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TESTIMONY BEFORE THE UNITED STATES CONGRESS

Senate Finance Committee

HEALTH CARE

Issues Impacting Cost and Coverage

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INTRODUCTION

The two most important problems with American health care stem from its high cost. The high cost of U.S. health care is the reason that tens of millions go without health insurance. In addition, the unsustainable trajectory of the federal deficit and debt are driven by growth in public spending on health care, a problem primarily driven by growth in the price of health care services. If unsustainable public debt forces the United States to engage in aggressive fiscal austerity at some point in the future, it will be those most dependent on public health expenditures—the poor, the elderly, and the vulnerable—who will have the most to lose.

Hence, reducing the growth of national health expenditures is the most important domestic policy problem facing the United States.

Today, those most adversely affected by the high cost of U.S. health care are the working poor and lower-middle earners: individuals and households without employer-sponsored coverage who are not poor enough to benefit from Medicaid and ACA exchange subsidies, nor old enough to qualify for Medicare.

While the Affordable Care Act's subsidies have helped millions of these individuals afford coverage, its regulations have frozen millions of others out of the health insurance market. Furthermore, the ACA's structure has exacerbated long-standing problems with the U.S. health care system, and substantially weakened the long-term sustainability of public health care assistance. These problems require the urgent attention of the U.S. Senate.

DESTABILIZATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET

The Affordable Care Act has had the greatest impact on the individual insurance market: the market for people who buy health coverage on their own, instead of having it purchased on their behalf by the government or their employer.

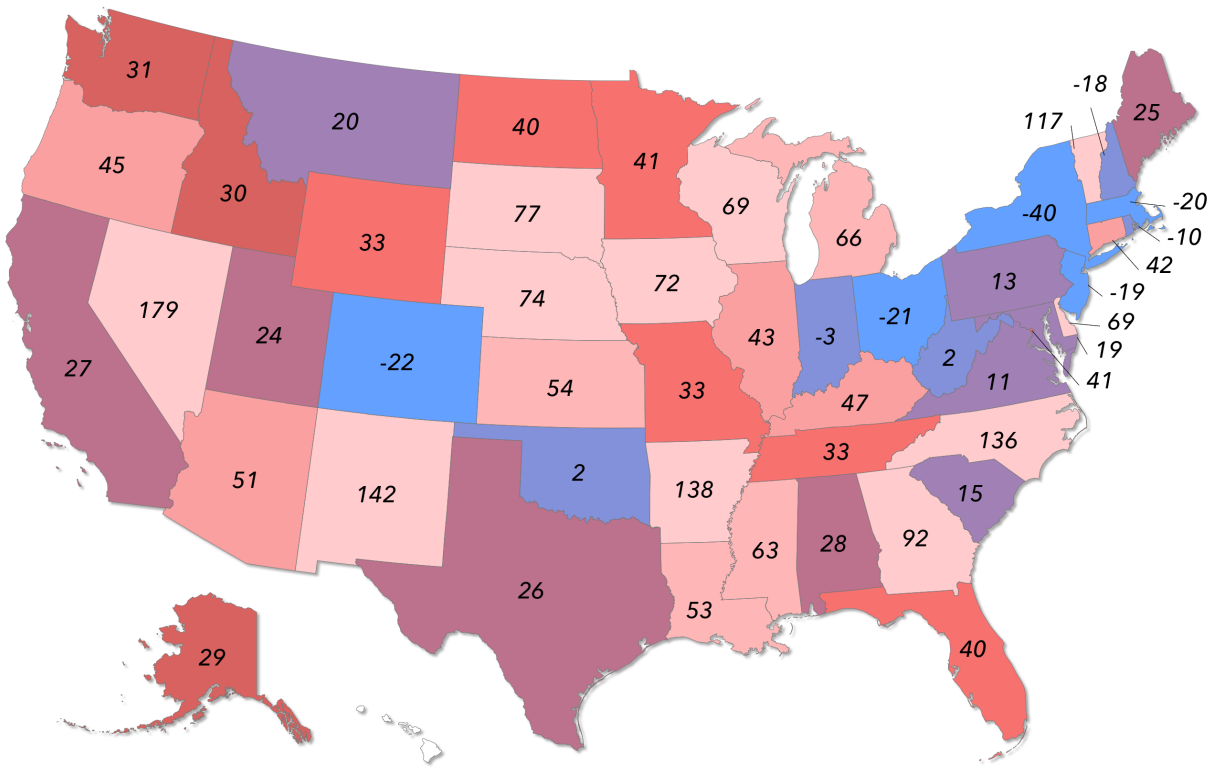
This market was—and is—worthy of substantial attention by policymakers. The individual market—sometimes called the "nongroup market"—is often described as small, because a relatively small proportion of U.S. residents own individually-purchased health insurance policies. However, those who are uninsured today represent an important part of the individual market: those who choose to remain uninsured, rather than buying coverage, because of its high costs. According to the Congressional Budget Office, 18 million U.S. residents purchased nongroup coverage, while an additional 27 million went uninsured. That amounts to a total individual market of 45 million, comparable in size to Medicare.

