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This submission to the Robert Wood Johnson Foundation's Actuarial Challenge by five thought leaders from the healthcare actuarial field provides a roadmap for healthcare reform designed to improve access to health insurance and be affordable for both consumers and taxpayers. Built on a foundation of sound actuarial principles, the resulting program will be self-sustainable over time, without relying on cross-generational subsidies.

Increasing Stability in the Health Insurance Market

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1 - Executive Summary

We welcome this opportunity to submit recommendations to increase stability in the individual health insurance market. The focus of our proposal is the individual market but we believe that to achieve long-term sustainability, it must address underlying issues in the U.S. healthcare system. Our solution incorporates aspects of the ACA, HIPAA, traditional commercial insurance, and Medicaid, with emphasis on actuarial sustainability, transparency and inducements to maintain continuous coverage. To this end,

Varied benefit structures must be offered as follows:

- Medicaid coverage no less generous than current, with expansion in all states to 138% of the Federal Poverty Level (FPL)
- A Basic Benefit Plan, mirroring benefits provided under Medicaid, through commercial insurers, with providers' payments equal to Medicaid fee levels, for individuals between 138% and 200% of FPL and for individuals who present for care, but without Qualifying Previous Coverage (QPC)
- Plans from commercial insurers with Minimum Actuarial Value (MAV) of at least 50%
- Elimination of Metal Plan structure requirements
- Deletion of pediatric dental and vision services from Essential Health Benefits (EHB)

It is essential that as much as possible of the population be insured, as follows:

- Individuals must enroll in a plan which meets or exceeds 50% MAV
- Absent coverage, at the time of care, an individual will be automatically enrolled in a qualifying Basic Benefit Plan, with a special deductible equal to the value of premiums (after subsidy, if any) due for the lesser of:
    - the number of months without coverage, or
    - 12 months
- In Medicaid, if the household would qualify under the 138% of Federal Poverty Level (FPL)
- If the individual is a member of a household where the combined premiums for a plan with MAV of 50% exceeds 10% of the household's Modified Adjusted Gross Income (MAGI), subsidies would apply
- For individuals with QPC, on enrolling in a new plan, pre-existing conditions are covered, with guaranteed issuance, provided the actuarial value of the new coverage is,
    - At annual renewal, no more than ten percentage points above the prior coverage; or
    - At other than annual renewal, no higher than the prior coverage

With universal availability of coverage, the need for COBRA coverage should be eliminated, reducing employer burden.

No long-term solution to the affordability, and thus stability, of healthcare coverage can be achieved without addressing provider payment and delivery and its complexities. These initiatives are recommended to accelerate the adoption of alternative payment methods and enhance competition to bring down fee levels:

- Providers must charge the same prices to all fee-for-service patients (other than Medicare, Medicaid and other governmental programs), whether insured or not, with any discount limited to that due to demonstrated administrative efficiencies
- Provider-insurer fee arrangements open to the public
- Billed charges on provider billing statements limited to filed negotiated fees
- Indicators of fraud and abuse collected with suspect claims held pending investigation
- Restrictions implemented for direct to consumer advertising of medical services and drugs
- National standards established for mid-level professionals to practice independently
- Rigorous assessment of actual need before licensing of facilities and related services

Insurers must provide information to the potential insured before the individual enrolls in coverage:

- The carrier must file with the regulatory entity and provide to the potential insured
  - The percent of premium paid out for claims, and
  - The percent of premium applicable for the insurance distribution method

Quality of care initiatives leverage modern technologies to assure that physicians have the best information, and patients have access to appropriate care sites, including:

- Computer algorithm assisted diagnosis
- Standards of practice across the spectrum of diagnoses
- Evaluation of professional provider practices against standards of practice
- Standardized electronic medical records, available to patients and their designees
- Medical homes for referral and to coordinate care
- Patient ownership of their records, with access for treating providers
- Availability of access to primary care during non-working hours
- Access to and triage into lower intensity settings than facility emergency departments

Premiums must be actuarially sound, incorporating within limited bands, adjustments for age and health status. The premium rate of any given class must not be required to subsidize another, as follows:

- Separately for adult males and females, from age 21 to age 64, using actuarially determined and justified ratios
- Premium rates per child, with premium payment required for each child
- Premium rates for adult dependent children age 21 to <age 26 as for adults of the same age
- For health status, a surcharge or discount limited to 20% of the otherwise applicable rate

A national reinsurance pool, funded by actuarially sound charges applied to every individual with health benefits coverage, must be established to provide reinsurance at 90% of claim costs above $250,000 per individual incurred in a given calendar year.

All of the above will require the following:

- An administration mechanism to verify coverage, as has currently existed under HIPAA
- A means of collecting information for the determination of eligibility for Medicaid or subsidies, as has currently existed under the ACA

- Reporting mechanisms in the event of an uninsured individual presenting for care
- Administration of the financial penalty, should the individual presenting for care be not enrolled in a qualifying benefit plan
- A source of money to pay for the cost of Medicaid eligible individuals
- A source of money to pay the subsidy for an individual with coverage costs in excess of the individual's ability to pay
- A mechanism for establishing an individual/household's eligibility for subsidy, and the amount of applicable subsidy, including the time period for which the subsidy applies
- The means to administer and distribute the subsidy
- The process whereby insurers receive and appropriately credit the subsidy to insureds
- A recertification process regarding qualification for and amount of any subsidy on no less than an annual basis

Impacts on the various stakeholders would include the following:

- Enhanced consumers' perception of the individual marketplace through access to plans more suited to their needs, with lower premiums and cost sharing due to lower provider fees
- Benefits for all healthcare consumers (insured, self-insured, Medicaid, Medicare and supplemental coverage) through quality of care initiatives to eliminate waste and avoid adverse side effects of unnecessary care, designed to help providers deliver the right services at the right time in the right place, while reducing the opportunities for fraud and abusive practices
- A more stable market for insurers, thereby encouraging additional carriers to enter the market, thus increasing competition, good for both consumers and the insurers
- Insurer flexibility to introduce innovative plan designs (e.g., reference pricing, expanded plans linked to health savings accounts, and value based benefits) and innovative provider reimbursement arrangements
- Quality of care initiatives enabling providers to move further toward using modern technologies to assure the best information used in the most appropriate manner to provide optimum care for the patient, through:
    - Computer algorithm assisted diagnosis,
    - Access to standards of practice across the spectrum of diagnoses and
    - Access to the patient's complete electronic medical records
- Providers' ability to determine appropriate treatment, as well as information about prior care including testing and imaging, decreasing overall cost through:
    - Better use of provider assets, both professional and facility; and
    - Reduction in duplicate imaging and testing
- Diminished federal regulatory roles relative to ACA, only establishing the required minimum plan design and other features
- Federal rate review process under ACA would be eliminated
- State governments would adopt conforming statutes and administrative regulations necessary to implement the proposed solutions

2 – Introduction

We welcome this opportunity to submit recommendations for increasing stability in the individual health insurance market. While the focus of our proposal is the individual market, we believe that to achieve true, long-term sustainability, it is essential to address underlying issues in the U.S. healthcare system.

William Arthur Ward said, "The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails." Our current healthcare system provides ample reasons to complain, as well as room for much optimism. So, let's set about adjusting those sails to put us on the right tack.

