



Advancing Quality Health Care in the U.S.

A Roadmap for Consumer-Focused Reform

About

The Alliance for the Adoption of Innovations in Medicine (Aimed Alliance)

Aimed Alliance is a tax-exempt, not-for-profit organization that works to improve access to quality health care and preserve practitioner-patient relationships. We achieve this mission by conducting legal research and analysis; developing sound, patient-centered recommendations; and disseminating our findings to inform policy makers and increase public awareness. Aimed Alliance's supporters are disclosed at <http://www.aimedalliance.org/collaborators/>.

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Introduction



Congress passed the Patient Protection and Affordable Care Act (“ACA”) in 2010 in efforts to provide quality and affordable care to all Americans regardless of health condition.¹ In the seven years since it passed, over 20 million Americans gained access to health care, including individuals with chronic, debilitating, or rare diseases whom insurers often excluded from coverage previously.²

While the ACA resulted in certain improvements to the U.S. health care system, it also had some unintended consequences. For example, Americans with expensive health conditions often cannot access high quality treatment because insurers exploit loopholes using benefit utilization management policies.³ Many young, healthy individuals pay high premiums for mandatory coverage while others elect to forego the costly purchase and instead pay the \$695 annual tax penalty.⁴

Moreover, the insurance marketplaces (also referred to as exchanges) have become unstable in many U.S. counties, leaving consumers of small group and individual plans with few options.⁵ Large insurers initially offered lower premiums and deductibles to undercut smaller and non-profit insurers that attempted to offer quality health care.⁶ Unable to keep up with the competition, the smaller and non-profit insurers exited the marketplace.⁷ Simultaneously, the U.S. Congress halted federal funding intended to assist insurers in managing the risks of operating in new marketplaces serving patients with pent-up demand for health care.⁸ Larger insurers then increased their premiums and patients’ deductibles. In some places, only one insurer exists in the marketplace, creating a monopoly situation.⁹ As of June 2017, some 45 counties face the prospect of having no marketplace plan available in 2018.¹⁰

Despite these flaws, the ACA contains many protections that are worth preserving, and repealing the ACA without passing an adequate replacement law may result in 23 million Americans losing their health care.¹¹ In considering its options, Congress should take a sensible, consumer-focused approach to health care reform. A replacement law is essential and should be crafted to preserve access

to non-discriminatory health insurance coverage; stabilize the marketplace; retain and expand consumer protections; place practitioners, in consultation with patients and their caregivers, in charge of medical decision making; incentivize Americans to make informed health care decisions, and guarantee that insured consumers have access to first-rate health care -- without facing the prospect of bankruptcy -- when life’s inevitable health challenges arise.

Additionally, federal policy makers must do a better job at recognizing and communicating the fact that paying for high-quality health care cannot be left to government or employers alone. As savers and spenders, Americans must recognize the importance of health care and prioritize it among the top necessities in life, like groceries and housing.

In drafting this paper, the authors reviewed and analyzed ten health care proposals introduced between January 2015 and April 2017, as well as the ACA.¹² Serious and thoughtful consideration has been given to the strengths and shortcomings of each legislative option. Similarly, the authors acknowledge the political realities of the day, including the fact that any action short of a full repeal of the ACA, as of June 2017, is not viable. The purpose of this paper is to provide a roadmap for a replacement law. It recommends that several key consumer protection provisions remain in place, but also recognizes that fundamental reforms are needed to stabilize marketplaces, address cost concerns, and improve access to medically necessary treatments.

Keeping Crucial Patient Protections

The ACA has expanded access to affordable, quality health insurance to millions of Americans.¹³ Before the enactment of the ACA, individuals without access to employer-based health insurance had difficulty finding reasonable health plans and often remained uninsured because they could not secure or maintain coverage.¹⁴ At that time, insurers could require consumers to pay excessively high premiums and deductibles for plans offering sparse coverage, discriminate against consumers based on preexisting conditions that ran the gamut from acne to cancer,¹⁵ or end existing coverage when consumers became ill after the plan year began.¹⁶ In other words, health insurance was not there for purchasers when they needed it. The ACA addressed many of these problems by establishing several important provisions to protect consumers.

While the ACA is not without criticisms, the federal law has improved health care overall for many Americans nationwide through strong consumer protections. For that reason, the following parts of the ACA must be included in a replacement law.



A. Dependent Coverage

The ACA expanded access to health care to new populations of individuals who previously lacked coverage, including dependents under the age of 26. Under the ACA, both married and unmarried individuals under the age of 26 can receive coverage through their parents' health insurance plans.¹⁷ This requirement applies to all plans in the individual market and all employer plans that offer dependent coverage.¹⁸ Essentially, if a plan already offers dependent coverage, it must continue to offer such coverage at the same level and price to all dependents under age 26.



