’ economic security.

¹ Paul Starr, 1992, *The Logic of Health Care Reform*, Knoxville: Grand Rounds Press.

The United States has historically faced a massive gap in insurance coverage.

Tens of millions of uninsured Americans

The United States has historically faced a massive gap in insurance coverage. In 2013, one year before the major coverage provisions of the ACA went into effect, more than 43 million adults under age 65 lacked coverage, and uninsurance rates had hovered above 15 percent for decades.² Poor and low-income adults, as well as people with serious pre-existing health conditions, were particularly likely to lack coverage, primarily because coverage was unaffordable or unavailable.³ Unlike other affluent countries, all of which have some type of universal health insurance framework that guarantees coverage, health insurance coverage in the United States has always been contingent and piecemeal – a patchwork of coverage through employers, Medicare, Medicaid, the Veterans Health Administration, and other programs. Those not covered through such larger systems were relegated to the very expensive and loosely-regulated private individual insurance market.

To reduce the coverage gap, the ACA used a variety of approaches, including: a major expansion of Medicaid to cover previously uninsured poor adults, new rules for insurers that prohibited turning individuals away due to pre-existing conditions or limiting access to basic services, a requirement that individuals obtain coverage or else pay a fine, tax credits and cost-sharing reduction payments to improve affordability, and the establishment of regulated health insurance exchanges to increase and streamline access to private insurance plans.

The Medicaid expansion extended coverage beyond specialized populations (e.g., children, pregnant women, persons with disabilities) to include all low-income adults under age 65. Due to a Supreme Court ruling following the passage of the law,⁴ however, states gained the option of choosing whether or not to participate in this expansion. To date, 31 states and the District of Columbia have implemented the Medicaid expansion, leaving 19 that have not. This has created an unexpected “coverage gap” of 2.6 million Americans in states that did not expand Medicaid – a number that includes those

² Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, 2016, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2016, National Center for Health Statistics, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>.

³ Rachel Garfield, Rachel Licata, and Katherine Young, 2014, “The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA,” Kaiser Family Foundation, <http://kff.org/report-section/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca-introduction/>.

⁴ 567 U.S. *National Federation of Independent Business (NFIB) v. Sebelius*, 2012, <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

individuals too poor to receive tax credits, but outside of the categories that qualify for traditional Medicaid coverage.⁵

To make health plans more affordable and accessible to low- and moderate-income individuals and families now required to comply with the new health insurance coverage requirement, the ACA also offered premium tax credits and cost-sharing reductions and established health care exchanges to facilitate the purchase of standardized health insurance plans for individuals not otherwise covered under a federal, state, employment-based, or group health insurance plan. Overall, the ACA has succeeded in extending coverage to over 20 million people, reducing the national uninsurance rate across all ages to 8.6 percent – the lowest in the country’s history – and to 11.9 percent among adults under age 65.^{6,7}

Inadequate policies left even covered Americans underinsured

Prior to the ACA, the health care plans that many people purchased on the individual insurance market – that is, plans not purchased through an employer or another group – often failed to cover the full range of health-related risks faced by consumers. Insurers often excluded coverage for pre-existing conditions, leaving many without insurance for the conditions that most required coverage. Since the individual market lacked a

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broad risk pool with adequate enrollment of healthier consumers, carriers underwrote coverage in the individual market to the fullest extent possible. Health insurance companies could – and often did – deny applications for coverage based on an individual’s medical history, leaving others without coverage all together.⁸ Consumers who purchased plans on the individual market could suddenly see their coverage dropped if they became sick, based on allegations of omissions to their medical history forms from the insurance carrier. Women were frequently required to pay more than men for coverage.

⁵ For a more detailed discussion of the coverage gap, please see: Rachel Garfield and Anthony Damico, 2016, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, Kaiser Commission on Medicaid and the Uninsured: The Henry J. Kaiser Family Foundation, <http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

⁶ Cohen, Martinez, and Zammiti, 2016.

