TOP 5 IDEAS FOR IMPROVING OBAMACARE HEALTH INSURANCE PLANS

2019 IDEAS FOR 2020 HEALTH PLANS

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Top 5 Ideas for Improving Obamacare Health Insurance Plans: 2019 Ideas for 2020 Health Plans

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1st Edition

Forward

This book is intended to serve as a tool for discussing politically viable ways to improve PPACA, Obamacare, Health Insurance Plans on a National basis across all health insurance markets. There are many known issues with the program as operating today; and the ideas here are a starting point towards addressing some items that will have significant impact in the short term. These fixes should help the far majority of people in the Country, with actually allowing for more affordable and comprehensive health insurance plan options by 2020.

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Executive Summary

This book and the ideas presented here are based on experience with the health insurance marketplaces and understanding of the need to find balance between all the players in the healthcare system, with competing interests, with the understanding that change happens slow; and that Government and Private Industry operate in very different ways. Another important aspect related to healthcare is that it needs to be "local", meaning people need basic healthcare services where they live, from people in their own communities, not dozens or 100's of miles away.

Where we are Today…

In general, PPACA, Obamacare, has not delivered on the promises of Affordable and High-Quality Health Insurance that were made when it was created and signed into Law, other than for those covered by Medicaid expansion. It's unfortunate; but the reality of where we are today, keeping in mind that many parts of the Law 'end' by 2026, under Congressional Budget Rules. Some reasons we are where we are today are due to PPACA promoting the consolidation of healthcare Providers (hospitals buying doctor's groups) and limiting options for negotiating drug prices. Today, many doctors are now cash-only; and even hospital networks are offering cash-only options.

We must also remember that Traditional Medicare costs $200-to-$300 per-month per-person, as each person must purchase Parts B, C and D, except for those also covered under Medicaid. Only Part A is covered at No Cost, for most people. Part B is "income-based", meaning the more you make, the more you pay. Also, people getting their Health Insurance through work typically pay $100's per-month per-person for their health insurance, not including copayments and $1,000's in deductibles.

Top 5 Ideas

1) How to have Better Health Insurance Plans

Implement a "New Standard" for the Actuarial Value Calculator (AVC) Tool by changing the 'basis' for costs and utilization from the "national per-capita (per-person) average cost" of healthcare in the entire Country, to the "median per-person" cost and utilization. This should result in approximately a 20% to 30% "decrease" to Health Plan Actuarial Values, from today's values.

"Separate" the Medical and Pharmacy Out-of-Pocket Maximum health plan expenses into two (2) separate categories, just like we do with Medicare today. This would allow for better Prescription Drug pricing negotiations; and allow people to pick a plan that best fits them, depending on if they need a health plan with better medical or better Rx benefits.

2) How to have Cheaper Health Insurance Plans

Re-establish the High-Risk Reinsurance Pools, on Federal and State Levels, utilizing a Medicare rate shared-risk model. Since 1% of people spend approx. 30% of all dollars, and 5% spend approx. 50% of all dollars, Reinsurance Pools could realistically decrease the cost of a health insurance plans by 20% to 30%.

3) Prescription Drug Affordability and Availability

One step to address Prescription Drug cost management and availability of low-volume and older generic drugs is by working with the new, just launching, Not-for-Profit and Non-Profit Consortium's that plan on manufacturing and distributing prescription drugs; and have them operate under historical models of Regulated Industries, limiting their Profitability.

4) Ways to Address Surprise and Balance Billing

Establish new “Out-of-Network” limits for what a person can be charged by an Out-of-Network Provider. For example, allow for billing a maximum of a multiple of Medicare rates for services provided at an In-Network provider that is also a Medicare provider; and for extending pre-negotiated discount health plan rates to non-covered services at contracted network providers.

5) Ways to Positively Promote Healthy Living

Establish a “Healthy Living Rewards Program” with Guidelines that incentivizes a healthy lifestyle, instead of penalizing people by charging them more for their health plans, unless they participate in pre-determined program. Think of this as establishing a new National “Health Rewards Program” system that allows others to help pay for your health insurance and your healthcare expenses, based on healthy living spending habits.