Prior to the ACA, many health insurers could and did remove young adults from their parents' policies upon high school or college graduation regardless of whether they had obtained insurance elsewhere.¹⁹ As a result, a large percentage of young adults were uninsured because they did not have access to employer-based insurance and could not afford private, individual plans.²⁰

The dependent coverage provision of the ACA expanded insurance opportunities to a previously underserved population. In 2013, a study by the Commonwealth Fund found that 7.8 million individuals between 19 and 25 years old joined or stayed on their parents' plan in the prior 12 months.²¹ Furthermore, allowing young adults to stay on their parents' plan broadens the number of younger, typically healthier, Americans who are able to participate in the health insurance market.

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B. Preexisting Conditions Protection

The ACA prohibits insurers from discriminating against individuals based on preexisting conditions.²² This feature of the law is one of the most important – and politically popular -- protections for consumers.²³ According to a 2016 survey, 88 percent of privately insured Americans believe insurers should be prohibited from refusing coverage based on preexisting conditions.²⁴

Prior to the ACA's enactment, insurers could inquire about a potential plan enrollee's health status and then refuse to offer coverage or charge higher premiums based on a health condition, or offer coverage that excluded benefits

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Over one quarter of adult Americans under 65 years old have preexisting conditions

for the condition.²⁵ At that time, individuals with preexisting conditions often had to obtain insurance through high-risk pools, which are non-group health insurance plans that were prohibited from excluding such individuals from coverage.²⁶ However, such plans were permitted to charge significantly more in premiums, deductibles, and other out-of-pocket costs for individual with preexisting conditions.²⁷ For example, premiums were twice as much for individuals with certain conditions than for healthy individuals.²⁸ The combination of high out-of-pocket costs and serious health conditions sometimes left individuals bankrupt.²⁹

In contrast, under the ACA, no group health plan or insurer offering health insurance may prohibit a consumer from enrolling in a health plan, charge more, deny coverage, or limit benefits based on a health condition he or she had prior to enrollment.³⁰ As a result, health insurance became affordable to a significant population of Americans who previously could not afford it. In fact, it is estimated that over one quarter of adult Americans who are under 65 years old (27 percent) have preexisting conditions, thereby illustrating how important this protection is.³¹

C. Essential Health Benefits Packages

The ACA improved both the affordability and quality of coverage that many consumers receive. In those places where the marketplaces have flourished, it has expanded consumer choice through market-based competition. One way that the ACA achieved these goals was by requiring individual and small group health plans to offer essential health benefit (“EHB”) packages. “EHB packages” must include (1) coverage for 10 EHBs; (2) minimum levels of coverage for tiered plans; and (3) an annual cap on out-of-pocket costs for individuals and families.³²

1. EHBs

As part of the EHB package requirement, individual and small group health plans must cover the following ten categories of EHBs: ambulatory patient services (outpatient care), emergency services (trips to the emergency room), hospitalization (inpatient care), maternity and newborn care, mental health and substance use treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventative services, and pediatric services.³³ While the ACA does not dictate how to implement EHBs, it does require that EHB packages be balanced, nondiscriminatory, and address the needs of diverse populations.³⁴



Prior to the ACA, states determined their own sets of mandatory health benefits, which varied considerably in comprehensiveness from state to state.³⁵ While most states required coverage of hospital and physician care, many did not require coverage of the remaining EHB categories.³⁶ For example, before the ACA was enacted, 62 percent of individual plans did not cover maternity services, 34 percent did not cover substance use treatment services, 18 percent did not cover mental health services, and nine percent did not cover prescription drugs.³⁷ EHBs created uniformity among state individual and small group plans. Insurers can still be innovative in complying with the mandates. The differences in EHB design facilitated comparison shopping among individual and small group plans.

Some health care proposals have recommended giving states the ability to waive EHB requirements and determine their own categories of mandatory benefits.³⁸ They argue that EHBs are too expensive to cover, and insurers could offer plans with lower premiums, deductibles, and out-of-pocket costs if they were not required to cover all EHBs. Yet, removing EHBs is not likely to lower premiums for most people. Hospital care, doctor visits, and prescription drugs are the top three categories of benefits

Before the ACA was enacted, 62 percent of individual plans did not cover maternity services.

that contribute to premiums costs, and insurers are unlikely to eliminate those.³⁹ Additionally, if insurers exclude entire categories of care altogether, individuals with certain health conditions could see their out-of-pocket costs rise significantly because their particular treatments may no longer be covered. For example, if maternity coverage were removed, premiums could go down between \$8 and \$14 per month, but pregnant women could pay between \$30,000 and \$50,000 in out-of-pocket expenses, especially because caps on out-of-pocket costs are tied to EHBs.⁴⁰ Moreover, removing coverage for treatment of substance use disorders could exacerbate the nationwide opioid overdose epidemic and surge in suicide rates.⁴¹ Therefore, EHB requirements should remain in place.

