CHAPTER TWO

Reform #1: Expand Affordable Private Insurance

Principal Features of Reform #1: Expand Affordable Private Insurance

- Permit all insurers (including all companies available on any state or federal exchanges) to offer true high-deductible, limited-mandate catastrophic coverage (LMCC) plans to all citizens, covering hospitalizations, outpatient visits, diagnostic tests, prescription drugs, and mental health.
- Transfer ownership of coverage to the individual so that it is portable; employer still available for sign up and automation of payments
- Permit insurers to eliminate Obamacare's 3:1 age-based premiums
- Permit insurers to risk-adjust premiums for obesity, as is already allowed for smoking.
- Eliminate the health insurance premium excise tax.

The Importance of Private Health Insurance

Broad access to doctors and hospitals comes with private insurance, not government insurance. The harsh reality awaiting low-income Americans is that most doctors already refuse to take new Medicaid patients because of government-defined low reimbursements, numbers that dwarf by eight to ten times the percentage that refuse to take new private insurance patients.[1] According to a 2014 Merritt Hawkins report, 55 percent of doctors in major metropolitan areas refuse to take new Medicaid patients.[2] The Department of Health and Human Services reported in December 2014 that even of those managed care providers signed by contract and

on state lists to provide care to Medicaid enrollees, 51 percent were not available to new Medicaid patients.[3]

Like Medicaid, a superficial look at Medicare appears satisfactory to most of its beneficiaries, but on scrutiny we see a different scenario unfolding today. While the population ages into Medicare eligibility, a growing proportion of doctors do not accept Medicare patients. According to the Medicare Payment Advisory Commission, 29 percent of Medicare beneficiaries who were looking for a primary care doctor back in 2008 already had a problem finding one.[4] In 2012 alone, CMS reported that almost ten thousand doctors opted out of Medicare, nearly tripling from 2009; according to the Texas Medical Association, the number of Texas physicians accepting Medicare patients dropped to 58 percent in 2012. In a 2014 physician survey, about one-quarter of doctors no longer see Medicare patients or limit the number they see; in primary care, 34 percent refuse Medicare patients.[5] The percentage of doctors who closed their practices to Medicare or Medicaid by 2012 had increased by 47 percent since 2008.[6]

Beyond access to care, the quality of medical care is also superior with private insurance. For those with private insurance, that quality includes fewer in-hospital deaths, fewer complications from surgery, longer survival after treatment, and shorter hospital stays than similar patients with government insurance.[7] Restricted access to important drugs, specialists, and technology under government insurance most likely account for these differences.

The Harmful Impact of the ACA on Private Insurance

Affordable private insurance options have clearly not been improved by the ACA. As a direct result of the ACA's new regulations on pricing and its new mandates on coverage, the law has already forced more than five million Americans off of their existing private health plans. The Congressional Budget Office (CBO) projects that a stunning ten million Americans will be forced off their chosen employer-based health insurance by 2021—a tenfold

increase in the number that was initially projected back in 2011.[8] Meanwhile, private insurance premiums have greatly increased under Obamacare and are projected to skyrocket in 2016, in some cases increasing by 30 percent to 50 percent and more. The shift into government insurance itself also increases private insurance premiums. Because government reimbursement for health care is often below cost, costs are shifted back to private carriers, pushing up premiums. In some calculations, the underpayment by government insurance adds $1,800 per year to every family of four with private insurance.[9] Nationally, the gap between private insurance payment and government underpayment has become the widest in twenty years, doubling since the initiation of Obamacare, according to a 2014 study by Avalere Health.[10] Even more ominous, consolidation among the five big private insurers has accelerated, a trend that most analysts believe will raise premiums for individuals and small businesses. This rise will impact not only the individual but also taxpayers, because taxpayers subsidize those increasing premiums under Obamacare.

Choices of private insurance and covered providers under them are dwindling as well, despite the theory that the law would increase insurance choices and competition. According to a December 2014 study,[11] the exchanges offer 21 percent fewer plans than the pre-Obamacare individual market, with a decrease to 310 nationally in 2015 compared to 395 insurers in the individual market in 2013, the last year before this implementation of Obamacare.

