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EXECUTIVE SUMMARY

The following outline is designed to start with current ACA law, with the proposed modifications overlaying current law and changing it where noted.

Following are the "steps" or ideas that are being proposed to jump-start the ACA. They are presented as steps as an aid to policy makers in thinking of the process and in realizing what it would truly take to cover as many people as possible. This is a monumental effort, and the extremities that the proposal covers might be considered too much, but, as a starting point, one has to go to the extremes to know where it makes sense to pare back.

STEP 1: INCENTIVE PAYMENT TO SIGN UP FOR HEALTH COVERAGE, A "ONE-TIME OFFER"

STEP 2: CELL PHONE BILL PAYMENT OF PREMIUMS

STEP 3: IMMEDIATE PAYMENT OF PENALTIES, CONCURRENT WITH THE YEAR OF NON-COVERAGE

STEP 4: OUTSIZE PENALTIES AFTER THE INITIAL YEAR: ONE & A HALF TIMES AVERAGE LOWEST COST SILVER PLAN (THE FULL COST OF THAT PLAN)

STEP 5: RETURN TO INCOME-BASED SUBSIDIES IN THE SECOND YEAR

STEP 6: INCREASE THE SUBSIDY AMOUNT TO COVER MORE OF THE MIDDLE INCOME COST, ESPECIALLY IN EXPENSIVE AREAS AND CITIES

STEP 7: INDIVIDUAL PREMIUMS ARE TAX DEDUCTIBLE TO SAME EXTENT AS GROUP COVERAGE

STEP 8: MODIFY LAW TO INCLUDE WITHIN THE ACA ALL INDIVIDUALS IN NON-EXPANDED MEDICAID STATES

STEP 9: WELLNESS CREDITS AND HEALTHY LIVING PREMIUM SUBSIDY

STEP 10: OPTIONAL PHARMACY COVERAGE

STEP 11: TAXABILITY OF EMPLOYER GROUP COVEAGE TO THE EMPLOYEES

STEP 12: GOVERNMENT RESPONSIBILITIES: TRUST FUND CREATION AND MORE

STEP 13: HEALTHCARE PROVIDER IMPACT

STEP 14: INSURANCE IMPACT

STEP 15: MODIFY RATIO OF 3 TO 1 FOR OLDER TO YOUNGER TO 5.5 TO 1

STEP 16: COBRA MODIFICATION

STEP 17: ELIMINATE GRANDFATHERED AND GRANDMOTHERED PLANS

STEP 18: MEDICAL LOSS RATIOS

The summary of the plan in the steps above will be expanded on below. Following the "expanded steps" there is further detail on several of the options that have been included. The very last part of the plan is an appendix of notes that formulates some additional ideas. There is definite room for improvement in clarifying the details of the plan that have been mentioned, and perhaps room to cut back on certain options where there is some redundancy. The goal was to to make drastic changes to achieve drastic results.

THE SOLUTION:

STEP 1: INCENTIVE PAYMENT TO SIGN UP FOR HEALTH COVERAGE, A "ONE-TIME OFFER"

The following proposal describes an aggressive payment offer to entice younger and healthier members to sign up for coverage, effectively paying for the first year of coverage for members who have not yet signed up for individual coverage and don't have health coverage. This "payment" or subsidy will be made in monthly installments, and will cover the premiums for at least the lowest cost Bronze or Silver plan. If the person chooses a higher cost plan, the premiums will be payable each month. This subsidy will not depend on the person's income level, and is a one-time offer, after which premium subsidies will return to levels mandated by law or otherwise proposed in this paper. There would be an extreme marketing blitz to advertise this campaign and the subsequent consequences if uninsured people don't take action. This incentive should also be offered at Medicaid-eligible income levels, and designed so that a small payment is made each month, just as is done with ACA-eligible persons, to encourage signing up for health coverage among the large population that is simply foregoing health insurance.

The marketing blitz portion of this Step 1 is one of the most important aspects of the plan. Much more work needs to be done to determine how to do this in all fifty states. It is a prime example of both federal and state governments needing to do extensive work to make this happen and work well.