The ACA created an entirely new layer of federal regulation to restrict how nongroup health insurance policies could be designed, and devised new taxes on health insurance premiums and health care products.

The effect of these regulations and taxes has been to double, on average, the underlying price of individual market insurance premiums, with even greater increases for those who are younger and/or in relatively good health.[1] In 2014 alone, the ACA increased individual-market premiums by an average of 49 percent.[2]

[1] Individual Market Premium Changes: 2013-2017. Office of the Assistant Secretary for Planning and Evaluation. 2017 May 23; https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

Figure 1. Change in Individual Market Premiums Under ACA, 2013-14 (Percent)



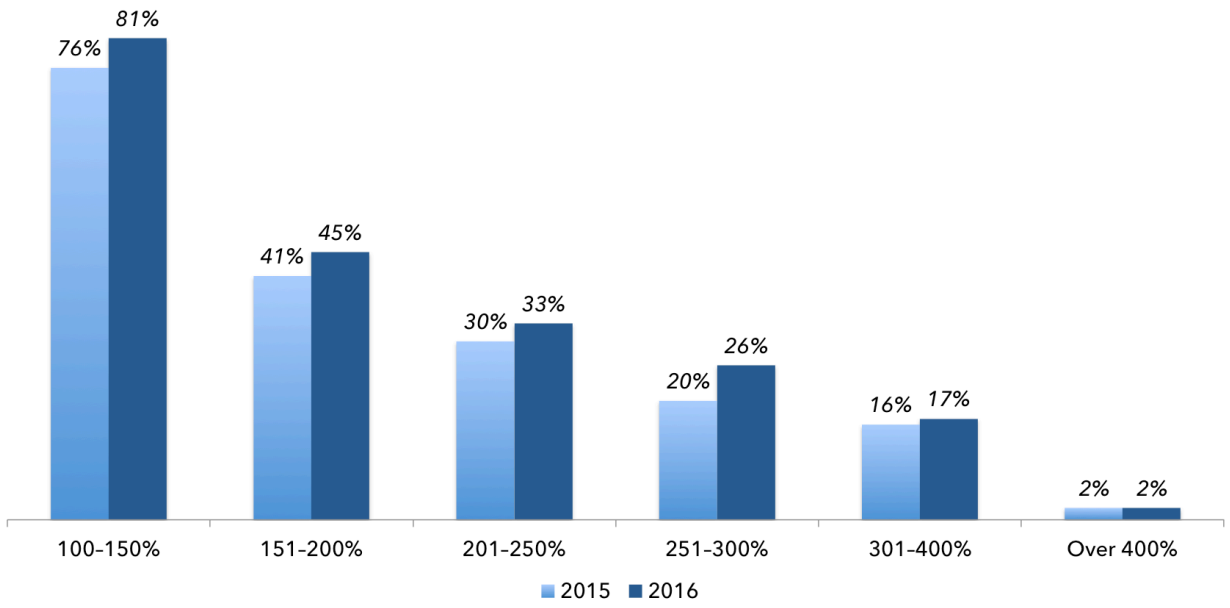
Rate shock in the non-group health insurance market. Prior to 2010, the market for health insurance purchased by individuals on their own was almost entirely regulated by states. The ACA added a new—and costly—layer of federal regulation upon this market. Many healthy individuals experienced rate increases of 100 to 200 percent. Even when taking into account those with pre-existing conditions, the ACA increased underlying rates in the average county by 49 percent. *(Source: Manhattan Institute)*