Idea Detail Section

Ways to Make Health Insurance Plans Better

Implement a "New Standard" for the Actuarial Value Calculator (AVC) Tool by changing the "basis" for the AVC from the "average per-capita (per-person) cost and utilization of healthcare services" in the entire Country, to either: 1) The "median per-person" cost and utilization of healthcare services for Commercial-only plans, keeping Medicare, Medicaid and VA per-person costs and utilization out of the calculation. Or, 2) A standard population as chosen by HHS, also excluding Medicare, Medicaid and VA per-person costs and utilization.

The result should be approx. a 20%-to-30% "decrease" in AVC Health Plan Values for all health plans from today. This would mean that "all" deductibles and co-payments should decrease; and that *very few plans would be subject to the Cadillac Plan Tax* (currently delayed for 2 more years).

Basically, this does not change the "cost" of your health plan; however, it does mean that insurance companies would be able to offer you better health plans, with lower deductibles and lower co-payments on your healthcare services.

"Separate" the Medical and Pharmacy Out-of-Pocket Maximum health plan expenses into two (2) separate categories, just like we do with Medicare today. We could keep the same Out-of-Pocket maximums that are under PPACA; but instead of having them add together to one (1) single out-of-pocket maximum, we could have them add up separately. For example, Medical expenses could add to no more than $3,000 per person; and Prescription drugs could add to no more than $3,000 per person, meaning the maximum would be $6,000 per person. This would be similar to how Medicare plans work today!

There would be several results that could come out of this change, with the most important being that insurance companies would be able to sell to people health plans that best fit their individual and family needs.

Basically, a person that has a lot of Medical expenses with very few Pharmacy expenses would be able to buy a health plan that keeps their out-of-pocket Medical expenses low while having higher out-of-pocket costs on their Prescription drugs, while a person with high Prescription Drug expenses and low Medical expenses could get a health plan with good Rx benefits and higher out-of-pocket Medical costs.

Ways to make Health Insurance Plans Cheaper

We need to Re-establish the High-Risk Reinsurance Pools that existed before PPACA, on a Federal Level, with State Level support. It is important to understand that 1% of all people spend approx. 30% of all healthcare dollars; so, we need to pay for them a better way! The best way is to have everybody in the Country chip into one large pool to help pay those expenses; and to not do what PPACA has done today, which is to transfer those big costs to just a small group of people in the Individual and Small Group marketplaces within each State.

The major result here would be a "decrease" in what we pay for health insurance plans, if done properly, throughout the Country. Some States have started doing this on their own and reduced, on a one-time basis, the costs of health insurance plans in their State. However, the best approach would be a "shared-risk" model, meaning that everyone shares in the costs to cover the really sick people; and that healthcare providers and pharmaceutical companies "do not" get to bill unlimited costs.

The best way to create a shared-risk model is by extending the Medicare Reimbursement Rates to all people placed in the pool, probably people with a million dollars or more per year in expected expenses. If it becomes a question of funding the Pool, a shared-risk pool could be created. Pool example: Medicare pays 1/3rd of what a Commercial health plan pays; so have insurance companies pay 2/3rd's of the Medicare rate to put people in the pool, while costs are paid out to Providers/Drug companies at 1/3rd the cost, with 1/3rd of the cost going toward paying for the pool expenses and reserves, with any excess funds being evenly distributed back to the Providers/Drug companies for keeping the costs manageable for the people in the pool.

Prescription Drug Affordability and Availability

We need to consider many different ways to manage Prescription Drug costs and the availability of low-volume and older generic drugs. There are a number of new Not-for-Profit or Non-Profit Consortium's being formed in the Country that plan on owning, manufacturing and distributing prescription drugs, with the goal being able to keep down prices and make older and little used drugs more affordable and more available for hospitals and for people. However, there are many details that still need to be addressed on how these organizations will operate for the benefit of all.