Our team is composed of highly qualified healthcare actuaries, with diverse expertise consulting with major players across healthcare segments. We have 188 combined years of experience working for and consulting with the full spectrum of the following: insurance companies, PPOs, HMOs and other health plans active in the individual, small group and large group markets, Medicare, Long Term Care and Medicaid insurance markets; trusts and large employer plans for employees and retirees (insured, partially self-insured and self-insured); as well as healthcare provider entities such as hospitals and physician groups.

Why is the Individual Health Insurance Market Unstable?

Insurance applied to any situation functions most effectively when several conditions are met:

- The insurance covers a broad spectrum of the population for whom risk might occur.
- Selection of insurance coverage is made without prior knowledge of specific risk, and specifically before a risk or its precursor has actually occurred.
- Coverage is maintained over an extended period of time.
- The premium charged by class of insured is consistent with the risk exposure of that class.
- The premium rate, in and of itself, does not affect the coverage decisions of the population – that is, they do not deem it too high for the risk they believe they present – and thus make choices to adversely affect the size of the population necessary for a broad spectrum of risk.
- The population has a fundamental understanding of the financial risk for which it is purchasing insurance.
- The aggregate risk of the population to be insured is predictable resulting in the predictability of future losses within an acceptable range.
- There is sufficient competition for market forces to operate (at both the insurer side and the provider side) resulting in choices for consumers.
- Premiums rates are equitable for the risk being assumed, adequate to cover the costs of claims, expenses and provide a return on capital, and competitive in the marketplace.

In the post-ACA individual market, several of the fundamentals/conditions of insurance are not functioning. Many of those without employer-based coverage lack understanding of the magnitude of their actual exposure to risk, and the potential financial loss associated with the cost

of health care services. The lack of understanding of exposure to risk can, and has, caused individuals to choose to use funds which would otherwise go toward health insurance premium payments for other expenditures. Some other individuals, usually those that have current on-going conditions, are fully cognizant of the cost of health care services required to treat their specific conditions. These individuals will readily pursue the purchase of insurance, especially if the premiums are less than their known and/or expected costs. The result is that coverage for a broad spectrum of the potential population has not been attained in many cases.

Historically, assessment of the potential risk of an applicant seeking coverage in the individual market was made prior to the issuance of coverage, assuring that either the insured did not present an immediate existing risk at the time of coverage, or that the premium rate charged was consistent with the risk presented. (It should be noted here that it is theoretically possible to set an actuarially sustainable premium rate for any class of risk, where the risks of the population covered are similar and quantifiable, as long as artificial limitations are not imposed.) However, under the provisions of the Affordable Care Act (ACA) applicable to individual health insurance, no assessment of potential risk could be made. In other words, individuals with pre-existing conditions (prior knowledge of a specific and/or immediate risk) have been guaranteed enrollment, and further, at the same premium rates as individuals without prior knowledge or immediate risk, so self-selection could be made with prior knowledge of risk. For example, a woman nine months pregnant has prior knowledge of a specific, immediate risk, and enrollment immediately prior to delivery would assure the cost of delivery would be covered by the insurance, even though payment of premium was made for only a single month.

The presence of special enrollment periods under the ACA (as well as possible questionable verification regarding eligibility for the special enrollment) has also permitted individuals to terminate coverage after having obtained health care services, and in many cases subsequently re-enroll should another risk arise. This “just-in-time” insurance coverage guarantees a failed market with unsustainable premium levels.

Historical data from large covered populations free from self-selection related to risk have demonstrated that health care service costs rise with age. While there are definite differences associated with gender at each age category, the larger differences are those associated with age. The provisions of the ACA artificially limit the older age groups’ premium rates to no more than three times the premium rates applicable to the youngest adult age group. In order to realize sufficient premium to cover the entire population of younger to older, premium rates for younger adults were forced to be markedly higher than the demonstrated cost for that age population. And the rates for the older age groups were lower than the expected costs for that population. At the specified ratio set by the ACA, to maintain the required overall premium, it would be necessary to enroll one person from the youngest group and charge that young person significantly more than their needed premium to subsidize the shortfall in the premium charged for each person in the oldest group. As a result, premium charged by class – in this case age – is not consistent with the risk of that class.

But if younger people do not perceive value in paying significantly more than their expected costs of risk, and do not enroll in coverage, then there is insufficient premium available to subsidize the shortfall in premium for the enrollees in the older age group, who as a group are paying less than their underlying risk. (In general, the exposure to significant health care needs is markedly lower in a younger population, and it is unlikely they have an understanding of their actual expected cost.) And with premium rates for the older group at lower than the risk presented, the older group perceives greater value from the coverage than the premium cost of the coverage. So the premium rate, in and of itself, affects the coverage decisions of the population, and presents an environment where fewer of the younger age group, and more of the older age group, would enroll. It is our collective experience that anytime there is an artificial requirement for one class to subsidize another class, the enrollment in the class providing the subsidy (i.e. overcharged) is significantly less than the enrollment in the class receiving the subsidy (i.e. undercharged). This is not unexpected as individuals make choices to maximize their own economic well-being.

Finally, there is the issue of individuals understanding the financial risk presented by failing to insure for unexpected health care needs. They may be younger adults, who have by virtue of their youth not been exposed to significant health care issues in the past. For example, most young couples expecting their first baby would likely be unaware that the costs of a premature infant or sick newborn could easily reach more than one million dollars. Thus, that specific segment of the population would not have a fundamental understanding of the financial risk for which it should purchase insurance.

Other adults who previously have had employer-based coverage could have been insulated from the true cost of health coverage due to employer contributions toward that cost. Further, for previously insured individuals, the benefit structures under which they have been covered – the portion of the true cost paid by the coverage – could have insulated them from understanding the full risk of the cost. This group, too, would likely not have a fundamental understanding of its financial risk.

The end result is that the fundamental principles of insurance have not been met by the basic premises of the Individual Health Insurance Market (and the Small Employer Market) as prescribed by the ACA.

3 - The Solution

What are the Problems?

The problems with health care and its coverage through Medicaid, Medicare, individual and employer-based health plans in the U.S. are many, often complicated, and always intertwined. For the sake of the Actuarial Challenge, we will view the issues through the following admittedly limited lenses, keeping in mind that often, straightforward solutions for one aspect may adversely affect another, and may not therefore be easy or even feasible due to constraints imposed and issues unrelated to health care and its coverage.

Access to health insurance

One of the fundamental issues with the U.S. healthcare system is that, for the vast majority of the population, only the presence of some form of high quality insurance coverage offers assurance of access to timely, quality treatment, should medical crises occur. However, for individuals without known health conditions who believe themselves unlikely to access the health care system, health insurance ranks low against more pressing needs, such as food, shelter, and education and often even below less essential desires that provide more immediate satisfaction, e.g., cell phones, entertainment, fashion. This is especially true for younger and lower income individuals. Further, for much of the U.S. population, there is typically a disconnect between the actual cost of health coverage and the perceived value of that coverage, due in part to a long-standing insulation from the actual cost of care due to the nature of employer provided health benefits. And finally, there is a pervasive notion that they should "get their money's worth out of their health insurance", in contrast to expectations regarding auto insurance or homeowners' insurance (or even life insurance).