⁷ Research by The Commonwealth Fund found that, in 2013, marketplace enrollment accounted for between a 1.7 to 2.3 percent reduction in the uninsurance rate among adults under age 65, while Medicaid expansion further reduced the uninsurance rate by between 0.76 and 1.0 percentage points; Sherry Glied, Stephanie Ma, and Sarah Verbofsky, 2016, How Much of a Factor is the Affordable Care Act in the Declining Uninsured Rate? The Commonwealth Fund, <http://www.commonwealthfund.org/publications/issue-briefs/2016/dec/aca-declining-uninsured-rate>.

⁸ Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila Rustgi, 2009, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, <http://www.commonwealthfund.org/publications/issue-briefs/2009/jul/failure-to-protect>.

And many plans did not cover common, critical health needs and services such as maternity care, prescription drugs, and mental health or substance abuse treatment.⁹

To improve the quality of health insurance coverage on the individual market, the ACA included multiple reforms to protect consumers. The law significantly limited the practice of underwriting by insurance carriers, but these were balanced with stabilizing influences, such as the formation of a single risk pool of consumers and an individual mandate for health insurance coverage to broaden the enrollee base. Although some existing plans that failed to meet these standards were “grandfathered” in by the ACA¹⁰ (and subsequent legislation), the ACA ended coverage exclusions and premium surcharges based on pre-existing conditions for all non-grandfathered plans in the individual market and for all plans – including grandfathered plans – in the group market. Today, insurance companies can no longer cancel an enrollee’s plan for any reason other than fraud or failure to pay.

To extend affordable coverage for young adults, the ACA allowed individuals under the age of 26 to remain insured through their parents’ health plans. Additionally, the ACA put into place some protections and limits on out-of-pocket health care costs for consumers. For example, the law eliminated annual and lifetime caps on coverage, capped out-of-pocket expenditures for in-network services, and prohibited insurers from selling coverage with an actuarial value below 70 percent. It also required insurers to spend at least 80 percent of premium revenue on care instead of administration, marketing, advertising, and profit. To encourage the use of preventive care, the ACA additionally mandated that plans offer many preventive measures, like annual check-ups, without cost-sharing.¹¹

High provider costs system-wide

A key argument made by supporters of the ACA was that the U.S. health care system pays much higher provider and pharmaceutical costs than those of any other country in the world. If not brought under control, these health costs threaten to consume

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⁹ Heidi Whitmore, Jon R. Gabel, Jeremy Pickreign, and Roland McDevitt, 2011, The Individual Insurance Market Before Reform: Low Premiums and Low Benefits, *Medical Care Research and Review*, 68(5), 594-606.

¹⁰ A “grandfathered health plan” is a group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010. If these plans or policies make certain significant changes by reducing benefits or increasing costs for consumers, they may lose their “grandfathered” status under the law.

¹¹ Robert Wood Johnson Foundation, 2011, What consumer protections are embedded in the Affordable Care Act?, Issue Brief, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71392.

an unsustainable share of federal and state budgets, and to erode Americans' already stagnant disposable incomes.¹² This policy challenge addressed by the ACA is beyond the scope of this section (for a discussion of reining in prescription drug prices, see 2.d of this *Report*).

The ACA included a variety of measures to help contain health care cost growth, particularly in Medicare and other public programs, but also across the entire health care system. These measures included: payment reforms that aimed to slow the growth in spending on providers and health plans contracting with Medicare; delivery system reforms that aimed to shift provider payments from a system of fee-for-service reimbursement to one that better focuses on episodes of illness or injury and care coordination across different providers and settings; and investments in prevention and public health that aimed to prevent costlier illness and injury in the long term.¹³



Policy Challenges

The ACA's implementation has revealed challenges that need to be addressed in order to further improve access to and the affordability of health insurance coverage.

Insufficient competition in the health care exchanges

While most of the ACA's health insurance marketplaces opened with competing health insurance providers, competition between insurance companies had dropped dramatically in many states since 2014. This drop has been particularly striking for sales going into 2017; over a third of exchange market regions will have only one insurance carrier within their marketplace.

¹² RAND, 2011, *How Does Growth in Health Care Costs Affect the American Family?*, http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9605.pdf.