STEP 2: CELL PHONE BILL PAYMENT OF PREMIUMS

After the choice has been made to take the health insurance offer, administration of the offer will be made through the cell phone bill wherever possible. This will set up each person for a whole year of small payments based on their choice of health plans and the cost. There could even be a small rebate off their cell phone bill over one year, based on size of the one-time incentive offer. This also sets up each person for an immediate penalty or payment of premium in subsequent years. Portability of the cell phone number would be required, and the number could be "parked" but kept if the person truly wanted to reduce costs. Cancellation would not be allowed. In addition, Social Security number and other identifying information would be collected for current and future years, to determine whether the IRS would need to submit a bill for payment of penalty or nonpayment of health insurance premiums.

STEP 3: IMMEDIATE PAYMENT OF PENALTIES, CONCURRENT WITH THE YEAR OF NON-COVERAGE

Anyone who has coverage currently and continues it, but then lapses will incur an immediate penalty, which is payable starting with the year and month in which they are canceling coverage. Likewise, anyone who is taking the one-time offer but lapsing coverage in a subsequent year and month will incur an immediate penalty. Penalties will be tied to the cell phone bill and also each person's Social Security number and the IRS. Cell phone number would be as permanent as the person's Social Security number.

CONSUMER IMPACT:

STEP 4: OUTSIZE PENALTIES AFTER THE INITIAL YEAR: ONE & A HALF TIMES AVERAGE LOWEST COST SILVER PLAN (THE FULL COST OF THAT PLAN)

The size of the penalty for not having health insurance will be drastically increased. This penalty is applicable to all non-insured persons, immediately following the year in which the one-time incentive payment offer was made, if the person does not continue coverage or cancels for any reason. Penalties will be charged in a monthly form and tied to the permanent cell phone number and cell phone bill as well as tied to Social Security number and the IRS.

STEP 5: RETURN TO INCOME-BASED SUBSIDIES IN THE SECOND YEAR

Costs of insurance to the consumer and the size of subsidies will be based on current law in the second year and later, with the exception of possible increases to the subsidy amounts. Increases will be made possible if there is funding from taxing employer group health premiums, or some other method is used to finance.

STEP 6: INCREASE THE SUBSIDY AMOUNT TO COVER MORE OF THE MIDDLE INCOME COST, ESPECIALLY IN EXPENSIVE AREAS AND CITIES

In cities and in many high cost health areas people do not have enough money to pay for coverage, even after traditional subsidies under current law are made. Subsidies should be increased to 25% more than they are right now at the lowest levels of income and stretched out to income levels that are 50% higher than they cover right now. Rather than going up to four times the poverty level, they should go up to six times the poverty level, and be graded down to 100% or 138% of poverty level, depending on which state is being considered.

STEP 7: INDIVIDUAL PREMIUMS ARE TAX DEDUCTIBLE TO SAME EXTENT AS GROUP COVERAGE

After subsidies the portion of the premium that is actually paid by the consumer should be tax deductible to the consumer, just as it is with employees under group insurance. This should be limited to the same extent that group health insurance premium “non-taxability” is limited, should that happen in the future. Right now, group health insurance premiums are not taxable at all to the employee. There should be some consideration of whether this is the right course. To the extent that there could be limits placed on this “benefit,” the full deductibility of individual health premiums should be limited for individuals who are at the same income levels as similar group health insurance subscribers.

STEP 8: MODIFY LAW TO INCLUDE WITHIN THE ACA ALL INDIVIDUALS IN NON-EXPANDED MEDICAID STATES

Clearly a huge hole in coverage is those persons who are below 100% of the Federal Poverty Level (FPL) and live in one of the nineteen states that have not expanded Medicaid. Modify ACA law to prohibit any state from cancelling expanded Medicaid after they have expanded it.

More work needs to be done to determine how this would be done. This is a very important aspect of the plan and without being able to do this the option to add these persons into the ACA and provide a large subsidy to them would need to be modified.

Then require everyone who is living in a non-expanded state and does not have health coverage to purchase it through the ACA at premiums which are equal to lower levels than the lowest income current ACA members. Premium costs could be set so that no more than 1-2 percent of income would be paid for health insurance. Alternatively, 0-2 percent of the FPL could be the required premium for those individuals who sign up in this category. As mentioned before, ownership of a cell phone and a cell phone contract would be the basis of collecting these nominal premiums. Penalties would still exist for this category, although the challenge here would seem to be reaching these persons and letting them know they had to stay covered as part of their cell phone plan. If they have a cell phone, they have to have health care coverage. Even if they don't have a cell phone, they probably have a family member who does, and everyone is required to get covered, anyway. Subsidies could even cover these individuals entirely, especially if they are part of the health living plan that will be described later.