The ACA attempts to use two tools to compensate for these premium increases: means-tested tax credits to subsidize premiums, and an individual mandate designed to force those with higher premiums back into the market.

[2] Roy A, 3137-County Analysis: Obamacare Increased 2014 Individual-Market Premiums By Average of 49%. *Forbes*. 2014 Jun 18; https://www.forbes.com/sites/theapothecary/2014/06/18/3137-county-analysis-obamacare-increased-2014-individual-market-premiums-by-average-of-49/#7239193a527b.

While the subsidies have worked to blunt the impact of higher premiums for those with incomes below 200 percent of the Federal Poverty Level (which amounts to $24,120 for a childless adult), millions of working families of limited means have not benefited from the ACA's policy mix. Indeed, data from insurer filings indicates that, even after ACA subsidies are taken into account, most individuals above 200 percent of FPL are paying higher premiums than they did prior to the ACA.[2]

Figure 2. Percentage of Eligible Individuals in Exchange Plans, by Income (% FPL)



ACA premium subsidies are not sufficient to compensate for higher ACA gross premiums. The ACA's premium increases, driven by the law's extensive regulations of the individual market, exceed the subsidies that most Americans are eligible for. As a result, as one ascends the income scale, net premiums are costlier today than they were prior to the debut of the exchanges in 2014. *(Source: Avalere Health, HHS Assistant Secretary for Planning and Evaluation)*

Furthermore, most independent research finds that the individual mandate is not doing much to drive the uninsured to enroll in the ACA's exchanges. In a 2016 article for the *New England Journal of Medicine*, MIT economist Jonathan Gruber and two co-authors wrote, "when we assessed the mandate's detailed provisions, which include income-based penalties for lacking coverage and various specific exemptions from those penalties, *we did not find that overall coverage rates responded to these aspects of the law*" (emphasis added).[3]

[3] Frean M et al., Disentangling the ACA's Coverage Effects—Lesons for Policymakers. *New England Journal of Medicine*. 2016 Oct 27; 375:1605-1608.

That is because, while a heavily coercive and strictly enforced individual mandate could drive Americans to participate in the ACA's high-cost market, the actual individual mandate stipulated in the ACA contains numerous loopholes and exemptions, with weak penalties for noncompliance.[4]

The end result has been a partial actuarial death spiral, in which those below 200 percent of FPL enroll in large proportions in ACA exchanges, while those above 200 percent do not. A study by Avalere Health, using HHS data, found that in 2016, only 33 percent of those with incomes between 200 and 250 percent of FPL had enrolled in exchange-based coverage, and 26 percent for those between 250 and 300 of FPL.[5]

In summary, recent discussions about "stabilizing" the individual health insurance market have been notable for the degree to which they have failed to address the actual causes of market destabilization.[6]

THE PRINCIPAL DRIVERS OF HIGH ACA PREMIUMS

As noted above, there are two categories of ACA provisions that have increased individual market insurance premiums: regulations and taxes. Within each category, a few provisions stand out for their disproportionately negative impact.

3:1 age bands. The ACA requires that insurers charge their youngest customers no less than one-third what they charge their oldest customers. Because 18-year-olds typically consume one-sixth of the health care that 64-year-olds consume, this provision has the effect of doubling premiums on the young, without any benefit for older enrollees, because as the young drop out of the market, premiums rise for everyone who remains.

