Patient-Centered Health Reform
How Patient Choice and Private Competition Can Achieve Universal Coverage

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ACA EXCHANGE ENROLLMENT FAR SHORT OF PROJECTIONS

Predicted vs. actual ACA exchange enrollment, 2014-2026 (millions of enrollees)

- CBO 2010
- CBO 2014
- CBO 2016
- Actual
- FREOPPP 2017
ACA EXCHANGE PREMIUMS HAVE DOUBLED SINCE 2013

Median annual single individual market premium for 27-, 40-, & 64-year-old non-smokers
A TALE OF TWO PLANS: 2013 VS. 2014

- Two Kaiser plans in Sacramento, CA
- Equivalent actuarial value
- Identical provider network
- Nearly identical deductibles and benefits (except Rx)

<table>
<thead>
<tr>
<th></th>
<th>2013 Kaiser 50/5000</th>
<th>2014 Kaiser Bronze</th>
</tr>
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<tbody>
<tr>
<td>Monthly premium</td>
<td>$100</td>
<td>$205</td>
</tr>
<tr>
<td>Actuarial value</td>
<td>60.5%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Deductible</td>
<td>$5,000</td>
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</tr>
<tr>
<td>Out-of-pocket maximum</td>
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<td>Coinsurance (after deductible)</td>
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<td>Preventive care</td>
<td>$0</td>
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</tr>
<tr>
<td>Primary care office-visit</td>
<td>$40</td>
<td>$60*</td>
</tr>
<tr>
<td>Specialty care office-visit</td>
<td>$40</td>
<td>$70</td>
</tr>
<tr>
<td>X-rays &amp; lab-tests</td>
<td>$10</td>
<td></td>
</tr>
<tr>
<td>MRI, CT, PET</td>
<td>$150</td>
<td>30%</td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td></td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Prenatal visit</td>
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<td>Labor &amp; delivery</td>
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<tr>
<td>ED (waived if admitted)</td>
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<tr>
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<td>$25</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>$55</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
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A TALE OF TWO PLANS: 2013 VS. 2014

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- 105% higher premiums
- Higher out-pocket maximum

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# A Tale of Two Plans: Young vs. Old

Components of Silver plan premium increases in Wisconsin, 2014 vs. 2013

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<th>Component</th>
<th>27 y/o Healthy Male</th>
<th>57 y/o Unhealthy Female</th>
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<tr>
<td>3:1 Age Rating &amp; 1:1 Gender Rating</td>
<td>44%</td>
<td>2%</td>
</tr>
<tr>
<td>Risk Pool Composition &amp; Adverse Selection</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Actuarial Value &amp; EHB Mandates</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>1:1 Health Status Rating</td>
<td>10%</td>
<td>-27%</td>
</tr>
<tr>
<td>Pent-up Demand</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Exchange Fee</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Insurers Fee (ACA §9010)</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Reinsurance Pay-In</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Research Fee</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Reinsurance Claims Impact</td>
<td>-15%</td>
<td>-15%</td>
</tr>
<tr>
<td><strong>Total Rate Change</strong></td>
<td><strong>146%</strong></td>
<td><strong>16%</strong></td>
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- Covering individuals with preexisting conditions is **not** the largest driver of ACA premium increases.
- Requiring **young people** to pay higher premiums is the single biggest issue.

Source: Milliman
HIGH PREMIUMS HAVE LED TO LOW ACA ENROLLMENT

Percentage of eligible individuals in exchange plans, by income (% of Federal Poverty Level)

- 100-150%: 76% (2015), 81% (2016)
- 151-200%: 41% (2015), 45% (2016)
- 201-250%: 30% (2015), 33% (2016)
- 251-300%: 20% (2015), 26% (2016)
- 301-400%: 16% (2015), 17% (2016)

Source: Avalere Health
THE ACA’S ‘THREE LEGGED STOOL’: IN THEORY

- Market reforms
  - Higher premiums
  - Adverse selection
- Subsidies (tax credits)
- Individual mandate
THE ACA’S ‘THREE LEGGED STOOL’: IN REALITY

- Market reforms
  - Higher premiums
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- Individual mandate
REBALANCING THE ACA’S ‘THREE-LEGGED STOOL’

- Democratic proposals
  - More regulations (limit cost sharing et al.)
  - Increase subsidies
  - (Strengthen individual mandate)

- Republican proposals
  - Reduce adverse selection
  - Reduce or reform subsidies
  - Replace individual mandate
REDUCE ADVERSE SELECTION

• Repeal **age-based community rating** (3:1 age band)
  • Means-tested (or age-adjusted) tax credit subsidizes coverage for near-elderly
• Reform **actuarial value** requirements (‘Copper’ plans)
• Return **essential health benefit** management to states
  • Consider subsidizing maternity coverage as a separate rider
• Repeal health insurance **premium tax**
REFORM PREMIUM AND COST-SHARING SUBSIDIES

• Preserve **means-tested** structure of ACA tax credits
  • This is essential for assisting those with high actuarial risk (aged, sick)
  • Improve administrative burden by using previous year’s tax returns
• Reform premium assistance structure
  • Incorporate age adjustment from BCRA to attract younger enrollees
  • Adjust sliding scale to account for premium cliffs
• Convert cost-sharing subsidies into **HSA deposits**
REPLACE INDIVIDUAL MANDATE

- Repeal individual mandate
- Limit ability to game the system
  - Six weeks open enrollment (instead of three months)
  - Documentation required for special enrollment periods
  - Longer time between open enrollment periods (2 years vs. 1 year)
  - Shorten grace period
  - Late enrollment fees
- Auto-enrollment?
THE RESULT: MORE COVERAGE, HIGHER QUALITY, LOWER COST

• Expanded coverage above ACA levels
  • 12 million additional insured due to exchange reforms
  • Reduces single commercial premiums by 25%
• Paired with broader reforms, can achieve significant savings
  • Deficit reduction of >$8 trillion over three decades
  • Reduction in net federal & state tax revenues
  • Medicare trust fund permanently solvent
  • Medicaid reform = improved state fiscal stability
  • Improved health outcomes for the poor
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