For middle-income Americans dependent on subsidized private insurance through government exchanges, Obamacare is also eliminating access to many of the best specialists and best hospitals. McKinsey reported that 68 percent of those policies cover only narrow or very narrow provider networks, double that of the previous year.[12] The majority of America's best hospitals in the National Comprehensive Cancer Network are not covered in most of their states' exchange plans. And as of late 2014, we are experiencing a severe shortage of the specialists essential to diagnose and treat stroke, one of the most disabling and lethal diseases in the United

States (in some cities, the number is actually down to zero) under Obamacare insurance plans.[13] The narrow network strategy is hitting even more Americans in 2015, as Obamacare exchange plans restrict access to doctors and hospitals far more than insurance bought off exchanges, in an attempt to quell insurance premium increases caused by the law itself.[14]

Keys to Expanding Affordable Private Insurance

Fundamental change to private insurance is vital to leveraging consumer power and expanding health care access for everyone. The ACA has made private insurance less affordable and pushed health insurance reform in the wrong direction. It has furthered the erroneous view that insurance should subsidize the entire gamut of medical services, including routine medical care. When that inappropriate function of insurance is combined with the cloak of secrecy shielding health care prices and provider qualifications, consumers have neither an incentive nor the necessary means to invoke value into health care decisions.

On the other hand, high deductibles with catastrophic coverage would restore the essential purpose of insurance—to reduce the risk of incurring large and unanticipated medical expenses. Because they would pay for most medical care directly, consumers would have the incentive to choose wisely. Provider prices would consequently become more visible and align with what consumers value, rather than being set artificially or by government decree.

The behavior of American consumers counters the ACA's approach to insurance reform and validates the argument that higher-deductible coverage both generates more affordable insurance and reduces health spending. In the decade since the tracking of this type of coverage, consumers have increasingly selected high-deductible plans (Figure 2.1), and among those enrollees, a shift toward higher deductibles has continued (Figures 2.2 and 2.3).[15] Consumer spending is significantly reduced for those in high-deductible plans,[16] without any consequent increases in emergency room visits

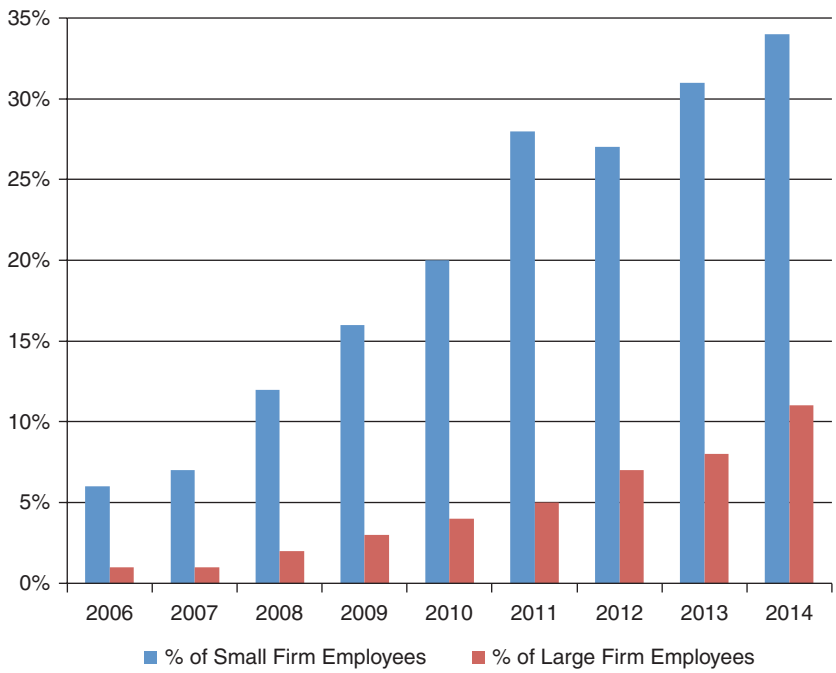

FIGURE 2.1. Percentage of Covered Employees with a Deductible of $2,000 or more, Single Coverage, by Firm Size and Year.
Consumers have increasingly chosen high-deductible coverage.
Source: Data compiled from Employer Annual Health Benefits surveys, Kaiser Family Foundation, http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