One possible solution is for them to operate by adopting historical models of Regulated Industries that have limits on their Profitability. This means that the Government limits their ability to generate Profits or enrich those that operate those Consortium's. There are several models that exist today that can be adopted; and consideration should be given to adopting a model that is best for the benefit of all. Another major issue is how these Consortium's would acquire the Patents and/or Licenses to manufacture and distribute these prescription drugs throughout the Country.

Another item to consider is related to "new" prescription drugs that are developed using "Public" dollars, either partially or entirely, through funding provided by Non-Profit, Not-for-Profit or Government Grants. There should be consideration to establish price limits on these drugs, as the risk of development is either partially of fully paid by "Public" dollars. This issue is best handled through Government Regulations.

By choosing an appropriate model, the main result would be more and lower cost drugs available to everyone. One approach, to address all these major issues, could be for the Government to

issue two (2) major regulations, related to drug patents/licenses and to the manufacture and distribution of these drugs.

1) Allow the current patent owners and licensors of the prescription drugs to either donate or license, at no cost, to the new Non-Profit Consortium's any prescription drug for which they control the rights "in exchange for" an ongoing and reasonable tax deduction/credit that they can use to offset profits from other drugs.

2) Limit the profitability of the new Not-for-Profit or Non-Profit Consortium's, as was historically done in Regulated Industries, to a multiple of the "actual cost of manufacturing" of the prescription drug, not including S,G&A expenses (Salary, General and Administrative), or limit the S,G&A expenses to no more than 30% of the manufacturing cost of the drug.

Ways to Address Surprise and Balance Billing

Since the rollout of PPACA / Obamacare, the entire healthcare industry has started rapidly consolidating; resulting in double-billing from hospital owned providers, known as "Facility Fee" bills; and there are now fewer available "In-Network" doctors, also resulting in additional Out-of-Network bills and/or bills for Non-Covered services. Therefore, we need to establish new "Out-of-Network" limits for what a person can be charged by an Out-of-Network Provider. These issues need to be addressed Nationally, and sooner, rather than later.

These are two (2) possible scenarios to address these 'new' issues that have come from PPACA / Obamacare.

1) If a Provider is working at a Network Contracted Provider, such as in a Hospital Emergency Room or Surgical Center, that is a "Certified and Licensed" Medicare Provider, then the limit of the Out-of-Network bill could be 3 times what Medicare pays for all the provided services.

2) If a person's health plan does not cover a service at a Contracted Network Provider, due to the insurance company deciding it is a "non-covered" benefit, including ER visits deemed non-emergency after-the-fact; then, the Insurance company "must extended the network discount price to the insured individual" even though it will not count towards the out-of-pocket maximum of the health plan.

The result is that many unexpected balance bills that people get today would at least be limited to be no more than what the insurance company would pay or 3 times the Medicare rate, instead of unlimited and sometimes outrageous bill rates. HHS/CMS should be able to issue guidance for Medicare Certified and Licensed Providers.

Ways to Positively Promote Healthy Living

The goal would be to create Integrated "Whole-Person" Centered Programs, with the understanding that health care services are one way a person maintains their health.

Today, we spend a lot of time concerned with "allowed" Benefit offerings, which are tied specifically to the Federal Tax Code. We should allow for more flexibility in the "offering" of Healthcare Benefits; and more ways to have more payers for the health insurance plans, even if it is on a "Taxable" basis.

For example; "new" programs could allow for Healthcare Providers to partner with Consumer Goods and Services companies to provide cash or cash-equivalent Incentives for healthy living; for one to buy healthy foods; and for one to Exercise. (pilot programs happening today)

Consumer Goods companies could offer to pay for your Health Insurance plan and/or to contribute money into your HSA account. Think of it as a "Health Rewards Program" that allows others to help pay for your health insurance and your healthcare expenses, based on healthy living spending habits.

There should be new Employer options for Employers to offer to Employees too. One new option could be to have an Employer offer a Defined Contribution for the Employee to buy their own health insurance plan; and/or for the Employee to contract directly with a Healthcare system of Provider that would be paid by the Employer for the Employees health plan. Employees should be able to have the funds paid directly to their healthcare Provider, pre-tax, through a TPA; or be able to purchase their own health insurance plan on a pre-tax basis.