2. Minimum Levels of Coverage

Under the EHB package requirements, small group and individual plans must also offer tiered plans that include minimum levels of coverage.⁴² The specific levels of coverage are defined using one of four actuarial value levels (i.e., the percentage of expected medical costs that a health plan will cover): 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum).⁴³ For example, a silver plan has an actuarial value of 70 percent, which means that the plan will cover 70 percent of the plan enrollee's health care expenses, and the enrollee is responsible for 30 percent in out-of-pocket costs.⁴⁴ For plans with higher actuarial value, patient will pay less in out-of-pocket costs and more for premiums.⁴⁵ For plans with lower actuarial costs, the patient will pay more in out-of-pocket costs and less for premiums.

The level of coverage requirement allows consumers to choose a level of coverage based on their individual financial circumstances and anticipated medical needs, compare insurance plans within and across tiers, and pay accordingly. In other words, this requirement helps ensure that marketplace purchasers can make informed decisions and take responsibility for maximizing the value of their health care expenditures by giving them "skin in the game."



3. Annual Limit on Out-of-Pocket Costs

Under EHB package requirements, small group and individual health plans cannot charge enrollees more than a certain amount per year.⁴⁶ In 2017, the out-of-pocket maximum is capped at \$7,150 for individuals and \$14,300 for families for all covered benefits.⁴⁷ Out-of-pocket expenses include copays, deductibles, and other expenses (excluding premiums). Another section of the ACA expanded this out-of-pocket cap requirement to all non-grandfathered group health plans, including large employer-sponsored plans.⁴⁸

At least 17 percent of employer-sponsored plans had no annual out-of-pocket cap before the ACA.

Before the ACA went into effect, many plans had out-of-pocket caps, but insurers could set the cap as high as they chose, and at least 17 percent of employer-sponsored plans had no annual out-of-pocket cap in 2010.⁴⁹ As a result, insurance consumers were not aware of how much money they needed to allocate per year to cover premiums and out-of-pocket costs. Treatment for certain health conditions was unaffordable for many of these Americans, sometimes leaving them bankrupt.⁵⁰ The out-of-pocket maximum enables purchasers of health insurance to know that, in the event they need health care treatment, they will receive it, and their annual costs will not exceed the cost of their premiums combined with their out-of-pocket maximum for covered treatments and in-network services. This provision fosters consumer responsibility in saving for, consuming, and paying for health care services. Therefore, the cap on out-of-pocket costs must be part of any new health care law.

D. Prohibition of Insurer-Imposed Annual and Lifetime Dollar Limits

The ACA also provides insured consumers peace of mind and access to health care by prohibiting insurers from imposing annual and lifetime dollar limits on benefits. Before the ACA, insurers could set annual and lifetime dollar limits on how much they would spend on or reimburse for a specific treatment or service under a particular plan.⁵¹ Once the annual or lifetime cap was met, the plan enrollee could no longer receive coverage for those benefits, meaning he or she had to pay out-of-pocket for any costs exceeding the limit.⁵² At that time, approximately 102 million Americans had plans with a lifetime limit, and approximately 20,000 people would hit the lifetime limit each year, meaning they would have to pay out-of-pocket for any additional years for which they were enrolled in their health plan.⁵³ For example, in 2010 (before the ACA went into effect), 10 percent of cancer patients reported that they reached their lifetime limits, and their insurers would not cover further medical care.⁵⁴

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The ACA changed this practice. The law prohibits all health plans offering EHBs, including large employer-sponsored plans, from establishing annual or lifetime limits on coverage of EHBs,⁵⁵ ensuring that consumers receive access to continuous health care and treatments.⁵⁶ Insurers may still impose annual or lifetime dollar limits on spending for treatments and services that are not considered EHBs.⁵⁷ Individuals no longer have to quit their plan and enter a high risk pool because they reached the lifetime limit.⁵⁸

This requirement does not have a big impact on the overall cost of health care because relatively few people have such high health care costs.⁵⁹ The prohibition of insurer-imposed annual and lifetime dollar limits goes to the core purpose of health insurance: to provide peace of mind that, in the event the consumer experiences an expensive health condition, he or she will have access to care.

E. Nondiscrimination and Prohibition Against Discrimination Based on Health Status

The ACA expanded access to new populations of individuals who were previously excluded from coverage by prohibiting insurer discrimination. Before the ACA was enacted, no federal law provided comprehensive protection against certain types of discrimination from health insurers.⁶⁰ For example, insurers in most states



were permitted to take health status and medical history into account in determining whether or not they would issue an insurance policy to an individual and the premium that the individual would have to pay.⁶¹ Insurers often designated individuals with chronic conditions, such as HIV, as uninsurable or offered policies with excessively high premiums and medical exclusions that would not cover the treatments they needed.⁶² Additionally, insurers often charged women more for health insurance than men, and many plans did not cover maternity services.⁶³

The ACA's nondiscrimination provision protects consumers from discrimination based on race, color, national origin, sex, or disability.⁶⁴ The ACA also prohibits discrimination based on health status by barring insurers from setting eligibility requirements based on medical condition (physical and mental illness), health status, receipt of health care, medical history, genetic condition, evidence of insurability, disability, or other related issues.⁶⁵ The provision states that, if an individual has a condition either before enrolling in a plan or after signing up for a plan, insurers cannot discriminate against the individual.