or hospitalizations and without the hypothesized harmful impact on low-income families or the chronically ill.[17] Health spending reductions averaged 15 percent annually, and the savings increased with the level of the deductible and when paired with HSAs. More than one-third of the savings by enrollees resulted from lower costs per health care utilization,[18] that is, value-based decision making by consumers. Additional evidence from studies of consumers' use of magnetic resonance imaging[19] and outpatient surgery[20] shows that introducing price transparency and defined-contribution benefits further encourages price comparisons by patients. While especially relevant to patients using high-deductible plans with HSAs, these reforms would reduce expenditures by all health care consumers.

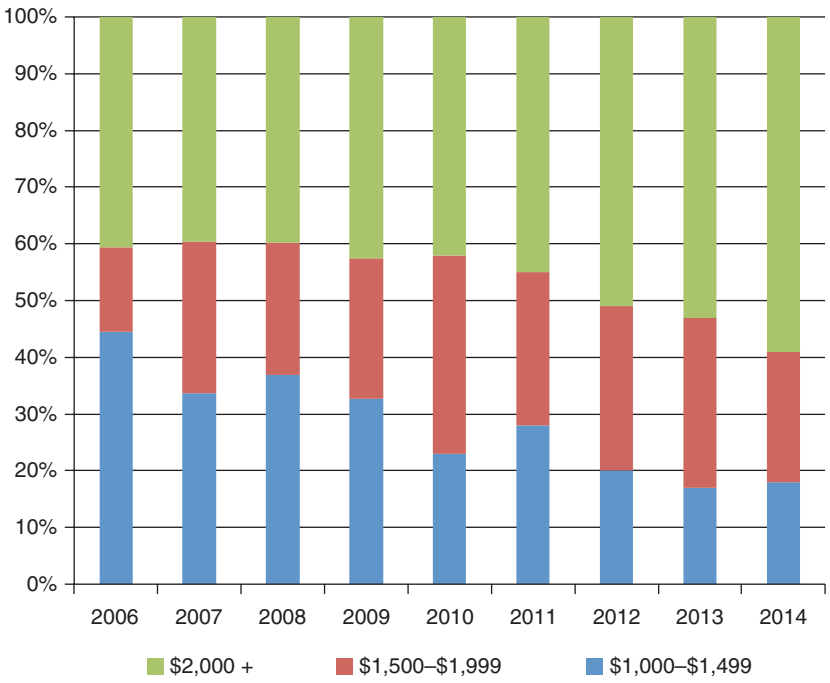

FIGURE 2.2. Deductible Distribution in High-Deductible Plans with Savings Account Options, by Year.
Among those enrolled into high-deductible coverage, consumers have shifted to higher deductibles. *Source:* Data compiled from Employer Annual Health Benefits surveys, Kaiser Family Foundation, http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

Affordable private insurance, specifically with high deductibles and HSAs, should be a principal focus of health care reform (see chapter 3) in order to both improve benefits and reduce costs. To expand affordable private insurance options, we need to reduce onerous regulations on insurance, many of which have specifically harmed high-deductible plans. While consumers are still increasingly opting for plans with deductibles greater than $2,000, the growth rates have slowed compared to the growth before ACA mandates and restrictions (Figure 2.4). In addition, the premiums of high-deductible plans are accelerating faster after the passage of the ACA than any other coverage[21] (Figures 2.5 and 2.6), although they remain less costly than other types of coverage. We cannot be certain whether these changes are entirely caused