Appendix

More on Actuarial Values and Risk Pools

Actuarial Values and Risk Pools

The Actuarial Value Calculator (AVC) – A Flawed Design

The Actuarial Value Calculator (AVC) and the accompanying Plan Design allocation Tiers (Platinum, Gold, Silver, Bronze) fundamentally undermine the entire National health insurance marketplace and the health care system, at the same time. The AVC basically forces everyone to have to enroll in a High Deductible or HSA plan by approx. 2022 *and* to pay significantly more than they pay today for their health insurance, even for people enrolled in Employer plans!

If everyone is not in a High Deductible or HSA health plan, by approx. 2022, then the health plan will be subject to a 40% Federal Tax. Yes, the 40% Cadillac Plan Tax. If the tax had not been delayed, today, over 60% of employer group health plans would already be paying the extra 40% tax, especially health plans that Government and Union employees have today.

The Fundamental Issue with the AVC

The AVC treats every person as an "average" consumer of health care services, which means each and every person spends approx. $10,000 per-person per-year for health care services, as of 2016, and rising rapidly! The problem is that over 50% of people spend less than $1,000 per-person per-year on average for health care services, while 5% of all people spend over 50% of all the health care dollars per-year.

Therefore, the AVC is fundamentally flawed… The reality is that there is no way to create a "tool" that can adequately determine the "Value" of covered health care services of a health plan; because health care spending is so lopsided to the 5%. The new PPACA, Obamacare, system is broken and needs to be fixed.

Whether people realize it or not, the design of "every single health plan in the Country" is controlled by the Government, at this time, through the Actuarial Value Calculator (AVC) Tool.

It may be okay to regulate and require a list of health insurance benefits (EHBs) to be covered by all health insurance plans; however, it is an entirely different issue when the Government tells insurance companies what to charge people for copayments, coinsurance, and deductibles, etc.

Understanding the AVC

The least understood issue of "affordability" of health insurance plans is the impact of the AVC and the fact that it sets ALL health insurance plan design and health plan costs using the "law of averages" for costs and utilization of healthcare services.

The AVC compounds the impact of not having a High-Risk Pool; because the AVC uses the "national average cost" (per-capita) for determining the cost-sharing by people purchasing health insurance plans, even though 1% of people spend over 30% of all dollars, and 5% of people spend over 50% of all dollars. Yet, 50% of all people spend less than $1,000 per person per year. What actually happens behind the scenes within the AVC Tool is that "all" the utilization and healthcare costs of the top 5% are placed on to the other 95% of all people.

For example, a typical person, in the 95%, may only go to a doctor 2 or 3 times a year. However, a high-risk individual with multiple chronic conditions may go 2-to-3 times per month. Basically, 3 visits per year versus 30 visits. The AVC Tool looks at the math and says, the average of the two is 15 visits; therefore, both people must pay for 15 visits per year!
This creates many issues that very few people understand; and is how the AVC Tool actually undermines the entire health care

system, as it destabilizes the health insurance marketplaces for Individual and Employer plans, including for Government and Non-Government Employer health plans.

Health Plan Math Example:

70% Silver Plan "How your price is pre-set by the AVC Tool":

A Silver Tier 70% Plan divides up the $10,000 current average (per-capita) per-person per-year spending on health insurance between the person buying the insurance (30%) and the insurance plan (70%); plus, up-to 20% more added for the health insurance company for administering the program.

Therefore: a 40-something (or the Employer) should expect to spend $8,400/year ($700/month) per-person for a Silver 70% Plan, not counting the up-to $3,000 in healthcare expenses the insured person would be expected pay. Adjust it for a 20-something, at half the rate, $350/month; or for a 60-something, at 1.5 times that, $1,050/month.

Note: The Catastrophic Plans are EXEMPT from the 3:1 Pricing Ratio under PPACA, hiding the fact the Ratio would be 5:1 or 6:1, as Catastrophic Plans are priced at ~50% less than the Standard 20-something rate. The Catastrophic Plan, available only to a person under age 30, costs approx. $175/month, compared to an almost identical Bronze (60%) Plan at approx. $350/month.