A fundamental principal of insurance is the spreading of the risk for financial loss – be it for service or disaster – over a broad base where a limited frequency of loss is expected to occur, but for which the financial cost of that loss is significant. As such, insurance requires enrollment of a population where the actual frequency of loss matches as closely as possible the expected frequency of loss. Thus, the viability of any insurance system is threatened by high levels of non-participation by those the system is designed to cover. And in the absence of health coverage, some in the population made decisions to forgo preventive or even medically necessary care, and so in a broader sense frustrate disease prevention and population health objectives.

Affordability to consumers and taxpayers

It is well known that the U.S. pays much more for healthcare services than any other nation. The high cost of health care services is such that the vast portion of the population is unable to directly pay out of their assets for any major service and that the health insurance premiums required because of these high costs are financially out of the reach for many, if not most, Americans without subsidization in one form or another. According to the Kaiser 2016 Employer Health Benefits Survey, employees paid about 20% of the total premium for single coverage and

employers paid about 80%; for family coverage employees paid about 30% and employers paid about 70% of the total premium.[1]

Employees, when surveyed, have identified health care benefits as among the most valuable they receive. In the absence of broad subsidization, a significant portion of the population chooses to forgo coverage. In general, an individual does not correlate the cost of healthcare with the cost of health insurance. There may be several reasons for such a disconnect, but certainly contributing to the lack of understanding of the cost of healthcare is the minimal information provided to the insured (where there is healthcare coverage) about the true cost of the care itself. This is often a byproduct of the lack of transparency, with the contractual fee arrangements between the provider of care and the payor of claims treated as highly privileged information and as a competitive advantage. To minimize uninsured rates, it is necessary to address the underlying cost of healthcare, identify the most efficient form of subsidization, and structure the program to encourage responsible consumer behavior regardless of health status.

In general, individuals do not have an understanding that health insurance premiums are a direct function of the use of services and the cost of those services, because patients lack sufficient information to correlate the cost of healthcare with the cost of health insurance. Administrative cost, as noted elsewhere herein, must be treated with transparency in providing the percentage of premium which is paid for administration and that for claims for healthcare.

Information, provided to patients in the explanation of benefits and provider billing statements, is often confusing and indecipherable by the typical plan member. While "billed charges" are often shown, these typically bear little relationship with the actual charges the provider has already agreed to with the health plan, and even less relationship to what would be charged in a fair market environment. Where a reduction is shown that reflects the health plan's negotiated rates, it is often referred to as something like "carrier write-off", implying that in most cases the provider would have received the billed charges, which is far from the truth. A lack of transparency, where contractual fee arrangements between providers of care and payors of claims are not disclosed, further insulates the individual from true costs. While patient cost sharing does reduce the cost of the service being insured, if a patient perceives a healthcare service as being of only nominal cost, such as an office visit with a minimal copayment, the patient may choose to access such services more frequently than necessary.

Once a patient has accessed the services of a health care professional, that professional then makes the decisions about the patient's subsequent use of healthcare services, including but not limited to testing, follow-up professional treatment, referrals to facilities and other professionals, and use of pharmaceuticals. And the patient is rarely in a position to question the professional.

[1] Kaiser 2016 Employer Health Benefit Survey ; http://kff.org/report-section/ehbs-2016-summary-of-findings/

Multiple legal cases and associated findings have documented self-dealing on the part of a small segment of the medical professionals. The costs – both financial and in terms of patient safety and care – have been repeatedly cited as adding billions of dollars to U.S. healthcare spend.

Patients themselves are also partly responsible for rising costs, by pressuring providers for services, tests, and pharmaceuticals which may not be necessary. The overuse of antibiotics, which drugs are often requested by a patient, has created both increased costs and the development of antibiotic-resistant microbes. Direct to consumer advertising is as effective in selling drugs, services and facilities to a patient as it is in selling breakfast cereals. The patient hears the benefits of the new drug, while the side effects are downplayed, and the physician finds the patient then demanding the "newest and best". As the patient is shielded from the true cost and the physician ends up with a satisfied customer, there is little deterrent for either the physician or the patient to make the change to that advertised.

Patient education with respect to health and the patient's particular condition, as well as care management, is time consuming and typically best undertaken by the patient's primary care physician. Present reimbursement models, however, reward procedural services at a higher rate than cognitive services. Realignment of provider reimbursement levels must be undertaken. One particular area related to pharmaceuticals – the opioid crisis – is already being addressed on a variety of fronts. While tracking narcotic drug prescribing practices at the physician level, and prescription fills by patient, are critical steps in protecting patient health and safety, intervention and education for those patients who evidence markers of addiction would over time reduce costs as well.

With more emphasis on the role of the primary care physician in patient care, education, and care coordination, the demand for primary care physicians exceeds available supplies. Making a more concerted effort to incorporate mid-level health professionals such as nurse practitioners, nurse midwives and physicians' assistants would meet part of the need. Further, the reimbursement levels for such providers have typically been lower than for the same services from physicians. And such mid-level health professionals rank high in patient satisfaction.

Facility providers, including both inpatient and outpatient services, account for a significant percentage of the healthcare cost. Such facilities often compete in offering perceived advantages to physicians to drive referrals. Free-standing specialty outpatient facilities which specialize in high-profit-margin services, such as orthopedic surgeries, have proliferated. Physician-owned testing facilities, such as imaging centers or laboratory entities, further complicate the picture. And often expensive equipment, such as MRI machines or PET scanners, are available at multiple locations in a geographical area, with none of the equipment being optimally used. Certificate of need procedures had historically addressed the multiplicity of facility offerings for medical care, but have fallen out of favor.

Normal free market conditions do not exist in the U.S. healthcare markets, due to the unique circumstance that the recipients of healthcare services are not responsible for the lion's share of

the cost, and the anti-competitive nature of current provider fee arrangements. Most times, both the physicians directing the care and the patient receiving the care are clueless as to the cost until well after the service takes place. Consumer driven health plans have had some limited success in overcoming these barriers, but the reality is that most healthcare expenditures take place at a time and/or place where consumers are ill-equipped to negotiate or shop around. Health plans have attempted to use volume to negotiate lower costs with their preferred provider networks, but this model has failed to produce the desired effect, partly due to the lack of price transparency and lack of meaningful data on provider quality.

Quality of care

Despite paying more than other nations, America does not enjoy the best outcomes from its health care system, as measured by standard population heath metrics. Statistics alone suggest there are significant inefficiencies in our current health system which need to be addressed if we are to achieve our goals. But statistics also tell us that there are significant opportunities to improve quality and eliminate unnecessary spending through a variety of actions and incentives.

Many of these inefficiencies can be traced back to unintended consequences resulting from our traditional health benefit structures, provider reimbursement mechanisms, and well-intentioned but misguided attempts to "fix" something, either regulatorily or legislatively. We must recognize and learn from those and avoid repeating past failures.