The protections extend to “covered entities,” which include any health program that receives any federal funding, U.S. Department of Health and Human Services (“HHS”) programs, and marketplace plans, among others.⁶⁶ Covered entities also include insurers that offer private plans, such as large-group plans, if such insurers also offer a federally funded plan.⁶⁷

Regulations interpreting the nondiscrimination section also state that insurers may not use formulary design or marketing practices to discriminate against consumers, thereby specifically prohibiting insurers from using benefit utilization management policies, such as step therapy,⁶⁸ to discriminate. Insurers also may not deny or limit health coverage; deny a claim; or impose additional cost sharing in a discriminatory manner.⁶⁹

As a result of these protections, insurers are prohibited from imposing common discriminatory restrictions. For example, it may be deemed discriminatory to use certain benefit design and cost sharing limitations, such as imposing age-limited benefits without a medical justification (e.g., covering hearing aids only for children under the age of six) or placing most or all drugs that treat a particular condition on the highest cost formulary tier.⁷⁰

The nondiscrimination provisions are essential. Without them, health insurers could revert back to discriminatory practices that treat certain populations differently. Plans that unfairly discriminate against an entire class of individuals based on their medical condition undermine the entire purpose of insurance and often result in plan enrollees receiving minimal, if any, value in exchange for their premiums.⁷¹

F. Mental Health and Substance Use Disorder Parity

The ACA specifically expanded access to health coverage for individuals with mental health conditions and substance used disorders (SUDs). Mental health parity recognizes that individuals with mental health conditions and SUDs should receive the same level of treatment coverage as those who receive coverage for physical illnesses. The Mental Health Parity and Addiction Equity Act of 2008 (“Parity Act”) required large-group insurance plans to provide coverage of mental health and substance use services no more restrictively than coverage of medical or surgical benefits.⁷² The ACA expanded those federal parity requirements by requiring small group and individual plans to comply with the Parity Act’s requirements.⁷³ As a result of this requirement, along with the inclusion of mental health and SUD benefits as a category of EHBs, 62 million Americans with mental health disorders and SUDs gained access to treatment.⁷⁴

Prior to this expansion of coverage under the ACA, approximately 30 percent of Americans with individual



plans lacked coverage for SUDs, and approximately 20 percent lacked coverage for mental health treatments, including outpatient therapy and inpatient crisis intervention and stabilization.⁷⁵ Yet, there is a significant need for substance use treatment. Currently, drug overdose is the leading cause of death among Americans under the age of 50.⁷⁶ Without parity protections, individuals with mental health and substance use disorders could lose their coverage.

G. Annual Review Process

The ACA also ensures that insurers provide value in exchange for premiums through an annual review process. Before the ACA was enacted, consumers were often subjected to large premium hikes with high variability across insurers and states.⁷⁷ Insurers often did not explain their justifications for raising their rates to regulators or the public.⁷⁸

The ACA increased scrutiny and transparency to the rate increase process.⁷⁹ It protects consumer interests by requiring states to establish an annual review process for health insurance premium increases and to make recommendations that marketplaces exclude certain health insurers if the insurers increase their premiums at an unjustifiable rate.⁸⁰ Each year, insurers must submit their plans to state insurance commissioners along with any justification for an unreasonable premium increase (i.e., an increase over 10 percent)⁸¹ prior to implementation.⁸²

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Unreasonable premium increases must be prominently posted on their websites, along with justifications, providing consumers with greater transparency around rate increases.⁸³ These steps prevent insurers from charging unjustifiable rates and allow consumer to understand their rates and make informed decisions when selecting a health plan.⁸⁴

H. Appeals Process

The ACA provided consumers with the right to contest unfair coverage denials. Under the ACA, consumers with individual and group health plans, including self-insured and government plans, have the right to a full and fair review of any adverse benefit determination.⁸⁵ An adverse benefit determination includes a denial, reduction, or termination of a benefit.⁸⁶ At minimum, health plans must have in place an internal claims appeal process as defined by the law.⁸⁷ The insurer must issue a decision in response to the appeal that explains the reason for any denial within a reasonable period of time. Insurers must also comply with the applicable state or federal external review process, in which enrollees are guaranteed the right to a review by an independent decision-maker not affiliated with the insurer.⁸⁸

These appeals requirements are necessary because, prior to the ACA, many states lacked or offered inadequate appeal laws.⁸⁹ Insurers could reject claims without providing any justification for the denial. Instead of appealing these denials, plan enrollees could only sue in state court, under legal theories such as breach of contract given that health plans are considered to be contracts between the insurer and the plan enrollee.⁹⁰ Courts often sided with plan enrollees because plans were drafted by the insurers and were often incomprehensible to lay people.⁹¹ Yet, the litigation process is expensive, and individuals denied coverage rarely sued.⁹² Moreover, even if an insurer did have an appeals process, it often was an inefficient process in which the insurers often took a long time to provide a response to the appeal, thereby delaying access to care. In contrast, the current protections require greater accountability and efficiency from insurers and allow consumers to advocate for themselves to access their treatment.