Actuarial value mandates. "Actuarial value," for a given insurance policy, represents the proportion of insurance claims that are paid by the insurer, relative to those paid by the enrollee, in the form of co-pays and deductibles. Prior to the ACA, the most popular plans in the individual market had an actuarial value of 40-45 percent. The ACA mandates that plans have a minimum actuarial value of 60 percent, and benchmarks "silver" plans to a 70 percent actuarial value. Because these mandates force insurers to pay more, these costs are directly passed through to consumers in the form of higher premiums.

Essential health benefits. Because of the plethora of state-based health insurance benefit mandates, the actual economic impact of the ACA's federal benefit mandates is smaller than the impact of 3:1 age bands and actuarial value mandates. But some of the ACA's mandates, such as the one for normal labor and delivery, create considerable adverse selection in the individual market.

Health insurance premium taxes. The ACA's sales tax on private health insurance premiums is passed onto consumers in the form of higher premiums, and has the paradoxical effect of increasing federal spending on premium assistance.

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[4] Roy A, Obamacare's Dark Secret: The Individual Mandate Is Too Weak. *Forbes*. 2012 Jul 9; https://www.forbes.com/sites/theapothecary/2012/07/09/obamacares-dark-secret-the-individual-mandate-is-too-weak/#34a209f26abf.

[5] Ip G, The Unstable Economics in Obama's Health Law. *The Wall Street Journal*. 2016 Aug 17.

[6] Future of Health Care: Bipartisan Policies and Recommendations. Bipartisan Policy Center. 2017 Aug 30; https://cdn.bipartisanpolicy.org/wp-content/uploads/2017/08/BPC-Health-Future-of-Health-Care-Recommendations.pdf.

Taxes on pharmaceuticals and medical devices. Similar to the direct premium taxes, these taxes are passed down to the consumer in the form of higher premiums.

Adverse selection. Because all of the above mandates drive premiums upward, they encourage high consumers of health care (i.e., the sick) to enroll in coverage, and discourage low consumers of health care (i.e., the healthy) from doing so. This degradation of the individual market risk pool drives premiums upward, separately from the inherent effects of the above mandates and taxes, because premiums are directly correlated to the average amount of health care consumed by enrollees in the individual market.

ACA'S SECTION 1332 DOES NOT PROVIDE MEANINGFUL STATE FLEXIBILITY

Some policymakers believe that the ACA's Section 1332 waiver process is a sufficient vehicle for state-based insurance market reform, and that further statutory reforms are not needed. This is entirely false.

Section 1332 of the ACA allows states to apply for waivers in which they would be granted exemptions from the ACA's individual and employer mandates, so long as they kept the remainder of the ACA's premium-increasing regulations in place. In addition, the Centers for Medicare and Medicaid Services are only allowed to grant state waivers if they conclude that the number of people with coverage in a given state would be equal to or greater than under the standard ACA model.

While it is possible for alternatives to the ACA model to result in comparable coverage numbers, such alternatives must include the flexibility to waive the ACA regulations that increase premiums and worsen adverse selection.

It is not sufficient for Congress to simply accelerate the decision-making timeline for Section 1332 waivers, as some have proposed. States must have genuine flexibility in how health insurance can be designed and purchased in their jurisdictions, so that premiums can come down, and enrollment can go up.

PAIRING REAL RELIEF FROM ACA PREMIUMS WITH COST-SHARING SUBSIDIES

At the urging of the health insurance industry, much of the recent policy discussions around individual market stabilization have revolved around congressional appropriations for cost-sharing reduction subsidies, or CSR subsidies. These subsidies, available to ACA exchange enrollees with incomes below 250 percent of FPL, substantially defray eligible enrollees' exposure to deductibles, co-pays, and other out-of-pocket expenses.[7]

While the ACA requires insurers to offer plans to these enrollees with extremely low deductibles—with actuarial values as high as 94 percent—the law does not appropriate funds to subsidize these extra costs that insurers incur. In *House of Representatives v. Price*, a federal judge ruled that the Obama administration had been illegally offering cost-sharing subsidies to insurers that Congress did not appropriate. As a result, the legal status of cost-sharing subsidies is in doubt.