It is widely acknowledged that the least costly care is the right diagnosis leading to the right care at the right time in the right setting. Care, other than solely well-care, must begin with the assessment of one or more diagnoses for the patient. The current listing (ICD-10-CM) has 69,101 distinct diagnosis codes. Presuming even the brightest physician with the best memory is treating a patient, it is unlikely the physician can hold in mind all possible diagnoses, and the symptoms associated with those conditions. Further, medicine and standards of practice are constantly changing which results in widely varying practice patterns which cannot be justified on the basis of outcomes analyses. Development and acceptance of computer assisted algorithms and standards of practice, many of which are already in place, could significantly assist physicians toward practicing in an optimal fashion. This would enhance patient care by speeding the process of getting to the right diagnosis and the right care at the right time in the right setting. An additional bonus of the widespread adoption of standards of practice would give the physician an "external" basis to cite against patient demands for unnecessary testing and treatment, including for pharmaceuticals.

Standardized electronic medical records of patient data, and findings by the physician, plus the results of any associated testing would not only preserve the data but provide a detailed patient history when accessed by other current or future treating physicians. Such a record would enable a reduction in testing by eliminating the need to duplicate that which had already been performed. Further, in the event of an emergency, where assessment and treatment of a patient must be performed when the patient is unable to provide a cogent history, access to standardized electronic medical records could increase the likelihood of a successful outcome.

Review of the electronic medical records would also provide a means of objectively evaluating the quality of providers of care, permitting identification of those physicians who could be assisted by mentoring or intervention, and those physicians whose practice patterns present a risk, either financial or related to health, to their patients.

Actuarial sustainability

By actuarial sustainability we mean a system sufficiently stable over an extended period of time to encourage healthy competition, allow for the estimation of future claims within a reasonable range, and avoid significant periodic market disruptions. The system must adequately reward market players who perform well on those aspects within their control, and not unduly penalize them for those aspects that are not manageable at the plan level. All of the aspects cited above (see Why is the Individual Health Insurance Market Unstable? In Chapter 2) are integral to the concept of actuarial sustainability. However, there are also external mechanisms which impact actuarial sustainability. Key factors include the ability to access a sufficiently large insured population, shifting of the cost for uncompensated care for individuals who do not have coverage to those who do, legislation and regulation at the state and federal levels, competition among insurers, lack of competition among providers of care, and the ability to address the infrequent but financially catastrophic large claimants.

In general, the amount of variability of risk in a given population or block of insured individuals is reduced as the size of the block grows. This is often referred to as the "law of large numbers." There is an actuarial term, "credibility", which carries much the same meaning in the actuarial world as in common usage – that is, one can in general rely on something that is credible. For actuaries, the larger the population that is insured, the higher the credibility rating that is applied to the population. In layman's terms, this means that for larger populations, the mix of risk, and associated costs, will remain similar from one period to the next. And even if the mix of risk in the next rating period is not identical, if there is a large enough population, the mix of risk will not change materially. In health insurance, it is typical that for a large covered population, about 10% of the insured individuals have health care needs that account for about 85% of the total claim costs. And further, of these, in a stable population covered over a number of years, only one third of those costly individuals are "high cost" in subsequent years. If due to self-selection or some other reason beyond the control of the insurer, the block of insured individuals is not representative of a normal population and consists of a higher than expected percentage of individuals with high health needs, actuarial sustainability is at risk.

Medical care, whether in a facility provider (e.g., hospital) or from a professional provider (e.g., physician) is not free. So when someone without insurance obtains care, and does not pay for it, the associated costs are incorporated into the costs the provider charges those who do have insurance and those who are self-funding their health care (private pay). As hospital providers are currently required to screen and stabilize an individual presenting at the facility emergency department with an emergency condition, if the required treatment is available at that facility, for those patients without insurance, the costs are typically uncompensated. The costs for

uncompensated and undercompensated care are, as a result, passed on to the payors which ultimately result in higher premiums for those with insurance and higher charges for those without insurance and self-paying.

Well-meaning legislation, usually seen as responding to a perceived need as identified by a section of the electorate, or protecting a special interest, can impair actuarial sustainability. A simple example is the mandate to include a specific benefit or class of provider, as a retroactive change to the contractual benefits for which the actuarially sustainable premium rate was developed. Further, the mandate of benefits, expanding the benefit contract for which premium rates had been established, would of necessity require an increase in premium rates at the next opportunity, above and beyond any medical inflation rate.

Regulation of insurance products in general provides protection for both the insurer and the insured. It assures that the policies sold comply with the applicable regulations, the methods by which the policies are sold accurately represent the policies themselves, and that the premium rates charged are neither inadequate or excessive. Regulation typically makes sure that competing insurers are operating on a level playing field with respect to required benefits and marketing practices. Further, regulators are in general charged with assuring the financial safety and adequacy of the insurers operating in their jurisdiction. It is typical that regardless of insurer size (number of individuals insured), all insurers are limited to reflecting administrative and other costs as a fixed percentage of the premium charged (also referred to as minimum loss ratio). (Under the ACA, if the actual loss ratio is less than the minimum loss ratio, the carrier must provide a premium refund.) There can be economies of scale for some administrative costs associated with large insurers, but a smaller insurer – with higher relative administrative costs – may offer individuals an advantage of a different sort, such as a more desirable network of providers or more helpful customer service. Under a fixed-administrative cost percentage the smaller insurer must make do with what would likely be an inadequate premium portion to cover costs, and end up being forced out of the market.[2] Another unexpected consequence of minimum loss ratio and the "one-sided" premium refund is that it is more difficult for carriers to replace capital that was drawn down due to losses sustained in the Individual Marketplaces.[3] This, in turn, creates additional risks for carriers participating in these markets. Carriers are required to maintain minimum levels of capital (called risk-based capital) in order to stay in operation. Losses sustained in the individual market must be made up in other markets, or the carrier would be forced to withdraw from the individual market, reducing competition. Regulation can also create challenges for actuarial sustainability when the determination of premium rates for a given product or block of insured individuals must be made far in advance of the time when the premium rates

[2] The ACA incorporates a credibility factor when determining compliance with minimum loss ratios in recognition that smaller carriers will have more fluctuation in experience.

[3] The "one sided" premium refund refers to the fact that carriers must provide premium refunds if experience is better than expected but cannot recover losses (surcharge) premiums if claims are higher than expected. Thus, carriers are in a position of having to refund in good years and not being able to use the additional funds to replace capital that has been drawn down in bad years.

are to be implemented, or which must be held unchanged in the face of changing circumstances. For example, changes in the practice of medicine, such as the marketing of new and extremely costly drugs, can directly impact the adequacy of premium rates until the rates can be adjusted to reflect the new costs. Regulation fails when it creates differences among insurers on basic requirements, such as required benefits, marketing practices, and financial adequacy. Competition among insurers is in fact competition only if all have to play by the same rules. Given that different states have differing levels of benefit mandate requirements and oversight, which in and of themselves impact premium rates, cross-border marketing would not generate true competition, but rather be expected to result in dominance by insurers with home domicile in states with the fewest requirements.