I. Guaranteed Availability and Renewability of Coverage

The ACA's guaranteed availability of coverage section ensures that everyone eligible for health care insurance has access to it regardless of health status.⁹³ Specifically, it requires any health insurer offering insurance coverage in the individual or group market to accept every small employer and individual in that state who applies for coverage.⁹⁴ Prior to the passage of the ACA, in most states, insurance companies could deny individuals coverage based health status, meaning an uninsured person who had a preexisting condition might not be able to purchase health insurance. Insurers could exclude coverage of preexisting conditions from any policy they offered.⁹⁵

The ACA's guaranteed renewability of coverage provision requires that insurers that continue to operate in the individual or small-group marketplace offer renewed

coverage of the plan enrollee's previous year's plan or a similar plan regardless of the enrollee's health condition, utilization of coverage, or any other related issues.⁹⁶ Insurers, therefore, cannot deny coverage to an enrollee who seeks to renew a health plan after experiencing an expensive health condition during the previous plan year. Prior to the ACA, in most states, insurers could drop or deny coverage to people based on their medical expenses or health status during the previous year.⁹⁷

The most common complaint about the guaranteed availability provision is that plan enrollees could stop paying premiums and then sign up for coverage again under a different plan with the same insurer without any penalty.⁹⁸ However, this problem was recently fixed under a new regulation aimed to stabilize the insurance market.⁹⁹ The new regulation requires individuals to pay past-due premiums before enrolling in a plan with the same insurer the following year.¹⁰⁰ Therefore, both the guaranteed availability and renewability requirements serve important consumer protection functions while allowing for stability in the marketplace.

J. Affordable Choices of Health Benefit Plans and Consumer Choice

The affordable choices of health benefit plans provision of the ACA allowed for the creation of the federal and state small group and individual marketplace, which must offer qualified health plans.¹⁰¹ Qualified health plans are those that provide EHBs (as explained in greater detail above), follow established limits on out-of-pocket costs, and meet other ACA requirements.¹⁰² Qualified health plans must also include a sufficient choice of health care providers in their networks, maintain accreditation regarding local performance on clinical quality measures, use a uniform enrollment process, and present plan information in a standard format, among other requirements.¹⁰³

The provision on consumer choice allows individuals to enroll in any qualified health plan through or outside of the marketplace.¹⁰⁴ It also created a marketplace for small

employers. Small employers and, in some states, large employers can offer a choice of qualified health plans at one tiered level of coverage (e.g., silver or gold) to their employees through the marketplace.¹⁰⁵

Before the ACA, consumers had few options to choose from when shopping for a health plan.¹⁰⁶ The affordable choice provision allowed for comparative shopping and transparency when selecting a plan and facilitated easy enrollment once a consumer made his or her selection. The creation of marketplaces through the consumer choice provision provided consumers who do not have employer-sponsored plans and do not qualify for government-funded plans (e.g., Medicare and Medicaid) with access to quality health insurance plans and increased competition among insurers.¹⁰⁷ The creation of marketplaces expanded options for consumers employed by small businesses as well.

Necessary Reforms Not Currently Addressed at the Federal Level

Many of the ACA's consumer protections should be included in a replacement law to ensure consumers have access to quality health care. Nevertheless, other provisions of the ACA have had unintended consequences, resulting in the need for additional reforms. Specifically, steps must be taken to stabilize the marketplaces as large insurers withdraw from them. Additionally, reform is needed to prevent insurer interference with the health care practitioner-patient relationship. Finally, more must be done to ensure that consumers value their health care on par with life other necessities, such as housing and food. This section will discuss recommendations to achieve these goals.

A. Strong Incentive to Purchase and Maintain Insurance Coverage

Consumers must understand and respect the importance of maintaining access to health care. For individuals who cannot afford to pay for all potential health care costs out-of-pocket and are not eligible for a public program, enrolling in a private health insurance plan should be a rational financial decision, even when they are healthy.