¹³ Kersten Lausch, Erin Shigekawa, Daphna Stroumsa, and Ruth E. Tabak, 2014, *Cost Containment in the Affordable Care Act: An Overview of Policies and Savings*, Center for Healthcare Research and Transformation, <http://www.chrt.org/publication/cost-containment-affordable-care-act-overview-policies-savings/>.

This reduction is in large part the result of major insurance carriers pulling out of the marketplace, as well as the failure of the coops, which seriously underpriced the market in almost every state in which they operated.

Excessive risk burden for health insurance companies

In the first few years of offering health care coverage on the exchanges, many insurance carriers have experienced risk pools that include more sick individuals and fewer healthy people than originally expected. Individuals signing up for health insurance coverage have tended to be less healthy than those who have opted out of purchasing coverage, though the risk pool has become healthier over time since the first open enrollment period.^{14,15} Many carriers are responding to the burden of a costlier-than-expected risk pool by raising premiums.

Insufficient verification of special Enrollment Periods

A common concern among insurers is that the Special Enrollment Periods – qualifying times for purchasing plans on the health insurance exchanges outside of open enrollment due to major life events, such as giving birth or losing a job – are too flexible. As a result, insurers believe that consumers are purchasing plans only when they are sick and then allow the coverage to lapse after using it, which contributes to their costs.¹⁶ CMS has acknowledged that there are some concerns with the Special Enrollment Periods and is piloting efforts to address the issues, though the size of the effect that these special periods have had on raising costs remains controversial.¹⁷

Insufficient protections for insurers from the “Three Rs”

The ACA provided three premium stabilization programs for insurers – the “Three Rs” – Risk Adjustment, Reinsurance, and Risk Corridors. Yet, these have not been implemented as promised or lived up to their full potential. Risk Adjustment was designed to level the playing field among insurers, such that those who take on healthier-than-average enrollees would pay funds to CMS to compensate insurers with a greater proportion of higher-cost enrollees. Reinsurance was designed to protect high-risk consumers from excessive premiums by compensating insurers for any spending above a certain threshold on an individual enrollee. Risk Corridors were designed to protect plans from excess aggregate risk and thereby encourage lower

¹⁴ Centers for Medicare & Medicaid Services, 2016, Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-Risk-Pool-Analysis-8_11_16.pdf.

¹⁵ For further discussion of the risk pool balance in the exchanges, see: Timothy Jost, 2016, CMS Report Cites Flat Per-Enrollee Costs in ACA Marketplaces, *Health Affairs Blog*, <http://healthaffairs.org/blog/2016/08/11/cms-report-cites-flat-per-enrollee-costs-in-aca-marketplaces/>.

¹⁶ Chris Carlson and Kurt Giesa, 2016, Special Enrollment Periods and the Non-Group, ACA-Compliant Market, Oliver Wyman, <https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf>.

¹⁷ Centers for Medicare and Medicaid Services, 2016, Special Enrollment Periods for the Health Insurance Marketplace, Fact Sheet, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-05-06.html>.

premium bids. The first two Rs worked roughly as expected, but Congress reduced promised and expected Risk Corridor payments through the appropriations process after the law and premium bids were in effect, and the House of Representatives has an ongoing lawsuit seeking to enjoin the cost-sharing reductions. As a result, the ensuing unexpected losses and uncertainty have intensified pressures for insurers to raise premiums and exit the marketplaces.¹⁸

Rising costs for consumers: Many consumers on the health insurance marketplace are, after two years of minimal premium increases, facing sharp increases in the price of coverage for 2017 – though these increases have been greatly cushioned by the tax credits available for coverage. Price hikes are particularly troublesome for the 20 percent of enrollees who do not receive premium tax credits and thus must pay the full cost of coverage. Increases in the premiums for coverage have been more prominent in some states than others, and are especially concentrated in states that elected not to expand Medicaid. Consumers have also seen higher cost sharing requirements through higher deductibles and co-pays as insurance carriers alter the design of their plans to control costs.

Burdensome application process for consumers

Consumer experience plays a critical role in determining whether or not uninsured individuals actually sign up for coverage through the new health insurance marketplaces. Yet, many who start the process of applying for coverage never complete it. For part-time workers or consumers with inconsistent work histories, the income estimator for tax subsidies is inefficient and is often unable to accurately estimate income. Health care navigators – individuals and organizations trained to assist with the process of securing coverage on the health care exchanges – are in short supply, and the exchanges are generally understaffed. When potential consumers do see their inherently complex plan options, moreover, many do not receive adequate explanation of the reasons for the costs or limits on provider networks.