It has been typical over at least three decades for health insurers to contract with providers of care – hospitals, doctors, and other similar medical care entities – for specified fees or discounts from charges, to help reduce the cost of the care provided, and thus the insurance premiums. The insurer which can promise a larger volume of patients to a provider typically gets the "better deal". As a result, the larger insurer in a given geographic area is usually able to contract for lower reimbursements than an insurer without the same geographic concentration. Further, these contractual arrangements are typically closely held business secrets by both the insurer and the provider of care – usually with nondisclosure clauses. But some particularly large insurers with high concentration of membership in a given geographic area have been able to negotiate "most favored" rates, which require the providers to accept as payment for any particular service the lowest rate contracted with any other insurer. As a result, all other insurers can be at a competitive disadvantage. This can force other insurers without the geographic concentration to leave the market, as they are unable to compete on a level playing field. Further, potential new entrants into the market typically find such arrangements a huge barrier. And in areas where there may be, for example, only one hospital or only one set of specialists in a particular practice area, insurers may find they are unable to contract for any discount and must pay whatever charge the provider chooses to bill.

There can also be uneven competition among insurers unrelated to the size of the population covered, administrative cost or contractual clout with providers of care. It is possible for an insurer with a significant financial reserve to deliberately underprice a product – that is, establish rates which it knows are not actuarially sustainable – for the sole purpose of cornering the market. Once other carriers, unable to offer coverage at insufficient premium rates, have withdrawn from the market, the surviving carrier is guaranteed the competitive advantage. Conversely, as seen repeatedly with the ACA co-ops, new entrants may come into the market with inadequate understanding of the risk presented, or simply determine to offer rates which are actuarially unsustainable. These can capture large market share, until running out of capital and being forced, typically by regulators monitoring insurer solvency, to terminate operations. During the time period from the original entry until termination, other competitors may find themselves uncompetitive, be shut out or, depending upon capital reserves, sustaining losses due to insufficient numbers of insureds required to fund overhead expenses.

Actuarial sustainability also is heavily reliant on historical information regarding the use of medical care, the kind and place of service of medical care, the rate of change of costs of medical care, and the degree to which changes have happened or are expected to happen over time. Premium rates must be based on the best information available, and are established for a time-limited period, after which time, new premium rates are again calculated to reflect changes in risk and cost. One of the underlying principles required for actuarially sustainable rate setting is the stability and predictability of the risks of the population being insured. If the mix of risk in the population being insured is not stable, then the prediction of future costs may not be sufficiently credible, resulting in inadequate or redundant premium levels.

There are some vertically integrated medical systems that have created insuring vehicles, such as HMOs. These systems assume the underlying risk of their members, although there will often be some services, such as drugs, for which they must contract outside the systems. The Kaiser model is often the system cited as an example of this approach. Some of these systems may allow providers to see patients not insured through the system, some do not. Theoretically these systems should be in the best position to manage the health of their population and control costs. They also offer the least choice for consumers in so much as the consumer is not allowed to seek care outside the system without a formal referral. However, provider systems have not necessarily flourished under the ACA, suggesting that regardless of the mechanism to deliver coverage, individuals of higher risk result in higher costs, even in the most highly managed care entities.[4]

Finally, actuarial stability must also rely on the ability of the insurer to protect itself should an extraordinary, extreme event occur, whether such event is one or more large claims far beyond the historical norms, or an unexpected change in health status for a significant percentage of the insured people, such as a severe influenza epidemic for which immunization was ineffective. Reinsurance – that is, insurance the insurer buys to protect against extreme circumstances of very high cost or frequency of cost – purchased by the insurer provides that protection, the cost of which is incorporated into the premium rates charged by the insurer. However, reinsurers typically provide coverage to insure only unexpected large claims or higher frequency of use of services. Historically, when prior to coverage, the reinsurer learns of individuals with known health conditions expected to generate large claims, the reinsurer excludes coverage of those individuals.

[4] McKinsey , "Exchanges Three Years In: Market Variations and Factors Affecting Performance", McKensey Center for U.S. Health System Reform, Intelligence Brief, May 11, 2016. Exhibit 2 shows that provider led entities excluding Kaiser, had more than twice the average market loss in 2014; when Kaiser was included the provider led entities as a whole had a 1.4% post 3-R, aggregate post-tax margin of 1.4%. http://healthcare.mckinsey.com/sites/default/files/Intel%20Brief%20-%20Individual%20Market%20Performance%20and%20Outlook%20(public)_vF.pdf

Proposed Reform Changes

Our solution for stabilizing the individual health insurance market is focused on a series of measures to promote conditions necessary for insurance to reliably function, and for premium rates to be actuarially sustainable. To this end, individuals must choose to be insured, the insurance premiums for those individuals must be paid, and the premiums must be actuarially sustainable in order that the insurers are able to provide contractual benefits. To achieve these criteria:

- Individuals without access to free coverage have to be induced to choose, and pay for insurance, through mandate or penalty, and
- Those who do not have the financial means to pay for their own coverage must be supported by premium subsidies from some source.

Access to health insurance

Benefit plan design

A variety of benefit structures must be offered to ensure that those who actively choose to be insured or otherwise covered have suitable choices.

To that end, the following benefit plans and/or modifications must be available:

- Medicaid coverage no less generous than current, with expansion in all states to 138% of the Federal Poverty Level (FPL)
- A Basic Benefit Plan, mirroring benefits provided under Medicaid, through commercial insurers, with providers' payments equal to Medicaid fee levels, for individuals between 138% and 200% of FPL and for individuals who present for care, but without Qualifying Previous Coverage (QPC)
- Minimum Actuarial Value (MAV) of at least 50% as measured under the ACA for any other plans offered by commercial insurers
- Elimination of Metal Plan structure requirements for benefit plans exceeding the MAV of 50%
- Deletion of pediatric dental and vision services from Essential Health Benefits (EHB)

Enrollment

To meet the condition that the insurance covers a broad spectrum of the population from both a health status and age perspective, it is essential that as much as possible of the population not otherwise insured through employers or social programs be insured. The "perfect" solution is that each individual is insured continuously from birth to death, with no gap in coverage.

- Individuals must enroll in a benefit plan which meets or exceeds 50% of MAV.
- Absent coverage, at the time of care, an individual will be automatically enrolled in a qualifying Basic Benefit Plan, with a special deductible equal to the value of premiums (after subsidy, if any) due for the lesser of the number of months without coverage or 12 months.
- If the household would otherwise qualify for Medicaid under the 138% of Federal Poverty Level (FPL), the member(s) of the household would automatically be enrolled in Medicaid.

Affordability to consumers and taxpayers

Provider fees

It is our opinion that no long-term solution to the affordability, and thus stability, of healthcare coverage can be achieved without addressing provider payment and care delivery and its complexities. Further, we believe that there is sufficient waste in the system that, were such eliminated, costs could be reduced to a level where far less intervention in insurance mechanisms and markedly lower subsidies would be necessary.

Reformation of provider fees will be a long process; we don't presume these recommendations to be final solutions, but only beginning steps which are feasible in the short term. Subsequent steps will be guided by data collected and the results under these revised policies:

- Providers must charge the same prices to all fee-for-service patients (other than Medicare, Medicaid and other governmental programs), whether insured or not, with any discount limited to that due to demonstrated administrative efficiencies.
- Provider-insurer fee arrangements must be available to the public.
- For in-network providers, billed charges on provider billing statements limited to the negotiated fees agreed to between the provider and the health plan.
- Identify indicators of fraud and abuse (such as incompatible diagnoses and procedure codes), holding claims which are reasonably suspect pending investigation and/or clarification.
- Restrict direct to consumer advertising for all medical services and prescription drugs to those instances where comparative effectiveness testing by independent assessment has established a clear advantage over less costly services or drugs. While restrictions on direct-to-consumer advertising may be challenged as impacting free speech, there are examples where restrictions have been implemented when it is in the public interest, such as tobacco products and alcoholic beverages.
- Develop national standards for the utilization of mid-level professionals to practice independently of physician supervision.
- Return to rigorous assessment of actual need, and licensing of such services consistent with the need, to assure facilities are available to provide needed services, and duplication is limited.