The real issue is that we should never have eliminated the High-Risk Pools when PPACA was rolled out in 2014. We should have left the High-Risk Pools in place for the 5%; and then, we would probably have far more affordable health insurance plans today, without also forcing everyone into high deductible health plans.

High Risk Pools

High-Risk Pools are probably the simplest, oldest, and most well understood and agreed-upon method for lower the cost of health insurance plans in the marketplaces today, addressing the "affordability" of health insurance plans. PPACA attempted to replace the High-Risk Pools with an incredibility complicated multi-layered system, which completely failed.

The original PPACA design of the merging of the High-Risk Pools into the greater population was estimated to have a 2%-to-4% cost increase impact on Individual health plan costs. However, the reality is that the integration turned into a cost impact of approx. a 20%-to-40% increase to health insurance plan costs in the Individual marketplaces.

The most important and most immediately impactful thing that can be done to make Individual health insurance plans more affordable is to re-establish National/Federal High-Risk Pool for all marketplaces that are also based on a risk-share model, meaning no unlimited billing by healthcare providers.

One way to address the risk-share model is to have High-Risk Pool members bills paid at a ratio of the Medicare reimbursement rate. It would reduce the funding required; and only be the equivalent of adding just one more year of Baby Boomers into the Medicare enrolled population. In fact, many of the Baby Boomers are statistically the people that would be placed into the High-Risk Pools today; therefore, they would be moving to Medicare reimbursement rates just slightly ahead of schedule.

<u>Example for Understanding High-Risk Pools</u>:

Over-simplified, using historical State of CT data…

Pre-PPACA, the CT high risk pool had losses of approx. $40 million dollars, for less than 2,000 people enrolled. Those losses were

charged back the insurance companies based on the number of people each insurance company insured in the State on a pro-rata basis, approx. 2 million people in CT. Therefore, the annual cost per-person was approx. $20 per-year! Very reasonable! Fast forward to today (adding inflation), that cost would now be approx. $40/year per person.

However, under PPACA, today, that $40 million would be divided up "only" among the 100,000 people in the Individual insured market, not across 2 million people. Therefore, each person would have to pay approx. $400 per-year to support those losses for the 2,000 people that were in the high-risk pool, who were moved to the Individual insurance marketplace.

But wait…we have to adjust for age-bands now… Since that cost is included in the price of health plans today, that means we have to adjust that payment based on each person's age. For a 20-something, it becomes approx. $200 per-year; and for a 60-something, it becomes approx. $600 per-year.

Now, add inflation, as we adjust the prices to today's dollars… The $400 per-year becomes at least $800 per-year; meaning a 40-something would be paying $800 more per-year, while a 20-something would be paying $400 more per-year, and a 60-something would be paying $1,200 more per-pear more to cover those loses. (The 3:1 Ratio)

To fix this issue going forward, we need to bring back the High-Risk Pools; and we should take a holistic and multi-faceted approach, including thinking outside the box…

<u>Holistically speaking, we should consider the following:</u>

1) A National High-Risk Pool to cover people with healthcare expenses above $500,000 or $1 million per-person per-year.

2) State High Risk Pools to cover people with healthcare expenses above $100,000 or $250,000 per-person per-year, to bridge to the National High-Risk Pool.

3) A Risk-Sharing or Cost-Sharing Partnership Program with Healthcare Providers and Pharmaceutical Firms for people with healthcare expenses that exceed the $500,000 or $1 million per-person per-year. Providers and Drug Firms should be part of the High-Risk pool strategy by accepting a multiple of Medicare Reimbursement Rates for people in the High-Risk Pools.

4) Allow Employer Groups to participate in the High-Risk Pools for their Employees, contingent that they can show reduced costs for other Employees and their Families. This should also motivate Employers to hire older individuals and individuals that may be perceived to be High-Risk individuals, such as those recovering from addiction.