The coverage gap

The ACA was designed to make private health insurance more affordable by offsetting costs for low- to moderate-income Americans through the subsidized exchange plans. The Medicaid expansion, in contrast, was designed primarily as a vehicle to extend coverage to uninsured poor adults. Yet, as a result of state decisions to reject Medicaid expansion, over two and a half million people still lack coverage. These individuals receive no federal support, even though individuals earning higher incomes (between 100-400 percent of the federal poverty line) are eligible for marketplace subsidies.

¹⁸ For a detailed explanation of the “Three Rs,” please see: Lisa Klinger, 2014, The “3 Rs”: Risk Adjustment, Reinsurance, and Risk Corridors, Leavitt Group, <https://news.leavitt.com/health-care-reform/3-rs-risk-adjustment-reinsurance-risk-corridors/>.

The family glitch

Premium tax credits are not available under the ACA to persons who have affordable employer coverage. When one family member has access to employer-sponsored coverage, the ACA determines whether the coverage is affordable based only on the cost of employer coverage for that individual – not for the cost of family coverage. Coverage that is affordable for an individual can frequently be unaffordable for full family coverage. Unfortunately, however, these family members are locked out of receiving tax credits for plans on the health care exchanges.

Policy Options

Faced with uncertain prospects of Congressional replacement, insurance companies would likely respond with extreme premium hikes, or even withdrawing from the marketplaces altogether. This would mean that the millions who have gained coverage for the first time in recent years would be forced to wait for hospitals or clinics to provide uncompensated care, often delivered too late, if at all.

If the ACA is to be wholly or partially repealed, Congress must replace it fully and swiftly to avoid chaos in the insurance markets and in the lives of the American people. Faced with uncertain prospects of Congressional replacement, insurance companies would likely respond with extreme premium hikes, or even withdrawing from the marketplaces altogether. This would mean that the millions who have gained coverage for the first time in recent years would be forced to wait for hospitals or clinics to provide

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In the following section, we assess a set of options under active consideration by Congress and the White House. In Section A, we begin by considering options that risk reintroducing the problems that the ACA was intended to address. We discuss both the reasons that lawmakers may find them attractive as well as their limitations for sustaining coverage and cost control. The subsequent section, further below, will identify options under active consideration by Congress and the White House. The final policy option is not currently under active consideration, but promises to advance the goals of improving coverage and controlling costs.

I. Policy options to repeal and replace the ACA

Eliminate the individual and employer mandates for health care coverage

Many opponents of the ACA deeply object to a federal mandate for the purchase of health insurance, and while most employers offer health insurance to their workers, they prefer flexibility to adjust those offers as market realities change. Under the ACA's employer mandate, employers with 50 or more employees must provide health insurance to a minimum of 95 percent of full-time staff, and must pay a fine if any of their full-time employees receive premium tax credits. The ACA's individual mandate, in turn, requires Americans who are otherwise uninsured and do not qualify for an exemption to either purchase coverage that meets a minimum set of standards or pay a fine. The goal of the employer mandate is to keep employers from dropping coverage once assistance is available in the individual market. The aim of the individual mandate, according to the American Academy of Actuaries, is to encourage enrollment of as many people as possible – particularly young and healthy people who are unlikely to purchase coverage without a mandate – to broaden the risk pool for insurance carriers and produce more stable premiums for everyone.¹⁹

Independent experts project a severe drop in coverage and higher premiums if the individual and employer mandates are terminated. The Congressional Budget Office has projected that repealing the individual mandate, along with the associated subsidy policies, would result in 22 million fewer Americans having health care coverage.²⁰

One of the most significant threats of terminating the individual mandate is higher adverse selection, in which people who are most at risk of high health care costs would be the most likely to enroll, while healthier individuals decide not to purchase coverage. Premiums for the remaining pool of enrollees would increase, further exacerbating adverse selection concerns. A premium spiral could result, with fewer and fewer covered individuals and higher and higher premiums.²¹