Premium Subsidies

It is acknowledged that due to income levels and healthcare costs driving premium costs, not all individuals would have the financial means to purchase minimally qualifying healthcare benefits. To ensure near-full population enrollment, and meet one of the requirements for insurance to be sustainable, subsidies will be essential.

- If the individual is a member of a household, where the amount by which the combined premiums for the members of the household for a qualifying Basic Benefit Plan exceed 10% of the household's (MAGI), subsidies would apply.

Medicaid Expansion

Medicaid expansion has proven to be the most effective aspect of the ACA, in terms of expanding coverage and reducing the uninsured population.

- Medicaid in each state is extended to qualifying individuals up to 138% of the Federal Poverty Level.

Insured Information

Individuals should have information in order to understand and appreciate the expected value of their health benefits, the percentage of premium costs expected to be paid for claims and the percentage required for administrative functions. To that end insurers must provide understandable and accurate information to the potential insured prior to the individual choosing to enroll in coverage and pay the associated premiums.

To achieve accurate information for the individual:

- The carrier must file with the regulatory entity, and at the time of premium quote, must provide to the potential insured that percent of premium filed as being paid out for claims.
- The carrier must file with the regulatory entity, and at the time of premium quote, must provide to the potential insured the percent of premium applicable for to the insurance distribution method – online, broker, or other.

Quality of care

Healthcare cost trends are composed of both price and utilization factors. In the previous section, we addressed price issues, but utilization is equally, if not more, important in efforts to rein in out of control cost escalation. Quality of care initiatives go to the heart of providing the right service at the right time in the right place. The criteria for a provider's participation in a health plan's network should include adherence with quality criteria as well as willingness to accept contracted fee levels. The following recommendations, if implemented, should not only improve patient care, but also reduce costs and give health plans reasonable measures for assessing provider quality.

Diagnosis support

To assure that the physician has the best information possible for all patients.

- Computer algorithm assisted diagnosis
- Standards of practice across the spectrum of diagnoses

Provider quality

- Evaluation of professional provider practices against standards of practice

Patient support

Provide patient ownership of their records to take advantage of modern technologies, and to ease the transition of care from one provider to another, including reduction in duplicative testing and imaging, regardless of current or past health plan participation.

- Standardized electronic medical records, available to patients, their designees, and in the event of emergency situations where the patient is not able to make a designation, to the treating providers
- Medical homes for referral and to coordinate care

Provider Access

To avoid the use of costly, inappropriate care sites and to promote care continuity.

- Availability of access to primary care during non-working hours
- Expansion of access to and triage into lower intensity settings adjacent to/incorporated with facility emergency department settings

Actuarial sustainability

Eligibility

Eligibility for coverage, whether under governmental programs such as Medicare and Medicaid or through employer health benefits or individual health insurance, must be available to all citizens. Further, coverage must be available to those with pre-existing conditions (PEC), who have failed to maintain Qualifying Previous Coverage (QPC) (as defined under HIPAA), but subject to retroactive premium payments, as described under the Enrollment heading.

Coverage of adult children up to age 26 would be continued but limited to children who are claimed as dependents on the household's federal tax return.

Premiums

To meet the criteria that the premium charged by class of insured is consistent with the risk exposure of that class, premiums must be actuarially sound, incorporating within limited bands, adjustments for age and health status. Further, premium rates that are seen by the potential insured as consistent with expected use of care increase the likelihood that individuals will choose to be covered. Those individuals with existing health care needs are motivated to obtain coverage. Those without existing health care needs have a higher likelihood of choosing to become covered if the premium rates reflect their self-assessed health status. These criteria also support the principle that the premium rate of any given class is not required to subsidize another class of coverage, whether it is by age, gender or limited criteria related to health status.

- Premium rates for adult males and separately for adult females, should be set based on a continuous curve from age 21 to age 64, with rates for age 64 set at a ratio which is actuarially determined and justifiable
- Premium rates for children should be set at step functions for age, with a premium payment required for each child
- Premium rates for adult children age 21 to <age 26 should be the same as premium rates for adults of the same age

- For health status, a surcharge or discount limited to 20% of the otherwise applicable rate, with context having been historically provided for similar surcharges and discounts for group health insurance.

Pre-existing conditions

To meet the condition that selection of insurance coverage is made without prior knowledge of specific risk, and specifically before a risk or its precursor has actually occurred, it is critical that individuals remain continuously covered.

- For individuals with Qualifying Previous Coverage, pre-existing conditions are covered with guaranteed issuance of coverage when the new coverage is at a benefit plan level no higher than the coverage carried prior to the break, if at other than at annual renewal.
- For individuals without Qualifying Previous Coverage or with a break of more than 63 days, care would be subject to a reduction in benefits or a retroactive charge as described under Benefit Plan, unless otherwise qualifying for Medicaid.

Risk Mitigation

- To protect the adequacy of premium rates from extraordinary circumstances and extreme per-claimant costs, a national reinsurance pool, funded by an actuarially sound charge applied to every individual with health benefits coverage, shall be established to provide reinsurance at 90% of claim costs above $250,000 per individual incurred in a given calendar year.

- The funding for this reinsurance will be a fee applicable to all health plans, both fully insured and self-funded, similar to the fee employed for the transitional reinsurance in the individual market in the first three years of the ACA.

Impact: How Will These Changes Improve Stability?

The proposed solutions incorporate many aspects already in place through the ACA, or having been previously in place, in both the individual and small group markets, as well as some modifications and some significant additions. As such, there are impacts on all aspects of the healthcare delivery and insurance systems.

One of the primary goals of this Team is to foster universal, continuous coverage for needed healthcare services.

Continuous coverage would eliminate part of the issue of addressing pre-existing conditions, typically defined as those which had been diagnosed, or which had manifested signs and/or symptoms which would have permitted a medical professional to render a diagnosis, prior to being covered for healthcare services. (The issue of an individual with an existing condition determining to upgrade coverage is addressed elsewhere herein.)

Continuous, universal coverage could be realized only with:

- Access to adequate coverage at a price within the individual's ability to pay, requiring some form of subsidy – either through Medicaid, actual subsidy covering some portion of the premium cost, or some means of recouping costs for premium for the individual; and
- A mandate that every individual be covered in at least a minimally qualifying benefit plan, or
- A financial penalty at the time of presenting for care in the absence of enrollment in a qualifying benefit plan.