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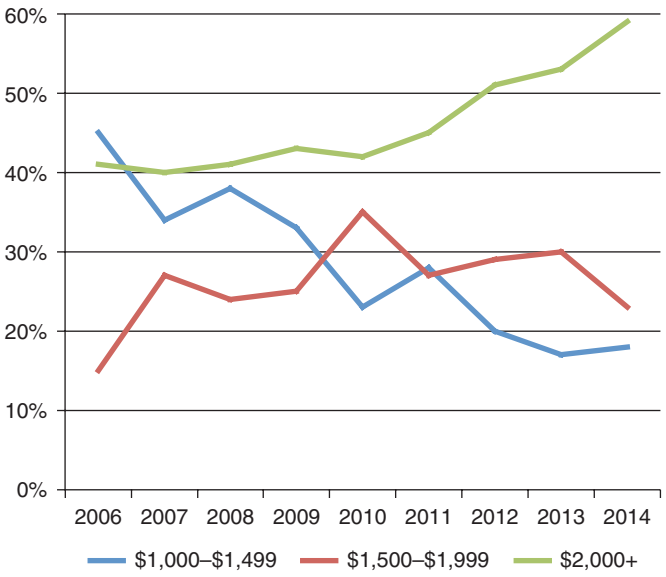

FIGURE 2.3. Trends in Deductible Distribution in High-Deductible Plans with Savings Account Options.
The shift of enrollment into higher deductibles for enrollees in high-deductible plans with associated savings accounts comes at the expense of the low-deductible range.
Source: Data compiled from Employer Annual Health Benefits surveys, Kaiser Family Foundation, http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

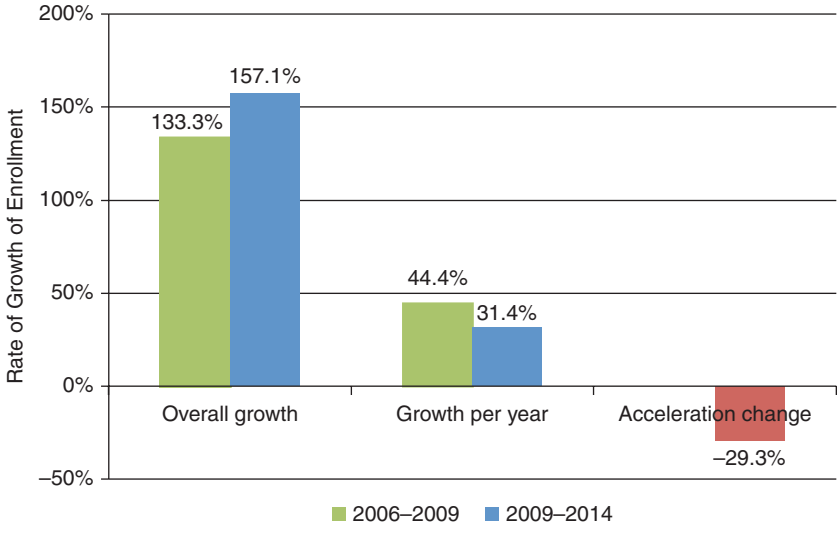

FIGURE 2.4. Enrollment Rate of Growth, Deductible of $2,000+, Single Coverage, All Firms, Before vs. After Passage of ACA.
The growth rates of enrollment into high-deductible plans have decelerated since the passage of the ACA.
Source: Data compiled from Employer Annual Health Benefits surveys, Kaiser Family Foundation, http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