STEP 9: WELLNESS CREDITS AND HEALTHY LIVING PREMIUM SUBSIDY

This method is a way to further reduce one's overall premium, based on personal responsibility. Even with all the mitigating factors, premiums will still be quite high for many people, and this program allows the subsidy amount to be increased. We use the term "Wellness Credits" to describe various actions that a person can take to maintain health. These credits apply to everyone at every income level and they are the only subsidy that a higher income person would potentially receive. Lower income persons would be able to receive the subsidies tied to their Wellness Credits as well as the subsidy tied to income level. More regarding this proposal is included later in the paper.

STEP 10: OPTIONAL PHARMACY COVERAGE

Pharmacy cost adds about 30% to the premium of a medical plan. Availability of health coverage that doesn't have a pharmacy benefit would be more attractive to the individuals who stated they couldn't afford to enroll in a health plan, according to a recent survey. Persons could sign up for a plan without a pharmacy benefit after their first year of coverage. To mitigate the anti-selection that would be introduced, this selection should be required to be maintained for two years, either selecting pharmacy coverage with the medical plan or excluding pharmacy coverage.

STEP 11: TAXABILITY OF EMPLOYER GROUP COVEAGE TO THE EMPLOYEES

One proposal is to fully tax employer group health premiums. This would be similar to the imputed income that once was taxable for domestic partner health coverage and the imputed income that is taxable for life insurance face amounts above $50,000. An alternative plan that would be less onerous to create a progressive tax schedule that would start at the same level that individual subsidies in the ACA population disappeared. For example, at six times the poverty level, or even below that, a progressive tax should be implemented that increases with

income. To the extent that group benefits are taxed the deductibility of individual health premiums should be limited for similar income levels. This is envisioned as an exponentially increasing rate that is tied to income level and should be automatically adjusted with demographic changes from year to year. More work needs to be done to determine the actual rates and administration of this item.

GOVERNMENT RESPONSIBILITIES

STEP 12: GOVERNMENT RESPONSIBILITIES: TRUST FUND CREATION AND MORE

Bringing back risk corridors and paying for cost-sharing for low cost Silver plan enrollees, adding back the reinsurance program and paying for the first year program going forward, for people who enter the health insurance market as young adults: all these are things that could benefit from a stable source of income that is not based on the vagaries of a particular Congress.

Much of the difficulty of the ACA working well is that it needs to have annual appropriations from Congress. A trust fund should be created that is funded by the taxability of employer group plans as just described. Other monies such as penalties could also be deposited here.

Furthermore, as mentioned earlier, the interplay between the federal government and the states in requiring states to keep offering expanded Medicaid needs to be better explored. Offering "Medicaid income eligible" persons the same ACA plans as other low-income Silver plan members is the goal.

As a model for what the states can do, California provides a very active role in the administration of its exchange and the selection of healthcare plans. All states can use California as a model. This needs to be better explored, but it is interesting that California has one of the lowest risk populations enrolled in the ACA in the nation. More research on how California's experience can be applied to other states needs to be done. More active involvement is essential to standardize health plans, reduce deductibles and cost sharing and generally make consumer-friendly enhancements to health care coverage.

STEP 13: HEALTHCARE PROVIDER IMPACT

There is a shortage of primary care doctors. There was once a federal program to pay for the medical education of doctors who agreed to go to underserved areas. This program should be reinstituted and it should apply to all primary care doctors who agree to work not only with the ACA population but also with Medicaid and Medicare members. There will be an immediate surge of members in both Medicaid and the ACA markets if this program is instituted. Additional help from other medical professionals (nurse practioners, etc,. and specialists) will be needed. Quality of care issues and sufficient time for appointments will be needed to address needs of the newly insured population.

Three free preventive visits per year are excessive. Making these be billed as a regular visit to the member or better determining a schedule for lower cost preventive treatments for very specific high value medical reasons is a better way to handle this.

STEP 14: INSURANCE IMPACT

Much of the problems of the ACA with health plans can be addressed with broader coverage and more time in the market, as well as the changes detailed above. In addition to the items above, current risk adjustment changes that are proposed or being considered should all be implemented in the permanent risk adjustment program. In addition, the risk corridor program and the reinsurance program should be reinstated and made permanent. As a model use Medicare Part D to get appropriate levels of risk sharing for these programs. Arguably, since medical care is more variable than prescription drug costs, there should be permanency and even higher levels of risk sharing within the ACA than that enjoyed by Medicare Part D. The exact levels need more work and more study needs to be done of Medicare Part D to see how this can apply to the ACA. However, a simple renewal of the programs and the trust fund as a means to pay risk corridor payments is a start.

