Lowering Health Insurance Premiums

OUR IDEAS

JME
Insurance Agency

Lowering Health Insurance Premiums – Our Ideas

Since 2010, premiums, deductibles, and out of pocket expenses have increased exponentially.

Since the passage of the Affordable Care Act (ACA) in 2010, health insurance premiums have risen significantly for individual as well as group policies, particularly small group plans.

As licensed health insurance agents with hundreds of employer and individual clients, we've seen the negative effects of these premium increases time and again.

In an effort to keep prices under control, insurance companies have:

1) increased deductibles and out-of-pocket limits on most plans while dropping up-front copayments for doctor visits and prescriptions,
2) modified their drug formularies, and
3) significantly modified their individual plan offerings by using smaller HMO networks.

At JME Insurance Agency, we've put this paper together to share our experiences and our thoughts about the factors contributing to the current instability in the individual and small group markets. We also have some ideas about how to reverse this disturbing and unsustainable trend.

Contributing Factors

Before we can determine how to reverse this trend in premium increases, we need to examine the factors that have contributed to these skyrocketing costs.

1

The ACA eliminated underwriting

Across all lines of insurance (health, life, auto, home, etc.), insurance companies base their decision to issue or decline coverage as well as the premiums they charge on the risk characteristics of the applicant. This is known as *underwriting*.

Under the Affordable Care Act, medical underwriting was eliminated in the individual and small group markets. Not only must insurance carriers accept all applicants, they cannot charge more for pre-existing conditions or place a waiting period on those conditions. Prior to the ACA, insurance providers in the individual market could decline coverage, place "riders" on certain conditions, or charge more for sub-par risks. In the small group market, while they had to issue coverage, insurance companies could "rate up" groups with above average medical conditions or claims cost. The rate differential could be up to 67% in the state of Texas and even more in some states. Additionally, carriers could impose a twelve-month waiting period on pre-existing conditions for people with group health coverage who had not had continuous coverage over the previous year.

As a result of the new rules and the resulting "adverse selection," insurers are rating all applicants as poor risks.

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Health plans are no longer insurance but pre-paid medical care

While cost sharing on both group and individual plans has increased significantly since 2010, requiring all consumers to pay more for medical care, this list of covered services, particularly for individual health plans, grew significantly because of the Affordable Care Act's "Essential Health Benefits" requirement. This increases the price of all health plans, even if the covered individual has no need for those services.

Imagine what your auto premium would be if automobile insurance policies had to cover new tires, routine maintenance, car washes, etc.

3

Maternity is a covered benefit on all ACA plans

To elaborate on the point that the essential benefits requirement increases premiums for everyone, maternity is now covered on all ACA-compliant individual and small group plans.

Prior to the Affordable Care Act, individual health plans provided maternity coverage only if the member elected a rider and paid an additional premium for a specified timeframe before receiving the benefit. For small group plans, an additional premium only applied to those in child bearing years.

4

The individual mandate is ineffective

Unfortunately, the penalty under the individual mandate for going without health coverage is very small relative to the cost of health insurance, and there are also a number of exemptions from the individual mandate penalties. Together, these make the individual mandate largely ineffective. As premiums increase and plan benefits

are reduced (higher cost sharing, smaller networks), the perceived value of health coverage decreases, causing even more people to forego coverage and simply pay the penalty. Many young people went without health insurance. Recently, older healthy individuals have started making the same decision.

There's also a gap in the individual mandate requirement. One of the individual shared responsibility penalty exemptions is for a short gap in coverage of three months or less. This means that people who have health coverage for just nine months out of the year are able to avoid a penalty.

The grace period is too long

People who have coverage through the Marketplace and who are receiving a premium tax credit have a 90 day grace period to pay their premiums. This is two months longer than the normal insurance grace period and leads to losses for both providers and insurers.

The marketplace website is too costly

The cost of establishing and updating the Healthcare.gov website and staffing the call center is very expensive. To help offset the cost, a fee is added to plans purchased through the Marketplace.

SEPs let people work the system

Special enrollment requirements were not enforced allowing people to enroll whenever they had a medical issue. Many would enroll when an issue was diagnosed, only to term again once their treatment had ended.