Consumers should have adequate choices to determine the level of health insurance coverage that is most appropriate for their needs and budget. This delicate balance requires consumer protections to make certain that health services are available to insured consumers when they need them, combined with proper incentives for consumers to take responsibility for maintaining continuous health care coverage. This dual purpose is based on the facts that 1) an individual's need for health care services is inevitable and 2) health insurance can only be affordable when risks are spread among a broad population that includes young and healthy individuals.¹⁰⁸

Under the ACA, individuals are currently required to maintain “minimum essential coverage” (i.e., have an actuarial value of 60 percent or more and cover EHBs) year-round or otherwise face a tax penalty.¹⁰⁹ Plans that offer only limited benefits, such as short-term health insurance, catastrophic plans, and fixed benefit plans, do not meet the requirements for minimum essential coverage. The relatively low tax penalty for individuals, on average \$695 per year, as contrasted against much higher insurance premiums and deductibles, has resulted in 6.5 million Americans opting not to purchase marketplace plans in 2015.¹¹⁰ This mandatory enrollment requirement, often referred to as the “individual mandate,” has been one of the ACA's most contentious provisions. Prior to its enactment, U.S. residents had never before been required to buy a good or service from a private business.¹¹¹ Republicans, who presently control the White House and both chambers of Congress, generally oppose the individual mandate and favor incentives as an alternative approach to insurance enrollment and coverage maintenance. A replacement law must, therefore, contain incentives to purchase and keep health insurance that are much more compelling than the ACA individual mandate.

Yet, if only those who have higher rates of health care utilization purchase health insurance, then premiums and deductibles will continue to rise.¹¹² Therefore, proper incentives must be in place to ensure that the risk is spread throughout the population of health insurance policyholders. To properly incentivize healthy individuals to enroll in health care, the individual mandate should be replaced with a continuous coverage provision. Rather than punishing those who do not have minimum essential coverage insurance by imposing a penalty, a continuous coverage provision allows individuals who maintain continuous coverage for 12 months to qualify for a refundable tax credit, which they can use to purchase health insurance.

Additionally, as long as the individual maintains continuous coverage, the insurer may not treat individuals with preexisting conditions differently from those who do not have preexisting conditions. However, if an individual fails to maintain continuous coverage for more than 60 days, the insurer could charge a premium that is 30 percent higher than other plan enrollees every month for 12 months when they repurchase coverage.¹¹³ With such incentives in place,



a continuous coverage provision would properly incentivize individuals to obtain coverage and stay enrolled in health insurance plans to receive a tax credit and avoid higher premiums.

B. Repealing the Employer Mandate

Repealing the ACA's employer mandate could also add stability to the marketplace. Under the ACA, large employers (i.e., those with 50 full-time employees including full-time equivalent employees) must offer a certain level of affordable health insurance coverage to employees, referred to as the “employer mandate.” Failing to do so could result in a penalty.¹¹⁴ If large employers do not offer plans that meet minimum value and affordability standards to at least 95 percent of their full-time employees and their dependents, and at least one full-time employee receives the premium tax credit for purchasing coverage through a marketplace, then the employer must pay a penalty per each employee who receives the tax credit per month.¹¹⁵ To avoid the penalty, some employers have cut the number of employees, employee hours, or benefits in order to avoid qualifying as a large employer under the ACA.¹¹⁶

Repealing the ACA's employer mandate would remove the incentive to make workforce reductions. A repeal of this provision would also provide employers with more autonomy. They could choose to offer quality health plans for market-driven and competitive reasons (e.g., to attract the most talented employees). Moreover, if an employer chose not to offer a quality health plan, employees would still have the option of purchasing insurance from the individual marketplaces, which would enlarge marketplace populations, spur competition among insurers competing for the employees' business, and ultimately, improve stability in the marketplaces.

C. Provide Greater Incentives for Consumer-Directed Health Care Savings Accounts

Consumers must understand what they are paying for in order to properly value their health care and moderate their consumption of health care products and services. One way to educate consumers on the need to control their own health care costs is through greater use of high deductible health plans (“HDHPs”) combined with health savings accounts (“HSAs”) or flexible spending accounts (“FSAs”). As their name suggests, HDHPs are plans with higher deductibles (typically starting at \$1,300 for an individual or \$2,600 for a family) and lower premiums than traditional insurance plans.¹¹⁷ Due to the high deductibles, plan enrollees pay more out-of-pocket costs than they would with non-HDHPs before the insurer starts to cover its portion.¹¹⁸



HSAs are savings accounts that individuals may use to pay for qualified medical expenses on a pre-tax basis.¹¹⁹ When individuals use HSAs, they can dedicate more of their income toward paying for qualified medical expenses like premiums, deductibles, and other co-pays because they do not have to pay federal tax on the income directed to the HSA. HSAs can only be used with HDHPs that offer minimum essential coverage.¹²⁰ By combining HSAs and HDHPs, plan enrollees can get a sense of how much their health care truly costs and how to properly budget for and limit those expenses. Given that HDHP consumers have to pay significant out-of-pocket costs before their insurer contributes, consumers may be more inclined to learn about their various treatment options and medical services available to them and become better comparative shoppers in the health care market.

FSAs are spending accounts that employers may set up for their employees, the funds of which employees may use to pay for copayments, deductibles, certain medications, and other qualified health care costs.¹²¹ Employees are not required to pay federal income taxes on the funds their employers direct to FSAs.¹²² Therefore, more of the employees' income is available to help cover their health care expenses.