Risk adjustment includes partial year special enrollment period factors, pharmacy claims, and a million dollar reinsurance program going forward. Other risk adjustment changes are anticipated but further research needs to be done in this area as well. It is understood that two options have been suggested for handling catastrophic claims.

STEP 15: MODIFY RATIO OF 3 TO 1 FOR OLDER TO YOUNGER TO 5.5 TO 1

Address wide concerns that young people are over-charged by changing to an actuarially justified cost spread of 5.5 to 1, which can be updated automatically if costs change by more than a prescribed amount. Young people should pay what they truly cost, and that will encourage them to remain in the system. Maintain the unisex pricing.

STEP 16: COBRA MODIFICATION

Employers should be required to pay for one year the cost of an employee's health insurance, if there is a termination. The employee would then be required to sign up for coverage or pay the stiff penalty. Administration should be done via the cell phone bill, so the employee can get the COBRA subsidy and also get in the system for any future payments or penalties.

STEP 17: ELIMINATE GRANDFATHERED AND GRANDMOTHERED PLANS

The goal is to create incentives to get healthy people into the exchange program. This is a "carrot and stick" approach. Since many of the "healthy" people are in transition and grandfathered plans, we need to speed up the phasing out of these options

STEP 18: MEDICAL LOSS RATIOS

Keep the medical loss ratios but require all rebates to be sent to the trust fund and an additional penalty to be charged to the insurer, to make this administratively less difficult.

MORE BACKGROUND INFORMATION FOR SEVERAL OPTIONS MENTIONED ABOVE

Proposed Amendment to the ACA to entice enrollment by those yet to enroll, Plus Much Greater Mandate Penalty.

BACKGROUND

A key premise of the individual mandate was to have all uninsured individuals, healthy and unhealthy, obtain health insurance. Having the younger healthier individuals enrolling was critical to the success of the "affordable" aspect of the law, while expanding coverage to all. As of 2016, the goal of having all citizens under age 65 covered at affordable cost, has yet to be met. The law mandates all individuals without coverage purchase coverage or pay a penalty, which is based on the honor system via one's individual tax return (Form 1040, page 2, line 45). The thinking was that people will sign up and purchase the coverage to avoid the penalty tax.

However in hindsight, the penalty has not forced all those who were uninsured to purchase coverage. According to statistics compiled by the Kaiser Foundation, less than half of those uninsured individuals purchased coverage, or about 40% nationwide. Moreover, speculation is that the sicker individuals actually enrolled while the healthy have not enrolled, leading to the selection spiral in the exchanges, causing large losses, leading to the major insurers to pull out of the exchanges. Those who enrolled in exchange health plans face significant premium increases for 2017, some as much as 60%.

A question to ponder is would the large insurers have left the exchanges if they would have had a pool of younger supposedly healthier individuals to enroll and balance out their claim pool? Assuming those who have yet to enroll are healthier, would their presence in the exchanges, and likely lower claims, have led to the need for much lower premium increases, hence keeping coverage more reasonably affordable for all? Why did less than half the uninsured population enroll in the program, and for those not enrolling, how many of them really paid the penalty? Assuming the average income of these people is close to the median household income of roughly 50,000, would they really face an audit to check whether they really had health insurance to avoid paying a nominal penalty, one that is still much less than the cost of health insurance?

PROPOSAL: INCENTIVE PAYMENT TO SIGN UP, A "ONE TIME OFFER"

So what amendments could be made to the ACA to get those supposed younger healthier uninsured individuals to enroll in health insurance? How about rather than a penalty tax, offering a government tax incentive payment which would cover the first year of coverage? These younger healthier people may not be enrolling because they feel they ae heathy and do not go to the doctor. Maybe the government paying them to join the first year would be a way to get them free coverage for the first year. However, this is a one-time offer to go into effect January 1, 2018. For those not taking the payment in January 2018, and do not enroll, the penalty goes back into play at 1.5 times the average cost of premium for the silver plan. This is another major change.