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The OOP limit drives up prices

We've already said that out-of-pocket costs have increased since the ACA was passed, so it seems odd to blame the OOP limit for higher health insurance premiums. After all, one way to keep premiums down is to increase the member's share of the out-of-pocket costs.

However, the ACA made two major changes to the out-of-pocket maximum. One change required insurance carriers to apply the copayments for office visits and prescription drugs to the plan's out-of-pocket limit. Copayments already shield consumers from the true cost of care, encouraging utilization. When these copayments apply to the plan's OOP maximum, consumers hit their cost sharing limit even sooner, their cost changes to zero, and utilization increases even more.

The health law also places a statutory maximum on out-of-pocket costs for all plans, not just High Deductible Health Plans. While some people appreciate this protection, others would happy with a limit of $10,000 or more. Under the Affordable Care Act, though, they're forced to purchase more costly plans with lower out-of-pocket exposure. In short, people who are well off financially and would like to retain more of the risk for their health care are forced to over-insure.

10

Actuarial Values reduce options

Not only are insurers forbidden from offering plans with higher out-of-pocket limits, they must fit their plan designs within specified Actuarial Value corridors that correspond to the four metallic tiers (bronze, silver, gold, and platinum). Only a de minimus variation of plus or minus 2% is allowed.

The result of these actuarial value requirements is that carriers do not have an effective way to vary plan designs and reduce premiums through relatively minor benefit changes and consumers are left with fewer options when shopping for health coverage.

11

Community rating hurts young, healthy clients

The Affordable Care Act pairs the guaranteed issue provision with new "modified adjusted community rating" rules. Not only can carriers not consider pre-existing medical conditions when pricing their plans, they also cannot rate based on gender. It is still permissible to charge a higher rate for smokers in the individual market, but an individual's weight, which was a standard question on individual medical applications before the ACA, is no longer a permissible rating factor.

Additionally, insurers used to charge older individuals as much as five times what they charged younger people for the same plan. The ACA reduced the allowable age rating to 3:1. While this helps older members, it increases the price for younger individuals and discourages them from purchasing coverage. As a result, not enough young people are enrolled in individual coverage to maintain a healthy insurance pool.

12

New fees add to the cost

As if the cost of coverage wasn't already high enough, Health Insurance and Reinsurance Fees of about 2.6% were added to the premiums for all plans. While this sounds relatively minor, it can cost families hundreds of dollars per year.

The Affordable Care Act has created what's known in the insurance industry as a DEATH SPIRAL. Because the guaranteed issue provision encourages a disproportionate number of unhealthy people sign up for coverage—a phenomenon known as adverse selection—premiums go up. As premiums rise, more healthy people drop their coverage, which causes premiums to increase even more. Tired of losing money on the bad business, insurance companies withdraw from the market, often leaving only one or two options for consumers.

When lawmakers talk about the need to stabilize the individual market, this is what they're referring to.

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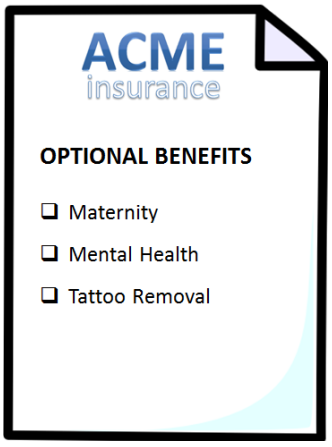
Our Suggestions

As you might imagine, after talking with our clients and examining the causes of today's soaring premiums, we've developed a few ideas to help reverse the trend. In addition to reversing some of the changes made by the Affordable Care Act, we would like to suggest the following:

LESS Comprehensive Health Plans

The Affordable Care Act expanded the list of benefits that must be covered on all health plans, but we believe plans should be less comprehensive. Instead of covering minor expenses like doctor visits for strep throat and sinus infections or inexpensive generic drugs under the health insurance plan, we believe people should budget for these costs.

Plans should be like the old indemnity plans that covered people for major medical issues. Covered benefits would include hospitalization, outpatient surgeries, MRIs, blood work, and prescriptions costing more than $50 per month. Lower cost services would not be covered, and that would save considerable dollars in claims processing, fixing keying errors, complicated accounting. With this change, we believe the metallic tiers tied to specific actuarial values should be eliminated.