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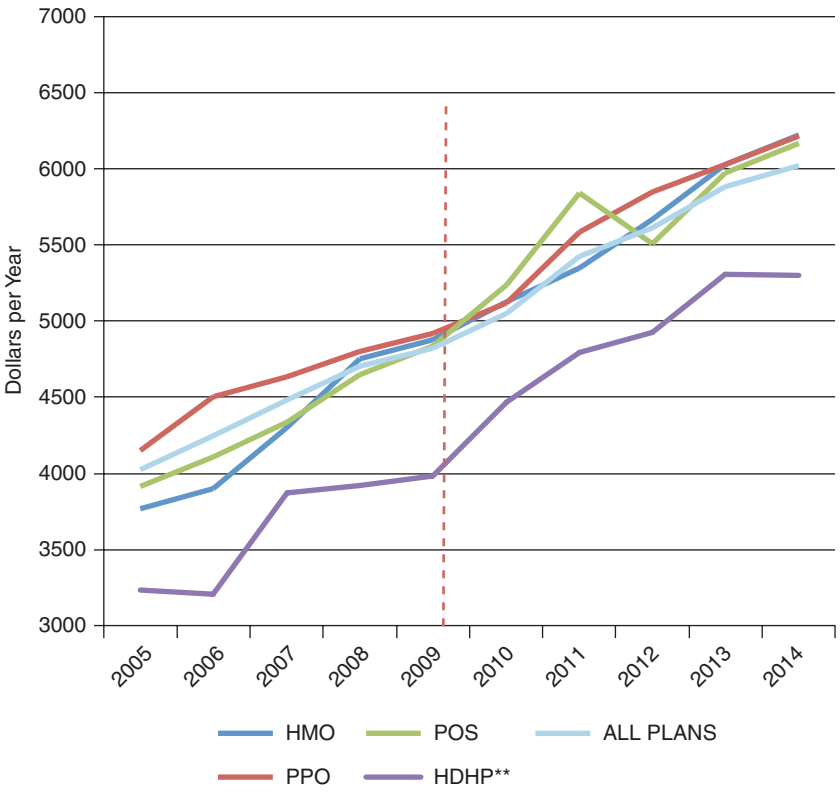

FIGURE 2.5. Premiums by Plan Type, Before vs. After Passage of ACA.
The annual premiums for all types of insurance coverage have increased over the past decade (vertical line indicates passage of ACA).
Notes: HMO, health maintenance organization; *PPO*, preferred provider organization; *POS*, point of service; *HDHP*, high-deductible health plan. Premiums include both employee and employer payments; **HDHP includes high-deductible plans offered with either a health reimbursement arrangement or HSA.
Source: Data compiled from Employer Annual Health Benefits surveys, Kaiser Family Foundation, http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

by Obamacare's regulations, such as limits on deductibles, but clearly health system reforms should not selectively make these plans less affordable for consumers. Restoring the choice of LMCC with truly high deductibles would add the more affordable coverage that many consumers value.

We should eliminate unnecessary coverage mandates that have ballooned under the ACA. Let's strip back many of Obamacare's so-called minimum essential benefits that have increased premi-

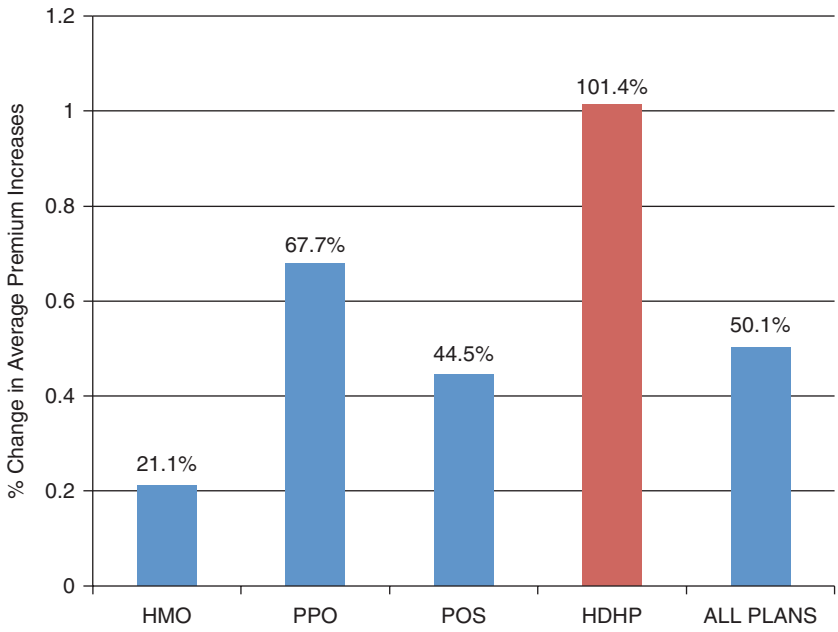

FIGURE 2.6. Acceleration of High-Deductible Health Plan Premium Increases (%) Before (2005–2009) vs. After (2009–2014) Passage of ACA.
Although all types of insurance plans have increased in price faster after the bill's passage compared to before the bill's passage, Obamacare regulations have accelerated the increase in premiums of high-deductible plans more than any other type of coverage.
Notes: HMO, health maintenance organization; *PPO*, preferred provider organization; *POS*, point of service; *HDHP*, high-deductible health plan. The high-deductible plans include those offered with either a health reimbursement arrangement or HSA; premiums include both employee and employer payments.
Source: Data compiled from Employer Annual Health Benefits surveys, Kaiser Family Foundation, http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