The premise is to perform a marketing blitz to get all those who have yet to enroll, take this one-time tax reward to get free first year coverage (i.e. 100% subsidy coverage). Under the assumption these are primarily lower risk individuals, why not reward them the first year with free coverage. They likely would not be larger users of care, and capturing them into the total exchange insured pool would help lower the average claims cost, and hence the average premiums.

Once they are enrolled, they begin paying their own way beginning in 2019.

The Mechanics: A high level Review

It will be helpful to look at some recent data regarding enrollment to date amongst the potential uninsured population across states. Based on information published by the Henry J. Kaiser Family Foundation, "Marketplace Enrollment as a Share of the Potential Marketplace Population", as of March 2016, s snapshot of actual enrollment versus the potential available enrollees is provided by state. Table 1 below provides the data for the states having at least 10 million in total population per the U.S. census bureau data for 2015.

TABLE 1
ENROLLMENT STATISTICS IN THE EXCHANGES UNDER THE ACA PROGRAM AS OF MARCH 2016

		Kaiser ACA enrollment Statistics			
		(A)	(B)		(B) - (A)
State	CY 2015 Total Census [1]	Exchanged Enrolled [2]	Estimated Potential Enrollees [2]	Percentage Enrolled [2]	Remaining Unenrolled
CA	39,144,818	1,415,428	2,986,000	47%	1,570,572
TX	27,469,114	1,092,650	3,084,000	35%	1,991,350
FL	20,271,272	1,531,714	2,654,000	58%	1,122,286
NY	19,975,791	224,014	1,036,000	22%	811,986
IL	12,859,995	335,243	836,000	40%	500,757
PA	12,802,503	412,347	891,000	46%	478,653
OH	11,613,423	212,046	702,000	30%	489,954
GA	10,214,860	478,016	1,169,000	41%	690,984
NC	10,042,802	545,354	1,008,000	54%	462,646
All Others	150,410,304	4,627,387	12,722,000	36%	8,094,613
Total	314,804,882	10,874,199	27,088,000	40%	16,213,801

[1] Based on United States Census Bureau data
[2] Based on data from the Henry J. Kaiser Family Foundation, Marketplace Enrollment as a Share of the Potential Marketplace Population

Removing those who have enrolled per the Kaiser data in Table 1, provides an estimate of the population yet to enroll and assumed to be paying the mandated penalty tax. The mandated penalty tax during 2016 which remains in effect for 2017 is calculated in two different ways, with the penalty being the highest calculation. The first method is 2.5% of an individual's adjusted gross income (AGI), with the maximum being the average annual premium for the Bronze plan

sold in the market. A second calculation is based on a rate of $695 per adult, and $347.50 per child in each household, with an ultimate cap per household of $2085. Based on U.S. census Bureau data, the average household size for all households was approximately 2.5 as of 2016.

The individual mandate and the associated penalty tax has yet to really be a major driver of the assumed healthy younger individuals to enroll into the exchange plans, as evidenced by the Kaiser enrollment data presented above. It also was perhaps the most contentious feature of the ACA law. What if instead of a penalty as a driver, which reflects negative sentiment, was turned into a tax incentive, or reward, regardless of income level for the remaining uninsured individuals? This could be a valuable "carrot" to those who have yet to enroll. Moreover, it is likely that the high earners have already obtained coverage through employer group coverage, or through successful self- employment where they have cost effectively set up coverage through a sole proprietorship or LLC.

The remaining uncovered individuals/households are likely at income levels where offering a full "one-time" offer to join the health insurance market place for free. To keep it simple, we ignore the existing subsidy structure, and offer the average national cost of the Bronze plan as a tax refund/payment to all individuals yet to enroll, ignoring income levels. According to the Kaiser published data, the national average cost for the Bronze plan in 2015 was $2484. To keep things simple, let's assume a 10% increase in this rate for three years gets us a tax reward payment amount of $3,300 ($2,484 x 1.10 x 1.10 x 1.10, rounded to the nearest hundredth dollar). Table 2 below shows the total potential cost of providing this "One-time" offer to the remaining uninsured population.