To further expand the use of HSAs and FSAs, an ACA replacement law should impose fewer restrictions on their use. The ACA currently restricts the amount an employer may contribute to an FSA to \$2,600 per year and only allows \$500 from FSA funds to carry over from one year to the next.¹²³ The law also prohibits individuals from using FSA and HSA funds for over-the-counter medications.¹²⁴ Additionally, the ACA limits tax-free HSA contributions to \$3,400 for individuals and \$6,750 for families, and subjects HSA distributions that are not used for qualified medical expenses to income tax plus a punitive 20 percent tax.¹²⁵ However, the law does not limit the amount that carries over from year-to-year for HSAs.¹²⁶

The current caps on FSAs are not enough to cover common expenses for copayments, deductibles, and other out-of-pocket expenses for many individuals, and therefore, should be removed altogether, thereby giving employers more flexibility to offer benefits packages that meet their employees' needs. Additionally, there should be no cap on the amount in an FSA that can carry over from year-to-year because such a cap can result in unnecessary health care spending at the end of each year. Additionally, the accumulation of personal health care savings year-to-year is a desirable outcome, as substantial savings can soften the financial impact of the high out-of-pocket costs that accompany complicated health conditions and allow consumers to save for annually increasing premiums.

Similarly, given that the current caps on annual HSA contributions are not high enough to cover deductibles and health care expenses that Americans normally incur in a given year, maximum tax-free HSA contributions should be increased to match annual limits on out-of-pocket costs for individuals and families.¹²⁷ To allow for greater use of HSAs, it should be permissible to use HSA funds to pay for nontraditional health care expenses, such as “concierge” fees for physician practice groups. Additionally, the restrictions that require HSAs to be tied to HDHPs should be lifted so that all taxpayers have financial incentive to save for health care, and over-the-counter medications should be HSA eligible to incentivize the purchase of potentially less expensive health care options when medically appropriate.¹²⁸ These changes can help Americans to prioritize health care savings, become informed health care consumers, and take an active role in maximizing the value of their health care expenditures..

D. Promoting Greater Stability Through Premium Rate Variability

One unintended consequence of the ACA was that younger, healthier individuals were required to obtain health insurance coverage, but many of them could not afford their premiums associated with market place plans.¹²⁹ The inadequate participation of younger people contributed



to the marketplaces' rising premiums and financial burdens on insurers that resulted in their withdrawals from marketplaces. Lower-risk purchasers are essential to the proper functioning of insurance markets.¹³⁰ Therefore, to enable lower-risk health consumers (i.e., younger individuals) to buy into a health plan, and to stabilize the marketplaces, marketplace insurers must have leeway to offer younger individuals plans with premiums that are lower than those mandated by the ACA.

Under the ACA, small group and individual plan premium rates may only vary based on three factors: (1) by plan or plan coverage type (i.e., family or individual); (2) by geography or rating area¹³¹ as established by the state; and (3) by age using a three-to-one "age-band ratio" for adults.¹³² An age-band ratio is a range that insurers can use to charge older consumers higher premiums over younger ones.

Reverting back to the 5:1 age-band ratio could decrease average premiums by approximately 25 percent depending on the actuarial value of the plan.

The age-band ratio, in particular, can result in younger individuals paying too much for their premiums.¹³³ Under the ACA, an older individual pays a premium of no more than three times the premium a younger individual pays. This ratio can lead to an age disparity where the younger, healthier enrollees are charged inflated premium amounts to subsidize older, more costly enrollees at relatively low, unrealistic premium rates.¹³⁴ If the ACA's individual mandate and age-band ratio were to remain unchanged, many younger consumers could be expected to choose to pay the relatively modest tax penalty for not maintaining coverage rather than sign up for a high-premium plan.¹³⁵ If the continuous coverage model with a 30 percent premium penalty for non-enrollment were adopted in an ACA replacement law, yet the age-band ratio were to remain at three-to-one, then many younger consumers could be expected to forgo health insurance until they developed a condition that necessitated costly health care, at which time they would have to pay 30 percent higher premiums for a year. Regardless of whether the ACA is repealed and replaced, the age-band ratio must be expanded.

To enable lower-risk, younger individuals to enroll in health insurance, the age-band ratio should be changed to a five-to-one ratio.¹³⁶ Prominent Republican and Democratic health policy experts support this policy recommendation, including Ezekiel Emanuel, who is often called the architect of the ACA, as well as Senate Finance Chairman Orin Hatch.¹³⁷ Prior to the enactment of the ACA, most states allowed a five-to-one ratio for age-band rating.¹³⁸ Reverting back to this age-band ratio could decrease average premiums by approximately 25 percent depending on the actuarial value of the plan.¹³⁹ Moreover, offering a less restrictive age ratio will restore greater equity across age bands, requiring older individuals who typically have higher associated health care costs to pay proportionately more than younger individuals who typically have much lower health care costs.

