Health Insurance Financial Assistance Program Modernization

(by Antonio Paulo Pinto – updated 5 May 2020)

Overview:

This document is an Executive Summary of my proposed redesign of the health insurance financial assistance programs created under the Social Security Amendment of 1965 to the Public Health Service Act of 1944 and the Patient Protection and Affordable Care Act of 2010. Fundamentally, the goal is to create programs that are simpler to administer, reduce socio-economic and ethnic discrimination, and support families in times of need while focusing on incentivizing economic independence.

The current COVID-19 crisis provides an opportunity to provide the necessary transitional funding and foundational funding for redesigning how people access health insurance. It is a unique opportunity to allow for a transition to a 401k-style health insurance plan system, where individuals own their health insurance plans and the employer contributes to the health insurance plan, inclusive of contributions to individual HSA bank accounts. For this to be feasible, a national risk pool with a shared risk model, meaning the national risk pool only pays no more than 2 times Medicare rates for claims, must be implemented, covering the top 1 percent of the population that represent 30 to 35 percent of all health care spend in the country.

Background:

I utilize demographic data in developing my recommendations; and that data is presented in detail in my most recent book. The government programs we have in place today have many of their foundational assumptions based on decades old assumptions, back to the days of dual-parent households with one working parent per household and another stay-at-home parent raising the family. As we all know, that is the atypical household of today. Unfortunately, the design of these programs has never been updated to properly address today's single adult and the single-parent households. The time has come to address these old assumptions within all government programs and to adjust them to todays modern households. The other major demographic driver for a change is the ongoing migration of the Baby Boomers into Medicare as they turn 65, another 30 million by 2028, then totaling 90 million or 28% of the US population, almost double what it was in 2010 with 47 million over age 65. With the X generation being 30 percent smaller, this means a significant number of employment opportunities will become available for Millennials, far more positions than current Millennial demographics will be able to fill, meaning a need for significantly more employees than will be available, assuming Baby Boomers retire.

Safety Net Program (Medicaid) Income Modernization

The time has come to review the original assumptions of how Federal Poverty Level is calculated, primarily focusing on "household" assumptions, as the typical household has changed significantly over the last 50 years. Single-parent, and single-adult households are now the majority of households, not a significant minority of households. The safety net program needs to not penalize households with two adults that are married; and therefore, incentivizing unmarried adults within a household. The intent of this modernization is two-fold; (1) provide greater and more realistic support specifically to single-parent households; and (2) specifically not penalize adults for "not" being married. Whether one wants to support marriage or not is not the issue, the approach is simply not to "penalize" people for being married, which in turn should help support stable households for children too.

The existing and proposed tables are below and focus on just one change, resetting the 2-person household to be two times the 1-person household. A single parent, or two adults, have core living expenses today that are significantly higher than they were decades ago, especially around housing.

A major secondary recommendation, noted later for health reform assistance, is to change to flat fixed dollar assistance levels within pre-designated ranges, as opposed to trying to calculate "to the penny" the assistance that a person should receive on an ever-changing and ever-sliding scale.

The "proposed" Medicaid FPL Table: (resetting the eligibility at a higher flat 100% FPL Guideline)
(supporting single parents and married adults)

Current Income by Percent of Federal Poverty Level (FPL)				Proposed Income by FPL (%)		
Household Size	100%	**138%**	150%	**100%**	138%	150%
1	$12,490	**$17,236**	$18,735	**$12,490**	$17,236	$18,735
2	$16,910	**$23,336**	$25,365	**$24,980**	$34,472	$37,470
3	$21,330	**$29,435**	$31,995	**$29,400**	$40,572	$44,100
4	$25,750	**$35,535**	$38,625	**$33,820**	$46,672	$50,730
5	$30,170	**$41,635**	$45,255	**$38,240**	$52,772	$57,360
6	$34,590	**$47,734**	$51,885	**$42,660**	$58,872	$63,990
For each additional person, add	$4,420	**$6,100**	$6,630	**$4,420**	$6,100	$6,630

**The 2019 Federal Poverty Level (FPL) income for one person = $12,490; plus $4,420 for each additional person.*
***The fundamental difference is to adjust PPACA's Medicaid eligibility criteria to 100% on the 'Proposed Income' table from the 138% of the current income table. Additionally, Medicaid must reimplement asset and needs based testing to focus on assisting the needy, with an Opt-Out provision for others.*

The above table supports single-parent and dual-adult households and does not penalize people for being married. In essence, many households today have unmarried parents living in them simply because if the parents were to be married then they would not qualify for multiple assistance programs offered by government agencies. This is a disservice to children and society as a whole!

Fixing the PPACA Subsidy (Financial Assistance) Program

This is specific to how PPACA operates today, showing both the existing and proposed tables for providing financial assistance. Fundamentally, asking people to predict future income, prove future income, and then pay back miscalculations, is completely absurd. One must be insane to think people can 100% predict their future income up-to 15 months in the future! Even Medicare relies of the income a person made in the prior year, 2018 income for 2020 premium payments when enrolling in 2019. Therefore, we need a simple program to administer that does not punish people for having a good year financially. Most significantly, PPACA punishes middle- and lower-income workers above all others, especially if their employer gives them a year-end bonus, which can result in full payback of the Subsidy.