TABLE 2
ESTIMATED COST OF TAX INCENTIVE PAYMENT TO THE REMAINING UNENROLLED POPULATION

State	Remaining Unenrolled [1]	One time Tax Incentive Equal to the Projected Bronze Plan 2018 Cost [2]	Total Estimated Cost of One Time Subsidy
CA	1,570,572	$3,300	$ 5,182,887,600
TX	1,991,350	$3,300	6,571,455,000
FL	1,122,286	$3,300	3,703,543,800
NY	811,986	$3,300	2,679,553,800
IL	500,757	$3,300	1,652,498,100
PA	478,653	$3,300	1,579,554,900
OH	489,954	$3,300	1,616,848,200
GA	690,984	$3,300	2,280,247,200
NC	462,646	$3,300	1,526,731,800
All Others	8,094,613	$3,300	26,712,222,900
Total	16,213,801		$ 53,505,543,300

[1] Based on data from the Henry J. Kaiser Family Foundation, Marketplace Enrollment as a Share of the Potential Marketplace Population
[2] Based on data from the Henry J. Kaiser Family Foundation, The Cost of the Individual Mandate Penalty for the Remaining Uninsured

Some could argue whether this is fair or not, considering the previously uninsured individuals already enrolled, receiving a portion paid through subsidies with the rest paid out of their own pocket. One might argue that this subset of enrollees wanted the coverage because they needed it due to their health status. They are sicker on average as a sub-group, which is why they enrolled. The remaining un-enrolled group may consider themselves healthy, hence having health insurance is of lessor value to them. Enticing these healthier enrollees into the system could benefit those sicker enrollees already enrolled, as the newly healthier enrollees would lead to a lower overall claims cost pool, and hence lower future premium increases.

A potential drawback of this approach could be that once all the healthy are in, they could leave once they get their first bill during 2019 indicating their new monthly health insurance premium cost. It would be imperative that an enforcement system be put into place to better track and monitor “the people’s” participation in retaining their coverage. The current tax form self-imposed honesty approach may not be the best way to track enforcement. It would be interesting to really understand how many people really paid the penalty by checking the box on their tax return indicating they did not have coverage. Assuming these households are earning about the median U.S. household income level of 50,000, it seems unlikely the IRS is going to audit these people to confirm they have paid the penalty when they not had insurance for the previous year.

While more modeling needs to be done, the estimated cost of this once time incentive is not that significant, given the ultimate value it could have in pulling in the remaining uninsured individuals who are perceived to be healthy and a benefit to the existing exchange pool from a cost perspective.

Finally, One way to pay for the estimated 58 billion in tax incentive payments would be to require the health plans enrolling the greatest share of these healthier members, to share a small portion in profits, spread out over 3 to 5 years. This process could work in a similar fashion to the existing risk transfer payments amongst the health plans.

Summary

With the improvement in data systems and risk score methods over the last decade, the healthcare actuaries are armed with powerful tools to model out these more complex financial risk sharing mechanisms to better align appropriate payment to those entities bearing the higher risks.

Actuarial Challenge Proposal: Increase the Stability of the Health Insurance Market with Wellness Credits and Optional Pharmacy

It is important to understand the reasons why individuals have remained uninsured under the ACA. I used the findings from the Commonwealth Fund ACA Tracking Survey (February – April 2016) as a guide to identify the demographics of the remaining uninsured and the reasons why they chose to stay uninsured. http://acatracking.commonwealthfund.org/

The proposal below assumes the uninsured haven't enrolled in a health plan because the price exceeded the value they see in having health insurance coverage. These individuals are addressed through the Wellness Credit section. The individuals who wanted a coverage but could not afford it, are addressed through the Optional Pharmacy Benefit section.

Wellness Credit – individuals will have the opportunity to earn credits that will be used towards reductions in premium. The goal is for a person that is able to earn all credits to have a total annual premium that is less than the average penalty. Credits will be awarded for:

a. Normal cholesterol levels
b. Normal blood glucose levels
c. Normal BMI
d. Normal blood pressure
e. Normal Vitamin D levels
f. Taking and passing an on-line nutrition test (a good one is offered by powerofvitality.com)
g. Other inexpensive tests that the medical profession feels are good indicator if general health.

Individuals with no insurance often have not had basic lab tests done and are not aware of their general health status. Normal test levels will lower their premium and make health insurance more affordable – the key is to convey the message that a person with all normal test levels will have a health insurance policy that will cost less than the penalty. This will be beneficial for individuals whose test levels are not all normal as they will become aware of their general health status and will be an eye opener for the need of having a health insurance.

This is already done by many employers, offering employees credits towards their contribution levels for good biometric screening results. For those not passing their screenings, personal health coaches are offered to help the employee better manage themselves so that they can pass and get their credits the next year.