[7] Roy A, A Short-Term Bailout of Obamacare? Only If Accompanied By Long-Term Reforms. *Forbes*. 2017 Aug 4; https://www.forbes.com/sites/theapothecary/2017/08/04/a-short-term-bailout-of-obamacare-only-if-accompanied-by-real-long-term-reforms/#20d7106e39f0.

Insurers have said that if they are forced to offer plans to those below 250 percent of FPL with low deductibles, without being allowed to recoup those costs through federal subsidies, they will increase individual market premiums by as much as 20 percent.

While the threat of increased premiums due to the cessation of cost-sharing subsidies is a serious problem, it is of no greater seriousness than the fact that nongroup premiums have doubled since the ACA's insurance regulations went into effect. It would be irresponsible of Congress to address the issue of cost-sharing subsidies without offering Americans with incomes above 250 percent of FPL relief from rising ACA premiums.

In theory, Congress could rectify the ACA's statutory sloppiness through either (1) relieving insurers of the requirement to offer high actuarial value plans to enrollees below 250 percent of FPL; or (2) explicitly appropriating funds for cost-sharing subsidies. Insurers have consistently advocated for the latter option, as it would lead to higher exchange enrollment and higher federal spending on premium tax credits.

The optimal short-term policy for Congress to consider would be to pair an explicit appropriation of cost-sharing subsidies for the plan years 2018 and 2019 with relief from high ACA premiums. This relief should include the following policies:

- Repealing the ACA's age bands, or widening them to 6:1;
- Repealing actuarial value mandates, or re-legalizing "copper plans" with a 50 percent actuarial value;
- Repealing the ACA's individual mandate beginning in 2021 or later, and replacing it with a six-month waiting period and state flexibility to institute late enrollment penalties; and
- Modifying Section 1332 of the ACA such that it includes the flexibility to waive a broad range of ACA insurance regulations.

Relief from the health insurance premium tax, pharmaceutical tax, and medical device tax could be added to a package that included the above reforms, but they are not sufficient in and of themselves as relief from high ACA premiums.

Appropriating funds for CSRs without addressing these underlying causes of individual market destabilization would do nothing to help those who are being priced out of the health insurance market today. Indeed, it would make that more important set of reforms more difficult for Congress to enact. Hence, it is of great importance that Congress pair these reforms in a single piece of legislation.

ADDRESSING THE BROADER DRIVERS OF HIGH HEALTH CARE COSTS

It is, of course, important to note that the high cost of U.S. health care far predates the passage of the Affordable Care Act. The exclusion from taxation of employer-sponsored health insurance, rooted in World War II-era wage controls, is the primary driver of high American health care prices, because it heavily subsidized the expansion of insurance policies into health care services that would, in a normal market, not be considered as appropriate for insurance. Medicare, which was modeled after the employer-based health care system, substantially compounded this problem.

Hospitals, pharmaceutical companies, and other health care industries charge extremely high prices because most patients do not directly purchase their insurance coverage, and are therefore in far less of a position to hold health care providers accountable for high prices. Two monographs published in the last twelve months—*Transcending Obamacare* and *The*

Competition Prescription—explore a wide range of policy options for tackling these problems.[8,9]

At the end of the day, the best way to reduce the cost of health care is to build a consumer-driven, patient-centered system in which private insurers compete to provide affordable coverage to everyone. This is why it is so important to make the individual market work for every American. If and when Congress succeeds in enacting meaningful reform of individually purchased health insurance, it will have laid the groundwork for us to finally bend the cost curve and put America back on a fiscally sustainable path.

[8] Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

[9] Roy A, *The Competition Prescription: A Market-Based Plan for Making Innovative Medicines Affordable*. The Foundation for Research on Equal Opportunity. 2017 May: https://drive.google.com/file/d/0B4VpAFwBu2fUOUJqNjRRS3VYclk/view.