This would require all of the following:

- An administration mechanism to verify coverage, as has currently existed under HIPAA
- A means of collecting information for the determination of eligibility for Medicaid or subsidies, as has currently existed under the ACA
- Reporting mechanisms in the event of an uninsured individual presenting for care
- Administration of a financial penalty, should the individual presenting for care be not enrolled in a qualifying benefit plan
- A source of money to pay for the cost of Medicaid eligible individuals
- A source of money to pay the subsidy for an individual with coverage costs in excess of the individual's ability to pay

Universal coverage would be expected to change patterns of use for those individuals previously without coverage, with a reduction in the use of emergency department services, identification of health care needs through a primary care environment with early intervention to prevent exacerbation of health conditions, and better coordination of care. Greater access to primary care would be expected to put pressure on the available primary care providers, with a rising demand for mid-level health professionals such as nurse practitioners and physicians' assistants. To further support the shifting of care from the emergency room to more appropriate settings, it would be incumbent on professional providers to be available during what are typically non-working

hours – that is, evenings and weekends – as well as for hospitals to maintain urgent care settings alongside their emergency rooms so that non-emergency patients do not have to be admitted into the more expensive setting.

It has long been recognized that provider costs for uncompensated and undercompensated care are incorporated into the charges by those providers for care for insured or otherwise covered patients, and thus incorporated into a cascading series of payments:

- Made to providers by insurers
- Made by employers who provide employees with health care coverage – either through insurance premiums or directly
- Made by employees in contribution to their employer health coverage premiums
- Made by patients themselves through deductibles, copayments, and coinsurance, and for those individuals that pay directly for their care, through higher charges by providers

Universal coverage, regardless of the source selected by an individual, would eliminate the need for cost shifting. Implementation of a system of universal coverage would have to be accompanied by appropriate outside review of provider charges, to be sure that such did not result in windfall profits. Estimates of the reduction in cost for insurance and other payors range from 5% to 17% of their total healthcare cost.

Universal coverage (including the retroactive enrollment of individuals presenting for care) would provide assurance to providers that all care would be either compensated or collectable, at least at a basic level.

A concern of facility and professional providers has been that if Medicaid enrollment were expanded, low-income individuals covered under employer coverage would choose to drop coverage in favor of enrollment through Medicaid. This would provide advantages to the low-income individuals, and to employers of those individuals currently offering and paying some portion of the healthcare premiums. However, as provider reimbursement levels under Medicaid are markedly lower on average than those through private insurers, the providers would realize lower payments. In particular, professional providers, other than those contracted to accept Medicaid patients, would have the choice of accepting additional patients reimbursed at Medicaid levels. And information to date has not suggested provider fears about such employee choices have been realized.

To further encourage continuous coverage, individuals need to be able to choose from plans at a variety of coverage levels. This would encourage carrier competition on the previously referenced level playing field. It would also permit individuals with a higher tolerance of financial risk to select to self-fund more out-of-pocket costs, and others with lower risk tolerance to select coverage requiring less out-of-pocket at the time of service. This flexibility in choice of plan is hampered by the current ACA tax on plans with a high actuarial value. A tax on higher value plans is most injurious to those individuals who would not have the financial reserves to make a large payment for deductibles and coinsurance at the time of medical care, but who are able to budget for a higher fixed monthly premium rate associated with higher actuarial value plans.

The change in the way pre-existing conditions are addressed, as proposed herein, in the light of continuous coverage requirements, eliminates any reasonable need for COBRA continuation of coverage through employer insurance. A qualifying event which would otherwise trigger COBRA eligibility would qualify for enrollment in the individual health insurance system. COBRA coverage has traditionally been most attractive to individuals with significant health care needs, who have chosen to remain on employer coverage, despite the additional surcharge to the premium. COBRA requirements have placed a burden on employers for administration and notification. Many smaller employers have purchased administrative services specifically to manage the COBRA requirements. Elimination of the employer responsibility could result in cost savings for the employer. And the individual with a qualifying event would have a choice of a variety of plans, with guaranteed issuance based on prior coverage criteria.

Deleting pediatric dental and vision services from Essential Health Benefits (EHB) as prescribed by the ACA, while being retained as present under the Medicaid system, would reduce premium costs. Such services would continue to be covered under Medicaid for children in those families qualified for Medicaid. However, for other families, the cost of those services would be at the level the professional providers charge, without the additional administrative costs (including commissions where applicable) associated with insurance coverage. It may be true that, absent insurance coverage for such routine care, some families may choose to not obtain vision and dental services for their children.

To support universal, continuous coverage, it must be acknowledged that there must be some consideration of premium subsidy. A significant percentage of the US population lacks the household income to pay the full cost associated with actuarially sustainable health insurance premiums. According to the US Census Bureau, in 2014, 30% of all adults ages 18 to 64 were characterized as under 200% of poverty (13.5% under 100% of poverty). Further, for children age 0 to under age 18, 43% were deemed living in situations under 200% of poverty (21% under 100% of poverty). And for the same time period, for individuals of all ages under 100% of poverty, the annual per capita income deficit was $2,943.[5]

According to KFF.org[6], in 2015 the healthcare coverage breakdown of the US population was as follows:

- 14% covered under Medicare
- 20% covered under Medicaid
- 49% covered by employer coverage
- 7% carrying individual coverage
- 2% covered through other public sources, e.g., military or VA
- 9% uninsured

5 https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf
6 http://kff.org/other/state-indicator/total-population/?currentTimeframe=0

For individual states, the range of percentages varies widely. For Medicare, the range is between 9% and 19%. For Medicaid, the range is from 10% to 29%. Employer coverage ranges from 37% to 61%. Individual coverage varies from a low of 3% to a high of 10%. The percentage of a state's population identified as uninsured varies from 4% to 16%.

When the health coverage status of only children ages 0-18 is considered, the national average shows 39% covered through Medicaid. That ranges from state to state from a low of 21% to a high of 53%. And for children with no health insurance, the range is from a low of 2% to a high of 13%.[7]

It is clear that a state-by-state solution would result in significant variation among US citizens, and particularly children, determined to some extent solely by their state of residence.

To implement a subsidy would require all of the following:

- A mechanism for establishing an individual/household's eligibility for subsidy, and the amount of applicable subsidy, including the time period for which the subsidy applies
- The means to administer and distribute the subsidy
- The process whereby insurers receive and appropriately credit the subsidy to insureds
- A recertification process regarding qualification for and amount of any subsidy on no less than an annual basis.

With a subsidy program, there is a risk that individuals covered under an employer's health benefits plan might choose to opt out, avoiding the employer's specified premium cost sharing, and move into the individual market in search of a plan which would be less costly, due either to benefit design or subsidy. Were a significant number of employees make such a choice in an employer's plan, the employer could find itself in violation of provisions associated with employment law.

In any event, to encourage continuous coverage, and properly administer the transfer of information regarding an individual's prior coverage, the mechanism currently in place under HIPAA could be used. This places reliance on both the insured individual and the insurer to accurately and timely comply with the HIPAA provisions. Further, the information transmitted under HIPAA may be insufficient to limit acquiring new benefits with a significantly higher actuarial value. A national registry, to identify individuals who are not insured, along with penalties, if any, as well as track from one insurance plan to another and from one state or status to another, may be necessary.