Continuous coverage requirements for insurance carriers

A continuous coverage requirement – a possible replacement for the individual mandate – is intended to protect consumers by requiring carriers to provide coverage for pre-existing conditions, as long as an enrollee had been covered continuously for at least one year. This would likely be a viable

¹⁹ American Academy of Actuaries, December 7, 2016, Letter to the U.S. House of Representatives Re: Consequences of Repealing ACA Provisions or Ending Cost-Sharing Reduction Reimbursements, http://actuary.org/files/publications/HPC_letter_ACA_CSR_120716.pdf.

²⁰ CBO, 2015, Re: Budgetary Effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf>.

²¹ American Academy of Actuaries, 2016.

solution for people who are already covered at the time of implementation or who have the means to purchase coverage on their own.

Continuous coverage requirements are unlikely to be effective, however, at reducing the number of uninsured individuals, or even maintaining the currently record-low rates achieved by the ACA.²² The reality for low-income families – many of whom currently receive subsidies to purchase care – is that continuous coverage is difficult to maintain in the context of volatile job markets and income, as well as competing priorities such as food and housing. Moreover, this approach would fall especially heavily on individuals who are not able to afford coverage but then become sick. Individuals who are fortunate enough to remain healthy and choose to forgo insurance coverage will never have to pay the penalty of out-of-pocket health care costs. Thus, a continuous coverage requirement would effectively end up penalizing people just as a mandate penalty does – in many cases at a higher dollar amount – but doing so only after they have become sick or injured and need health care.²³

Coverage through high-risk pools for individuals with significant health issues

High-risk pools are designed to provide a backup source of coverage for individuals who would have trouble buying coverage in an individual market where insurers can charge higher prices – or even refuse coverage – for sicker enrollees. Thirty-five states developed high-risk pools in the years – and in some cases decades – prior to the ACA, and the federal government operated a temporary program in the early years of the ACA's implementation. High-risk pools have proven ineffective for two reasons. First, these pools were not adequately and reliably funded over the long term, which meant that the pools were unable to afford to extend coverage to many of the individuals these plans were designed to protect. In addition, high-risk pools tried to keep costs down by including high deductibles, low lifetime limits, and limited coverage for a population that was already sick.²⁴

Implement tax deductions or tax credits to subsidize health care costs

Replacement proposals often include tax credits or tax deductions to assist individuals and families with purchasing individual insurance coverage. Tax credits reduce how

Tax credits are more effective than tax deductions to assist individuals and families with purchasing individual insurance coverage.

²² Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-March 2016 (National Center for Health Statistics, Sept 2016), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>.

²³ Timothy Jost, 2016, Taking Stock of Health Reform: Where We've Been, Where We're Going, *Health Affairs*, <http://healthaffairs.org/blog/2016/12/06/taking-stock-of-health-reform-where-weve-been-where-were-going/>.

²⁴ Jean P. Hall, 2015, Why High Risk Pools (Still) Won't Work, The Commonwealth Fund, <http://www.commonwealthfund.org/publications/blog/2015/feb/why-high-risk-pools-still-will-not-work>.

much is owed in taxes by an actual dollar amount and are the most promising approach discussed by replacement proposals. Tax credits are more effective than tax deductions to assist individuals and families with purchasing individual insurance coverage. Tax deductions reduce an individual's taxable income but are less helpful for individuals below the tax filing limit – the population most in need of assistance.

A universal, fixed-dollar, refundable tax credit would provide needed relief to low- and moderate-income families trying to purchase private health plans. Such tax credits are administratively simpler than income-based subsidies because they do not require calculations based on earnings, which can be particularly difficult for those whose incomes are unpredictable from year to year. However, a universal tax credit may not be generous enough to make coverage affordable for those earning the least or those who are exposed to greatest health risks.

Another option is means-testing for a tax credit that would decrease as income increases. This would provide higher levels of assistance to those with the fewest resources. However, there is potential that such a policy could disincentivize efforts to increase earnings; therefore, a fixed dollar amount is more appealing to some analysts.²⁵

Another option would be to age-adjust tax credits to help higher-risk, older adults purchase coverage in an underwritten insurance market. Regardless of how a subsidy is structured, an important consideration will be how the rates will increase (or decrease) over time to adjust for changing costs of plans and general inflation.