Illustrative example:

- Annual premium: $3,600
- Federal subsidy between 0% and 100%: assume 25%.
- Penalty 60% of premium after subsidy (60% x $3,600 x 75%): $1,620.
- Maximum wellness credits 50% of premium after subsidy. For an illustrative purpose, assume 5 possible wellness credits, each worth 10% of premium after subsidy (10% x $3,600 x 75%): $270. Studies will be needed to determine the % value for each wellness test.
- Premium after subsidy:

Wellness credits	Annual Premium
0 (not tests or all 5 abnormal tests)	75% x $3,600 = $2,700
1 (1 normal and 4 abnormal tests)	$2,700 - $270 = $2,430
2 (2 normal and 3 abnormal tests)	$2,700 – 2 x $270 = $2,160
3 (3 normal and 2 abnormal tests)	$2,700 – 3 x $270 = $1,890
4 (4 normal and 1 abnormal tests)	$2,700 – 4 x $270 = $1,620
5 (5 normal and 0 abnormal tests)	$2,700 – 5 x $270 = $1,350 – lower than penalty

Optional Pharmacy Benefit – Pharmacy cost adds about 30% to the premium. Availability of health coverage that doesn't have pharmacy benefit would be more attractive to the individuals who stated they couldn't not afford to enroll in a health plan (majority of the uninsured according to the survey). It is assumed that most of these individuals don't have chronic conditions, otherwise comprehensive health coverage would be a priority for them - hence retail pharmacy benefit is not a priority. Mandate medical coverage, but individuals should not be penalized if they opt out of the pharmacy coverage. It should be expected that there will be increased anti-selection with this approach since individuals currently enrolled in comprehensive plans that do not utilize the pharmacy benefit might switch to a plan with medical coverage only.

Appendix

This Appendix provides various notes and is being used to hold ideas that were being used to develop the paper. In some cases, there may be ideas that have not been developed in the paper that are available for use later on.

The solution: Describe your proposed reform changes. How do they address the problem?

The problem is that there is no current mechanism to force healthy people into the healthcare insurance system, and that preventing insurers from setting conditions around who can enroll in their plans creates a system where selection rules.

Not enough healthy people are enrolling in exchange plans, which is why premiums are going up, making health insurance increasingly less affordable. Making the exchange plans more affordable will allow more people to participate and contribute to a sustainable insurance market.

. Also, we need to increase the penalty for not enrolling. The carrot is to create "tax fairness", so that as eligibility for tax credits phases out at increasing income levels, the premiums become deductible.

How will your proposal affect consumers? Address at least access to health insurance (impact on uninsured), premium and cost sharing affordability, and access to health care providers. Focus should be concentrated on the individual commercial marketplace.

Policy premiums have increased 200%-300% since the pre-existing condition rule was removed. Also, age distribution change did not improve the costs for older consumers as was intended, since rates skyrocketed to more than they were before the change making premiums unaffordable for both young and old. Consumers who have been gaming the system by not signing up until they need coverage will pay a penalty for that – paying for their healthcare costs that are not covered due to the pre-existing condition clause.

If significantly more healthy people participate in the exchange, here's some of the things that will happen: Premiums will start to decrease, more carriers will enter the market, the long-term sustainability of the program improves.

How will your proposal affect providers? Address quality of care and supply of providers.

Providers will be at risk for payment when treating members that have no insurance coverage, just like they are today.

A more stable and vibrant insurance system is good for providers.

How will your proposal affect insurers and other health plan issuers? Address at least viability of plan offerings and regulatory burden.

Insurers benefit by increasing the number of healthy participants, and concentrating more of the insureds in exchange plans, versus the broad array of grandfathered and transitional plans currently in the market. This should reduce the number of offerings and the associated regulatory burden.

Issues/Problems:

- Cost for non-subsidized healthy and young population is high – higher than penalty
- Not enough healthy risk
- Less insurers participating = less competition
    - 20% of users on federal exchange only have one insurer offering
- Risk corridor failed from insurer perspective
- Drug pricing
- High deductibles must be met each year – financial strain on consumers
- People don't change unhealthy behavior
- People are becoming less healthy over time
- People are living longer and thus require more medicine and procedures to maintain health/quality of living
- Opioid addiction
- There are still uninsured people
- Public's lack of value placed on health insurance
    - Perception of "throwing money away" on premiums if consumers are not utilizing or have a higher deductible
- Not all states expanded Medicaid
- Premiums on individual policies are increasing substantially year over year
- The price of health care services are abstruse and secretive
    - "Billed charges" aren't realistic vs. what providers actually get paid
    - Commercial, Medicare, and Medicaid all have drastically different rates