A related idea is to allow people in the individual market to elect or refuse certain benefits, such as mental health or maternity care, rather than making these benefits standard on all plans. Would this lead to adverse selection? Would people who plan to have a baby be more likely to purchase the maternity rider? Of course. But carving out these benefits would reduce costs across the board and encourage more healthy people to purchase coverage.

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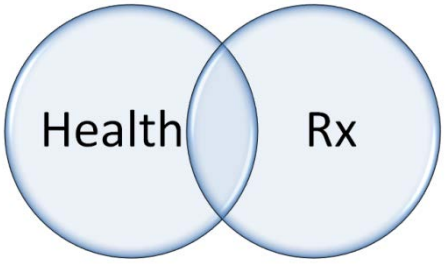
Kill the Copayments

Any services that are covered by the health plan should be subject to the deductible and coinsurance. Up-front copayments for lower-cost services should be eliminated.

Example: Cancer patients usually have to pay the full annual maximum out of pocket on their plan since most of their treatments are done in a hospital setting. Patients with Hepatitis C, on the other hand, can elect a copay plan and then pay a fixed cost for three months of a prescription to resolve their issue. The retail price of that prescription is about $90,000. This doesn't seem fair and is likely something that will change in the near future; insurers will almost certainly make these expensive specialty drugs subject to the plan deductible.



Cover Prescriptions Separately

As prescription drugs account for an ever-increasing part of the total claims costs, it may be time to separate prescription coverage from the medical plan. Perhaps a platform similar to Medicare Part D would make sense for the under-65 market as well.

Negotiate with Drug Companies

To complete the thought on prescription drugs, President Trump needs to negotiate with the big pharmaceutical companies for more reasonable prices on drugs sold in the United States. Why do some prescription medications cost five times as much in the United States as they do in another country?

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Expand Health Savings Accounts

Health Savings Accounts allow people to set aside tax-free dollars for eligible medical expenses and are a great replacement for the first-dollar copayments that we've already said should be eliminated. We believe that anyone with health insurance coverage should be allowed to utilize an HSA, regardless of plan design. To encourage people to choose less comprehensive plans, account holders should be able to contribute an amount equal to their health plan's out-of-pocket limit.

Get Rid of Provider Networks

Many lawmakers have suggested insurance across state lines as a way to create more competition, but for this to truly work we'd need to eliminate network contracting. Doing so would simplify the accounting efforts for both insurers and providers who would no longer have to negotiate pricing.

Without provider networks, major medical plans would be similar to older traditional plans with insurers paying their share after the member pays an annual deductible and coinsurance amount. The insurance payment would be determined on a Medicare Plus basis: Medicare +10%, Medicare +30%, Medicare +50%, etc. The higher the payment percentage in reference to the Medicare fee schedule, the higher the premium. This is known as *reference-based pricing*.

Under this system, we'd see an increase in price transparency. Providers could publish their true fee schedule and individuals could shop for providers based on the plan they chose.

If an insured needed knee surgery, for example, she could compare her options and choose whether to pay more out of pocket to use a

more expensive provider. In the process, though, she could use data on success rates to see if a lower cost provider would be just as effective as a higher priced provider. This one change would save administrative costs for both insurers and providers and large hospital systems would search for ways to become competitive.

Expand the Age Bands

To reduce rates for younger individuals, we should return to 1:5 age rating. With this change, maternity should only be available for younger people on individual plans so that older individuals are NOT charged for coverage they will not use. With the lower rates, young adults should be able to afford the maternity rider when needed.

Require Late Enrollees to Pay a Surcharge

We believe any new healthcare law should maintain coverage for pre-existing conditions, but if that coverage is dropped for any reason then the premium from that point on should be higher. This is similar to the way Medicare Part D is priced. If beneficiaries do not take or maintain a Part D drug plan under Medicare, they pay a lifetime penalty of 1% for every month they did NOT have coverage.