To assure premium rates are actuarially determined and sustainable, it is essential to provide for much wider variation in premium rates charged than currently under the ACA. The results will include all of the following:

[7] http://kff.org/other/state-indicator/children-0-18/?currentTimeframe=0

- Lower premium rates for certain classes of insureds, particularly younger adults
- Higher premium rates for other classes of insureds, particularly older adults
- Moderate variation in rates by health risk presented, where healthy individuals would realize lower rates and individuals with ongoing health care needs would realize higher premium rates.

Further, such variation, unless adopted uniformly by all insurers of individual coverage, would place additional regulatory burdens on state insurance departments, to ensure level competitive fields.

To achieve the transparency in provider charges and administrative costs at all levels, current levels of secrecy would have to be eliminated. Providers would no longer be able to engage in selective contracting for "in-network" services among carriers, nor in "most favored nation" arrangements. This would require realignment of traditional contractual arrangements between insurers and providers. With access to actual charge information, insureds might be incentivized to travel some distance to access care from lower cost providers, with savings achieved both in claims paid and in the patient cost sharing through deductibles and coinsurance. When an insured determines to pay the difference between the allowed charges and the charge of the specific provider who chooses to not contract with an insurer, the insured makes the choice knowingly, and the arrangement forces the higher cost providers to justify the rationale for their charges.

As insurers would be required to provide the insured with specific information on the percentage of the premium that required for administration, those insurers with efficient administrative and product distribution processes would become more competitive. It is likely that economies of scale might favor insurers with larger volumes of insureds in a specific geographical area. It is also possible that, particularly with a larger portion of the population comfortable with using online methods to purchase goods and services, the use of insurance brokers and agents would decline.

Finally, as noted above, the proposed solution does not directly address the actual cost of healthcare itself. To reach the healthcare services goal of the right diagnosis, with the right services, at the right time and in the right place, major modifications need to be applied to healthcare delivery, affecting providers of all kinds and patients alike.

4 - Consumer Impact

These proposed reforms will enhance consumers' perception of the individual marketplace through access to plans more suited to their needs and lower premiums and cost sharing due to lower provider fees.

- Align premiums more closely to purchasers' expected costs,
  - Subsidies for lower income individuals to entice them to purchase insurance.
  - Healthy purchasers will benefit from limited health status adjustments.
- Provide uninsured individuals with a much more affordable option with the comprehensive Basic Plan.
  - The lower provider payment levels for the Basic Plan will make it more affordable even while providing comprehensive coverage with very little cost sharing.
- Provide individuals choosing to remain uninsured a safety net via the Basic Plan, albeit with premium charge-backs consistent with their income status, should they seek care.
  - For those with adequate income, a charge back of premiums upon using the safety net reduces possible cost shifting to those who responsibly carry insurance.
- Provide more plan design flexibility and choices to meet individual's needs.
- Encourage currently insured persons to remain insured, with premiums decreased for a significant segment of the population, and increased much more slowly over time
  - Plan designs driven by the market, rather than regulation, make it more likely that these individuals will find plans with which they are satisfied, further improving retention.
- Encourage those covered by the Basic Plan, whether by default or by choice, by virtue of the narrow network of providers accepting Medicaid reimbursement levels, to select a higher benefit level with a wider network of providers, when eligible to do so.
- Guide individuals to select coverage to protect against the financial loss of a catastrophic medical event by tying the availability of richer benefit plans to past continuity of coverage, helping to manage anti-selection and stabilize premiums across all participants.
- Benefit group insurance and self-insured employer groups through healthcare affordability initiatives (e.g., enhanced fee transparency, fraud and abuse reductions, restrictions on advertising and billing statements).
- Benefit all healthcare consumers (insured, self-insured, Medicaid, Medicare and supplemental coverage) through the quality of care initiatives to eliminate waste and avoid adverse side effects of unnecessary care, designed to help providers deliver the right services at the right time in the right place, while reducing the opportunities for fraud and abusive practices.
- Enhance the ability of patients to engage meaningfully with their physicians, due to standardized electronic medical records and transparent cost and quality data.

5 - Insurance / Health Plan Impact

A more stable market would be created under the solutions presented, thereby encouraging additional carriers to enter the market, increasing competition. This is good for both consumers and the insurers.

- Health plans would be able to offer a much wider array of plans in terms of cost sharing and benefits, offering the consumer greater flexibility to purchase a plan that better meets his/her needs.
- Insurers would have flexibility to introduce innovative plan designs (e.g., reference pricing, expanded plans linked to health savings accounts, and value based benefits) and innovative provider reimbursement arrangements.
- Insurers would substitute rate variation based on age, gender, and to a limited degree, health status, for the risk adjuster process, and would bear the responsibility of accurate pricing.
- Insurers would enroll more people at a lower aggregate price, as younger individuals and healthier individuals of all ages would be more likely to purchase insurance at rates, thus insuring a more representative mix of risk.
- More accurate pricing and matching of risk assumed to the premium charged would reduce the need to establish required premium deficiency reserves and addresses risk-based capital requirements
- Reinsurance that is funded from both the individual and broader health plan markets would reduce the insurer's risk from unexpected and unforeseen catastrophic losses.

6 - Healthcare Provider Impact

The proposed changes will affect healthcare providers in numerous ways.

- Quality of care initiatives would enable providers to move further toward using modern technologies to assure the best information is being used in the most appropriate manner to provide the optimum care for the patient.
- Providers would enhance their ability to determine the right treatment through the use of:
    - Computer algorithm assisted diagnosis;
    - Access to standards of practice across the spectrum of diagnoses; and
    - Access to the patient's complete electronic medical records.
- Providers' ability to determine and access appropriate treatment, as well as information about prior care including testing and imaging would decrease overall cost through:
    - Better use of provider assets, both professional and facility; and
    - Reduction in duplicate imaging and testing.
- Providers should see improvements in outcomes resulting from the quality of care initiatives.
- With improvements in outcomes, provider comfort with and adoption of risk-sharing mechanisms should increase, leading to reduction in future cost increases concomitant with improved patient outcomes.
- Supply issues related to professional providers would decline with the use of independently practicing mid-level professionals:
    - Increasing patient satisfaction with the healthcare system due to improved availability and timeliness of access, and
    - enhancing physician lifestyle.
- Providers may realize short-term increases in cost and time, due to:
    - Increased investment in technology,
    - Time required to train staff to use the technology, and
    - Need to be available at times other than traditional office hours.

7 - Government Responsibilities

Role of Federal government under the proposed solution:

- Regulate minimum standards for Basic Health Plan.
- Provide funding for low income populations under Medicaid expansion and Basic Health Plan.
- Provide funding for premium subsidies in commercial market or Basic Health Plan for low income populations with or without QPC.
- Determine eligibility for premium subsidies based on household income.
- Establish a national reinsurance program for high cost enrollees in the commercial individual market.

Reduction in the Federal government activities under the proposed solution:

- Diminished Federal regulatory roles relative to ACA, only establishing the required minimum plan design and other features.
- Federal rate review process under ACA would be eliminated.

Role of state governments under proposed solution:

- Adopt conforming statutes and administrative regulations necessary to implement proposed solutions.
- Administer Basic Health Plan as a new program under the purview and supervision of the state Medicaid authority.
- Approve individual forms and premium rates in the commercial market.
- All other existing state regulatory functions with respect to health insurance as currently in place.