Promote the use of Health Savings Accounts to make health care more affordable

One of the most common components of ACA replacement plans is a provision for Health Savings Accounts (HSAs) to cover out-of-pocket medical expenses. HSAs allow individuals and families to make pre-tax contributions to an interest-accumulating account and then retrieve money from that account to pay for health care needs, or for any reason upon reaching the age of 65. Withdrawing money for non-medical expenses prior to age 65 results in a substantial penalty (20 percent excise tax). These accounts are usually paired with a requirement for coverage through a high-deductible health plan.

Research demonstrates that HSAs encourage people to be more mindful of how much money they spend on health care and to actually spend less

²⁵ Timothy Jost, 2016, Taking Stock of Health Reform: Where We've Been, Where We're Going, *Health Affairs*, <http://healthaffairs.org/blog/2016/12/06/taking-stock-of-health-reform-where-weve-been-where-were-going/>.

overall.²⁶ Research also shows, however, that HSAs are most effective in reducing spending and boosting awareness of health care costs among higher-earning individuals. A 2006 Government Accountability Office study (as well as more recent studies) reports that most HSA participants earned more than \$75,000 per year in 2004, and the average adjusted gross income of tax filers reporting HSA contributions was \$133,000 – more than double the \$51,000 reported for all tax filers under age 65.²⁷ The same study also found that high-income individuals contributed nearly three times as much to HSAs than low-income individuals; for instance, HSA participants with incomes over \$200,000 contributed an average of \$3,010 in 2004, compared to \$1,370 for HSA participants with incomes below \$50,000. These higher contribution levels provide disproportionate tax benefits for high-earners, and in fact there is evidence that more than half of tax filers reporting HSAs in 2004 did not withdraw any funds from their accounts, suggesting that many are using HSAs as a way to reduce tax liability, instead of funding medical care. HSAs are not, then, a policy tool for sustaining the new levels of coverage achieved over the past seven years. People with chronic health conditions or other costly medical problems and low to moderate incomes who are unable to fund a health savings account would not receive the tax benefits of HSAs and would face new barriers to coverage.

If HSAs are pursued by Congress as part of high-deductible health plans, lawmakers should avoid a “one-size-fits-all,” blunt approach to cost sharing. A more promising idea is to promote value-based benefit designs in order to better ensure that people with chronic conditions seek the care they need. The progression of potentially costly chronic disease may be blunted by allowing high-deductible HSAs to cover the first dollar of expanded preventive care or essential treatments, such as eye exams and insulin for people with diabetes.²⁸

Allow individual market insurance plans to be sold across state lines

Allowing insurance plans to be sold across state lines to increase competition and reduce costs to consumers is a proposal currently receiving significant attention from lawmakers. The challenge with this proposal, however, is how to allow greater flexibility for insurance market competition without undue interference in long-standing state discretion to set the terms of insurance markets, including requirements to ensure the financial solvency of health plans or their coverage of all comers, including those with pre-existing

²⁶ One difficult question, however, is the degree to which this reflects the self-selection of healthier people into HSAs—more research is needed in this area.

²⁷ Government Accountability Office, 2006, “Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage,” GAO-06-514, April 28; U.S. Government Accountability Office, 2008, Health Savings Accounts: Participation Increased and was More Common among Individuals with Higher Incomes (GAO, April); Lorens A. Helmchen, David W. Brown, et al., 2015, “Health Savings Accounts: Growth Concentrated among High-Income Households and Large Employers,” Health Affairs, 34(9), 1594–98.