ums by almost 10 percent[22] and eliminate most of the more than 2,270 state mandates[23] requiring coverage for everything from acupuncture to marriage therapy. We should remove archaic obstacles to competition, including barriers to out-of-state insurance purchases. To eliminate unfair cost shifts imposed by the ACA that raised premiums for younger, healthier enrollees by 19 percent to 35 percent,[24] we should remove the 3:1 ACA dictate on actuarial regulations for age-rated premiums. Finally, we should repeal the ACA's new annual health insurance providers fee ($11.3 billion in 2015) that insurers pass on to enrollees through increased

premiums, according to the CBO.[25] The ACA imposed this new sales tax on health insurance beginning in 2014, and the Joint Committee on Taxation (JCT) estimated that the tax burden will exceed $100 billion over its first decade and raise consumers' premiums by up to 3.7 percent per year. This specific tax will increase insurance costs by thousands of dollars over the decade for individuals, families, businesses, and even the beneficiaries of the government's own insurance programs—both Medicare and Medicaid.[26]

In addition, health insurance reform is a powerful opportunity to incentivize healthy lifestyles. Two behaviors deserve special consideration. Cigarette smoking and obesity are the two most important lifestyle behaviors, both proved to increase the risk for highly morbid chronic disease and worsen outcomes from those diseases, regardless of health care quality. Smoking causes $193 billion in direct health care expenditures and productivity losses each year, according to the Centers for Disease Control.[27] Extra medical care for obesity comprises up to 10 percent of total US health care costs.[28] Because of obesity's high prevalence and its association with multiple chronic diseases, worse treatment results, and more complications from even the best care, the annual US societal costs of obesity exceed $215 billion.[29] While smoking has declined, the burden of obesity to the US health care system and to taxpayers has increased to crisis levels. This situation will only increase over the coming decades, given that diseases from these risk factors typically show a lag time of twenty to twenty-five years. Even without a reduction, some of the costs could be alleviated. Eric Finkelstein of Duke University has projected that "*keeping obesity rates level could yield a savings of nearly $550 billion in medical expenditures over the next two decades*."[30] Health care reform in the United States urgently needs to embrace a new era of personal responsibility, and obesity, today's most serious public health problem of American society because of both costs and its damage to people's health, should be the highest priority.

Just as in other insurance, premiums that reflect the higher risk of disease and more frequent use of medical care as a consequence of voluntary, high-risk behavior are sensible, especially because three-fourths of health insurance claims may result from lifestyle choices.[31] Life insurance premiums are markedly higher for dangerous behavior such as smoking. Risky driving is a key factor in determining automobile insurance rates. Obesity and smoking are high-risk lifestyles, both of which are major drivers of health expense with well-known health hazards. A 1998 study showed that claims of individuals with a high body mass index (BMI) cost $3,537 (2015 dollars) more per year than claims of individuals with low BMI.[32] A 2012 study showed that annual medical costs for people who are obese were $1,429 higher in 2006 than those for people of normal weight; for Medicare patients, this difference was $1,723, with almost 40 percent the result of extra prescription drugs.[33] These numbers exceed the extra medical costs from smoking. A growing number of employers charge smokers higher insurance premiums. In the individual insurance market, the "obese BMI" category paid 22.6 percent more in premiums, and those with "overweight BMI" paid 12.8 percent more than "normal BMI" enrollees.[34] While acknowledging the complexity and limited knowledge about the influence of genetics on obesity development as well as the harmful health effects of obesity in any individual, actuarially based premium differences for obesity should be allowed in all health insurance plans.