for providers
- Majority of provider reimbursement is still FFS
- Does not incentivize providers to make people healthier
- Possible solutions:
- Subsidize cost in non-competitive regions to bring in more insurers
- Similar to Medicare Advantage and rural county original approach (or FFS Medicare rates in rural counties)
- Con: Where does money come from?
- Remove tax deductibility of employer sponsored health insurance to raise money for subsidies
- Pro: Current structure is “unfair” to individual purchasers vs. employer/group purchasers
- Con: Would likely lead to more uninsured individuals as some employers would drop coverage – counter productive
- Allow premium of individual policies to be tax deductible
- Pro: Lowers OOP premium cost
- Con: Costs money
- Con: Doesn’t address underlying cost of health care
- Force Medicaid expansion in all states
- Pro: Operational structure already in place
- Pro: Lower underlying costs since provider reimbursement rates are
- Con: Puts further strain on health care providers to make up losses some other way due to low Medicaid reimbursement rates
- Con: Some states may shut down Medicaid completely
- Lower Medicare age requirement
- Pro: Medicare reimbursement rates are generally lower than commercial rates
- Establish standardized pricing for procedures (similar to Medicare FFS rates)
- Con: Still FFS methodology so no incentive for providers to improve health of population
- Pilot program: have federal government purchase a health system and try to run it
- Pro: Cost is truly resources used divided by those who use it
- Con: Complexity what’s in the health system: specialists, radiology, anesthesiology, etc.
- Con: Only a pilot, slow fix if it works
- Pro/Con: A step towards government operated health care – no competition, no privatization
- Federal government involvement in drug pricing. For cures: block purchase of enough doses to cure all people with disease
- Con: Logistics of identifying people with disease and administering drug to all
- Pro: Known cost vs. manufacturers “holding hostage” people with disease and insurers

- Pro: Sooner all are cured may lower longer term health costs (e.g., Hep C)
- Improve risk corridor:
- Allocate a greater share of total premiums to the risk corridor
- Establish high risk pools
- Pro: Lowers chance that insurers will fail
- Con: Doesn't eliminate or lessen overall costs
- Offer a government run insurer to add competition
- Pro: Medicare Advantage and Medicare FFS have been running simultaneously for years
- Con: Complexity/administration: need a network and provider rates, etc.
- Expand indemnity/wrap around insurance
- Potentially model after Medicare Supplement policies
- Con: More complexity
- Allow OOP expenses to carry over through multiple calendar years
- Pro: Eases consumer financial position that would otherwise reset each year – especially with higher deductible plans
- Con: Shifts cost from insured to insurer – doesn't eliminate or lessen cost
- Allow all or a portion of premiums to accumulate and cover OOP costs
- Pro: Improves public perception of "throwing money away" on premiums
- Con: Adds complexity
- Con: Shifts cost from insured to insurer – doesn't eliminate or lessen cost
- Institute lifetime OOP maximums
- Pro: Lowers chance of financial ruin for sick/costly individuals
- Con: Shifts cost from insured to insurer – doesn't eliminate or lessen cost
- Con: Adverse selection/gaming potential – Consumer could pick cheapest plan for several years until they hit lifetime max
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- Tax credit for consumers who spend X% of their gross income on premiums and/or OOP costs
- Pro: Lowers chance of financial ruin for sick/costly individuals
- Con: Shifts cost from insured to government – doesn't eliminate or lessen cost
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- Eliminate calendar year policies – test 5 year policies?
- Pro: Stabilize premiums
- Con: More risk for insurers so may be more risk margin built into the rates
- Con: Doesn't eliminate or lessen overall costs
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- Increase the individual mandate
- Pro: More people may purchase plans – more healthy people in risk pool
- Con: If plans are truly unaffordable this puts consumers in a very tough spot
- Con: Not very sophisticated
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- Mandate minimum and maximum MLRs
- Pro: Insurers have less risk so should be more competition
- Con: Does not incentivize insurers to find ways to lower overall costs
- Government purchases insurance for ALL uninsured then if a non-purchaser wants to have insurer pay for care they have to repay all past due premiums
- Pro: Zero uninsured
- Pro: Healthy people now in risk pool
- Con: Large up-front cost for government
- Con: Consumer may not be able to afford past premiums