²⁸ Michael E. Chernew and A. Mark Fendrick, 2016, Improving Benefit Design to Promote Effective, Efficient, and Affordable Care, JAMA, 316(16), 1651-1652, <http://jamanetwork.com/journals/jama/article-abstract/2556007>.

medical conditions. Furthermore, forcing states to permit the sale of health plans across state lines would encourage insurers to be regulated in states with few consumer protections – and then those insurers could target the healthiest individuals in heavily regulated states with leaner policies. This would result in an even more segmented market, narrowing the risk pool and bankrupting local plans that could not relocate to lower-regulation states. As a result, while premiums for low-risk consumers would be reduced, those for sicker or lower-income individuals – or even those with moderate incomes who prefer the protection of more extensive health care coverage – would become even more costly.²⁹ Additionally, consumers who purchase coverage from out-of-state insurers would not have much recourse, if they ran into any issues, since they would have to appeal to a regulatory agency operating in another state.

Additionally, it is worth noting that states already have the authority to enact “across state lines” legislation, but only six have done so. Those states that allowed out-of-state insurers have little to show for it. Insurers did not enter the insurance markets of these states, or even express interest in doing so, due to practical problems associated with the local nature of health care, such as the costly tasks of contracting and building viable provider networks in another state.³⁰

II. Reforms to improve coverage and cost control

In lieu of a full repeal, lawmakers could elect to further reduce the number of uninsured Americans, improve the quality of individual health-insurance policies, and diminish health care costs by addressing the most widely recognized problems with the ACA.

Create more flexibility for consumers purchasing plans

Consumers are increasingly nervous over the limited number of choices available to them on the health insurance exchanges. To respond to their concern, and to boost competition between insurers, there are two strategies for increasing flexibility.

First, the federal government could offer subsidies for plans purchased on certain private health care exchanges, rather than just those purchased on the federal and state exchanges. There are several insurance companies and consultants that host their own private exchanges, just as some state governments do for their own employees. Many individuals and families use

²⁹ Linda J. Blumberg, 2016, Sales of Insurance across State Lines ACA Protections and the Substantial Risks of Eliminating Them, The Urban Institute, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000840-Sales-of-Insurance-across-State-Lines.pdf>.

³⁰ Sabrina Corlette, Christine Monahan, Katie Keith and Kevin Lucia, 2012, Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409.

private exchanges – and have done so for years – to find coverage. If private exchanges were to become eligible for subsidies, strong measures would need to be taken to ensure the quality of these exchanges and of the plans offered on them, as well as to deter fraud. This option would not only increase choices for purchasers, but also has the potential to mobilize health insurance brokers, resulting in greater investment in the marketplace and a potentially more robust workforce to assist consumers with the enrollment process.

Counting catastrophic coverage as a qualifying health plan still eligible for some level of subsidy could make insurance coverage affordable to younger and healthier consumers, improve the risk pool for insurers, and develop a habit and a cultural norm of being covered for individuals, who might then purchase higher-value plans over time as they age.

Second, the government could allow more flexibility in the metal level of qualifying plans. Particularly for younger and healthier individuals, the Silver Level plan can seem like an unaffordable expenditure for something that has insufficient practical value. Counting catastrophic coverage as a qualifying health plan still eligible for some level of subsidy could make insurance coverage affordable to younger and healthier consumers, improve the risk pool for insurers, and develop a habit and a cultural norm of being covered for individuals, who might then

purchase higher-value plans over time as they age.

Simplify the enrollment process for consumers

While efforts have been made over the years to simplify the enrollment process, further steps could be taken to assist potential consumers, particularly those who begin the process of finding coverage but give up mid-way through. Private health care exchanges may be more adept in improving the consumer experience. Government exchanges should be pressed to consider reconfigurations that improve assistance to potential consumers to help them find the right plan for their needs, and innovations to determine the amount of tax credits to be issued for workers with complicated or minimal past work histories.

Address issues with the Three Rs – Risk Adjustment, Reinsurance, and Risk Corridors – to protect insurance companies from taking on excessive and unsustainable losses

The Three Rs in the ACA were developed as risk mitigation policies with the intention of stabilizing premiums for consumers. While these policies were never fully afforded the opportunity to function as intended, there are policy options that could address the present issues.



The ACA's reinsurance program did cover excessive costs for a limited number of people facing significant health needs under the marketplace health plans, but the program was set to expire at the end of 2016. Offering an expanded and extended reinsurance option would give insurers a greater sense of security to continue offering plans on the exchanges.