In addition to the premium increase, the under-65 member should have a three-month pre-existing condition exclusion period so that he or she can't scam the system by dropping coverage and then signing up again later for only a short period of time because of a health issue. When people jump in and out of coverage, as some do now, it's like purchasing homeowner's insurance when a tornado is coming, collecting on the policy, terming the coverage, and then signing up again just in time for the next disaster.

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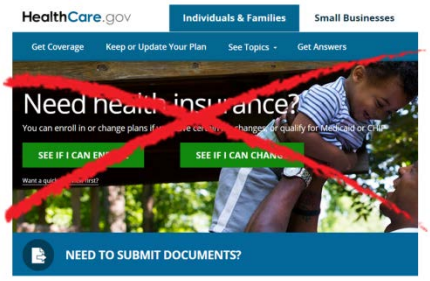
Unfortunately, the current proposal (in the American Health Care Act) that would require individuals to pay back premium to a carrier for the prior year before signing up for the next year won't work since it would allow them to simply choose a different carrier (if there's more than one in the area) and avoid the cost.



Discontinue Healthcare.gov

At this point, nearly all carriers have their own exchange, and those systems could be used to purchase plans with or without a subsidy directly from the insurer of choice (or, when choices are limited, from the only carrier offering plans in the market). This simple switch would save considerable funds and eliminates software glitches that often occur with file transfers, etc. It would also makes payments, address updates, etc. significantly easier.

Maintain the Subsidies

Some argue that Healthcare.gov is necessary for the government to deliver premium tax credits, but we disagree. For 2018, individuals could use the same amount they received in 2017 and then true up on their 2018 tax return. If they expect their income to rise and don't believe they'll qualify for a subsidy, they can simply purchase an off-exchange plan.

Ultimately, an income tax credit would be easier than the current system and also would provide many middle class individuals with the ability to purchase a plan instead of going without coverage.

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Move People from Subsidies to Medicaid

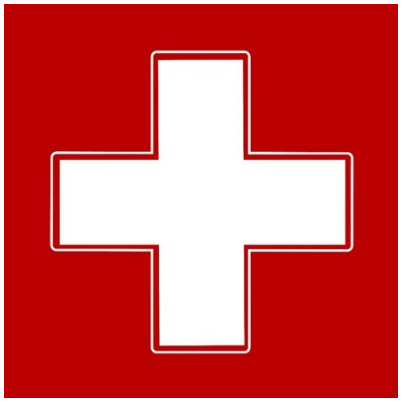
While there are talks of rolling back the ACA's Medicaid expansion, we believe Medicaid could be expanded further to cover those currently receiving significant subsidies and paying a very low premium of $100 or less per month. With the savings that could be achieved by eliminating Healthcare.gov, the States could receive funding to assist in paying for the medical costs of these individuals.

Increase Medicaid Reimbursements

To ensure access to providers for those who have Medicaid, reimbursements for providers who treat Medicaid patients should be increased to the base Medicare rate.

Bring Back the Risk Pools

We should consider reinstating the state high risk pools that existed before the ACA and that were funded by the member, the state, and the insurance carriers that sell in the state. To reduce claims within the pool and keep premiums down, those individuals with exceptionally high claims could be separated from the risk pool.



Standardize Charges for Emergency Care

Lawmakers should consider some mechanism so that people who have an emergency are **not** charged an exorbitant amount. Ambulance services and procedures within an emergency room are often billed at very high rates as they are often performed by non-contracted providers. Standard charges for emergency care should be tied to Medicare rates without any balance billing.

Important Final Item to Remember

No matter what changes are made, health costs are almost 1/6th of the GNP (Gross National Product) and that cannot be insured for $50 per month. The promise to increase plan benefits while reducing premiums will be a difficult one to keep. It is possible, though, to make some common-sense changes that will help stabilize the market, lower health insurance premiums, and give everyone who wants insurance the opportunity to purchase it.

About JME Insurance Agency

JME Insurance Agency was founded in 1984 and is based in Dallas, Texas. We help employers, individuals & families, and Medicare beneficiaries with their health, dental, life, and disability insurance needs. We'd love the opportunity to help you too!

To read additional white papers and blog posts, view tutorial videos, and access other helpful resources, please visit our website at **www.jmeinsurance.com**.

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