E. Reduce Unnecessary Expenditures

A contributing factor to the rising costs of health care is unnecessary administrative fees resulting from insurers' interference with the health care practitioner-patient relationship. For example, insurers can require prior authorization, in which health care practitioners or plan enrollees must secure the insurers' advance approval before agreeing to cover the cost of a procedure or treatment.¹⁴⁰ The prior authorization requirement, alone, can waste several hours each week as plan enrollees and health care practitioners battle with insurers to obtain coverage of medically necessary treatments and medications, thereby increasing administrative costs and delaying access to the prescribed treatment.¹⁴¹ On average, physicians spend twenty hours per week completing paperwork associated with prior authorization requirements for treatments and tests, and weeks can pass before a physician or patient receives a response, thus further delaying patient care and treatment.¹⁴² Moreover, each insurer has its own set of forms, and insurers often require a different prior authorization form for specific medications. There is no uniformity regarding how the forms are submitted, with insurers often requiring outdated modes of communication, such as faxing or mailing requests.

On average, physicians spend twenty hours per week completing paperwork associated with prior authorization requirements for treatments and tests.

While the ACA theoretically limits prior authorization if such a policy is applied in a discriminatory manner,¹⁴³ further reform is required in order to reduce unnecessary administrative costs. The prior authorization process should be streamlined by requiring uniform prior authorization forms, electronic submission processes for prior authorizations, and deadlines for insurers when responding



to a request. Such reforms can help reduce delays in the quality of care due to insurer interference and reduce administrative expenses wasted on inefficient processes.

F. Expand Transparency Requirements

For consumers to be able to make informed health care decisions and maximize the value of their health care expenditures, they must have access to complete and accurate information about their health care coverage so that they can make educated decisions when selecting a plan and making treatment decisions.¹⁴⁴ For this to occur, health insurers must improve plan transparency. The ACA currently requires insurers to provide uniform explanations of coverage in formats and languages that are easily understandable.¹⁴⁵ Yet, further protections are needed.

As part of the annual enrollment process, health insurers should be required to disclose plan limitations or restrictions; covered items (including drugs and services); benefit utilization requirements, such as prior authorization; incentives to providers to adhere to clinical pathways; cost-sharing requirements; actual costs of services; the claims appeals process and deadlines; and providers participating in the plan. Insurers should also be required to review and update participating provider network directories no less than every 30 days. To protect consumers from “bait and switch” tactics, insurers should be prohibited from making negative changes to their formularies (e.g., ceasing to cover a medication or increasing a medication co-pay) after the plan year has begun. With such information available, consumers can sign up for the plan most appropriate for their individual needs, proceed with peace of mind that the plan they purchased is the plan they will receive, and save and spend accordingly.

G. Additional Consumer Protection Improvements

Insurers must strike a much better balance between protecting their profits and providing consumers with access to quality care. To reduce costs and maximize profit, insurers employ policies that interfere with the health care provider and patient relationship. For example, an insurer may adopt a step therapy (also referred to as “fail first”) policy, in which it requires the patient to try and fail on less expensive treatments before it will cover the treatment prescribed by the patient’s health care practitioner. While step therapy may be appropriate if the “steps” are based on credible clinical guidelines, the standard of care, and medical necessity, it is inappropriate when the steps are based on cost alone.

The ACA theoretically protects against step therapy policies that are applied in a discriminatory manner,¹⁴⁶ yet the law does not protect against other inappropriate applications of step therapy. At least six states have enacted laws to allow a prescriber to request exemptions from the step therapy process if the prescriber finds it is in the best interest of the patient to avoid such process.¹⁴⁷ Similar reform is needed at the federal level.

Additionally, an ACA replacement law should prevent insurers from providing financial incentive to health care practitioners to influence treatment decisions. Currently, insurers may use internally-developed clinical pathways to steer providers toward their preferred sequence of treatment by offering them a financial incentive or disincentive.¹⁴⁸ This practice creates a conflict of interest for the prescribing practitioner to put insurer profits ahead of the patient’s individual health care needs, thereby interfering with the practitioner-patient relationship. A replacement law should prohibit this practice to ensure practitioners, in consultation with patients and their caregivers, be in charge of medical decision making.

Conclusion



Several of the protections afforded to consumers under the ACA are substantively strong, politically popular, well worth preserving. They have expanded access to quality health care coverage to populations that previously had no options or could not afford such coverage. They protect against discrimination and increase competition in the marketplace. However, the ACA yielded unintended consequences that necessitate substantial reform. By adopting the recommendations in this paper, Congress can address the health care needs of Americans by preserving broad access to non-discriminatory health insurance coverage; stabilizing the marketplaces; retaining and expanding consumer protections; putting practitioners, in consultation with patients and their caregivers, in charge of medical decision making; and empowering Americans to prioritize and save for their health care, make informed choices, and maximize the value of their health expenditures.

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