Comparative Financial Assistance Table:

Current Income (% FPL)	Current Expected Contribution	Proposed Subsidy / Financial Assistance* (Based on Age 40 and Median Commercial Plan Spend)
Up-to 100%	Medicaid or 2.06% of your income (varies by State)	Medicaid or Medicaid Opt-Out ($6,000/adult or $4,000/child per year)
100% to 133%	Medicaid or 2.06% of your income	Medicaid or Medicaid Opt-Out ($6,000/adult or $4,000/child per year)
133%-150%	3.09%-4.12% of your income	$4,000/adult or $2,500/child per year
150%-200%	4.12%-6.49% of your income	$3,500/adult or $2,000/child per year
200%-250%	6.49%-8.29% of your income	$3,000/adult or $1,500/child per year
250%-300%	8.29%-9.78% of your income	$2,000/adult or $1,000/child per year
300%-400%	9.78% of your income	$1,000/adult or $750/child per year

**Utilizing Proposed Medicaid FPL Table provided earlier with higher incomes for multiperson households.*
***Median Commercial Plan Spend requires changing PPACA language from current "per-capita" spend.*

The proposed age-band adjustments for assistance:

Age range	Your expected "adjustment" is
0 - 17	0-17 child rate (~2/3^{rds} of adult rate) or CHIP
18 - 25	30% adult rate reduction
26 - 34	15% adult rate reduction
35 - 44	Standard adult rate
45 - 54	15% adult rate increase
55 - 64	30% adult rate increase
65+	Medicare and/or Medicaid

Fundamentally, the idea here is to allow people to be better able to plan for the realistic cost of their health insurance plan; and to not overly penalize them if their income exceeds expectations.

Health Savings Account (HSA) Plan Note

HSA qualified plans were rolled out in 2004, following the Archer MSA Program from 1997, and have outlived the original program design. The other issue is that there still exists no real opportunity for people to shop for health care services; and that does not appear to be changing any time soon.

Therefore, HSA bank accounts should be expanded to all PPACA qualified health plans, the deductible should be uncoupled from the health plan deductible; and the pre-tax dollars should be allowed to be utilized for "any and all" health care related expenses, including the health insurance plan premium.

Based on data presented in my book: My Two Cents: Taking the Care Out of Health Care (2019)

Transitioning from Employer-Group to Individual-Owned Health Insurance Plans

In the big picture, one needs to understand that "ALL" health insurance programs are interdependent on one another at a fundamental level. The simple way to think of this is that people will always find the lowest cost way to purchase health insurance plans for themselves and their families. It may be through their employer, or it may be on their own; but the decision is based on cost, which is dependent on how the pool or group of insured individuals is spending money on health care expenses as compared to how much they are paying into the pool or group.

It is important to note that PPACA's current Medical Loss Ratio (MLR) regulations do absolutely nothing to lower health insurance plan costs or incite competition between health insurance carriers. In fact, the MLR incentivizes health insurance carriers to not compete and to sell really high cost health insurance plans, as PPACA basically guarantees them up-to a 20% share of the health insurance plan premium. Therefore, the more someone pays for a health insurance plan, means even more dollars, at 20 percent, for potential profit for the health insurance company.

One new issue that has come to light with COVID-19 is the real need for people to not have to switch health insurance plans, not have to restart health insurance plan deductibles, and not have to worry about losing access to their health care providers or prescription drug medications half way through the year, in the case of a sudden job loss or temporary unemployment. The COBRA program was never designed for a situation like the one we are facing today and is too inflexible to address our new reality.

Therefore, I am proposing an alternative Employer-based Individual-plan model for people to have health insurance coverage as an alternative to the Employer-based Group health insurance plan model. Basically, Employers should be allowed to form self-funded groups, or MEWA's, or Association Health Plans, Multi-State Plans, etc., that enroll people in Individual health insurance plans, as opposed to Group health insurance plans. This would be contingent on these organizations participating in the new national and shared risk pool and offering multiple health insurance plan options through the group to employees of the participating Employer groups. The health insurance plan costs and the administrative costs of the programs should all be treated as pre-tax dollars, meaning fully tax-deductible.

This new model should incorporate two very important criteria. (1) Employers must be required to contribute a minimum amount of funding per month of employment, or per year, to the employee health insurance plan cost and/or HSA account; or pay a comparable penalty to the national risk pool; and (2) Employers must offer these programs through an Employer-based exchange that provides advice to employees on how to pick the health insurance plan that is best for them and their families.

This employer program should require funding that is at least 50 percent higher than the newly proposed subsidy funding levels earlier in this document due to the cost shift benefit for employers!

The proposed Mandatory Employer Financial Assistance Level:

Employer Health Plan Assistance Requirement	Employer "Assistance"
Proposed Standard Minimum Assistance	$3,000/employee, $6,000/family
Proposed Maximum Assistance Level	$6,000/employee, $12,000/family

**It may be necessary to exempt Small Employers (under 50 employees) from this requirement.*

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