Risk corridors were intended to redistribute gains from setting premiums too high and to mitigate losses from spending more on covering individuals than expected. The provision was modeled after the permanent risk corridor program under Medicare Part D, which has operated successfully for the past decade. Under the ACA's risk corridor program, insurance companies with gains higher than three percent were required to give up a portion of those gains to compensate companies that faced losses greater than three percent. However, companies facing a loss have, as of yet, only received about 13 cents on the dollar back from the government. Fully reimbursing these insurers as promised – and potentially expanding the program for another several years or permanently, as under Medicare Part D – would help to restore faith in the program and the stability of the marketplaces.

Encourage insurance companies that offer Medicaid managed care programs to also offer plans on the marketplace

Lawmakers could consider incentivizing insurance companies making bids on Medicaid plans to also offer care plans through the marketplace. Consumers on the edge of Medicaid eligibility and individual market insurance could benefit from having comparable plans available from the same carrier between Medicaid and the health exchanges. If carriers currently offering Medicaid managed care also offered exchange plans, they would potentially have a more stable base of consumers, who, in turn, would enjoy greater consistency in their coverage. Such a policy would reduce churning – or frequent changes between plans or in and out of coverage – and the resulting disruptions in care continuity for enrollees.

Allow greater state flexibility with strong minimum standards

Under Section 1332 of the Affordable Care Act, states can apply for a State Innovation Waiver to pursue distinctive strategies for providing residents with the same access to affordable health coverage they receive through the regular provisions of the ACA. In the context of a replacement plan, this state flexibility could be retained, though the standards for the breadth and affordability of coverage would need to be adjusted to reflect other changes made. At a minimum, states should be able to apply to use funding under the replacement plan to pursue policies that demonstrably increase the share of state residents who receive comprehensive health coverage relative to the baseline.

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Use the purchasing power of government to reduce the growth of costs

The ACA made a number of changes in Medicare reimbursement that shifted the trajectory of its spending toward greater economy in the purchase of covered services and insurance. These approaches could be expanded and refined over time, most notably with regard to the purchase of prescription drugs under Part D of Medicare. Direct purchasing of medical devices and prescription drugs is common in other public health insurance systems in the United States – the Department of Defense and Department of Veterans Affairs (VA) both directly purchase prescription drugs (with a combined total expenditure of over \$10 billion in 2012), though the VA approach is generally considered more effective.

Another means of using government purchasing power would be to create various sorts of public insurance options. These could be developed at the state level under Section 1332, though states typically lack the experience, personnel, and administrative capacity to create strong purchasers. However,

An additional advantage of using Medicare's purchasing power to push back against high prices for services, drugs, and devices is that it could encourage private insurers to adopt similar innovations.

the federal Medicare program has a proven record of pursuing payment reforms that not only result in lower average prices than seen in the private sector, but also decreases in the variation of such prices across geographic locales and providers. An additional advantage of using Medicare's purchasing power to push back against high prices for services, drugs, and devices is that it

could encourage private insurers to adopt similar innovations. The successful competition in the Medicare program between traditional Medicare and private Medicare Advantage plans demonstrates the feasibility and advantageousness of public-private competition in health insurance markets.

Expanding Medicare's involvement in the market for services for non-elderly Americans could occur in several ways. A full-scale national plan, separate from Medicare, would be a substantial undertaking and is unlikely to be able to emerge in the near term given the other fundamental issues discussed in this *Report*. However, there are numerous demonstration approaches that could be adopted, including allowing consumers to buy into Medicare where health insurance competition is weak to nonexistent, or permitting "near-elderly" Americans not yet eligible for Medicare to buy into the program.



Conclusion

This *Report* offers a set of options that can help guide policymakers as they seek to improve coverage and lower the cost of health insurance. Health insurance reform is a complicated policy endeavor with many moving parts that must work together. Missteps could have devastating consequences for those who lose quality coverage or forgo necessary care because they can no longer afford the out-of-pocket costs. Policymakers would be well-advised to proceed with care, learning from experience and the best available evidence in this complex but vital policy area.

Health insurance reform is a complicated policy endeavor with many moving parts that must work together. Missteps could have devastating consequences for those who lose quality coverage or forgo necessary care because they can no longer afford the out-of-pocket costs.