TESTIMONY

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Hearing titled
"Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Flexibility"

Before the
Senate Committee on Health, Education, Labor, and Pensions

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Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for the privilege of testifying. I am Tarren Bragdon, the Founder and CEO of the Foundation for Government Accountability (FGA). FGA works at the state and federal level to advance policy reforms to free more Americans to experience the power of work and reduce the biggest payroll deduction for most Americans, the cost of health coverage. Our model reforms were introduced in 41 states this year and have passed in 29 states over the past three years.

As this committee leads with bipartisan ways to improve cost and coverage, I offer three recommendations for your consideration:

First, Americans with pre-existing conditions need premium relief as well as access to individual insurance, without being segregated to plans with fewer benefits or higher premiums than those available to everyone else. This can be achieved by employing proven strategies that have successfully brought down premiums and reduced the number of uninsured.

Second, states need real policy flexibility to allow a greater continuum of health coverage, particularly for those buying their own insurance on the individual market, with a clearly defined and reasonable process and timeline.

Third, bipartisan reforms that reduce the cost of health care should be carefully considered under any bipartisan reform effort, as ultimately the cost of coverage reflects the cost of care.

1. Lowering the cost of coverage for those with pre-existing conditions and everyone else with invisible risk sharing

As my fellow panelist from Oliver Wyman and, separately, actuarial firm Milliman[i] have noted, the guaranteed issue mandate is the main driver of individual insurance premium increases under the ACA (up to 45 percent premium increase on average, according to Milliman). Congress must embrace a reform with a record of success to both lower premiums and maintain access for everyone buying insurance on their own.

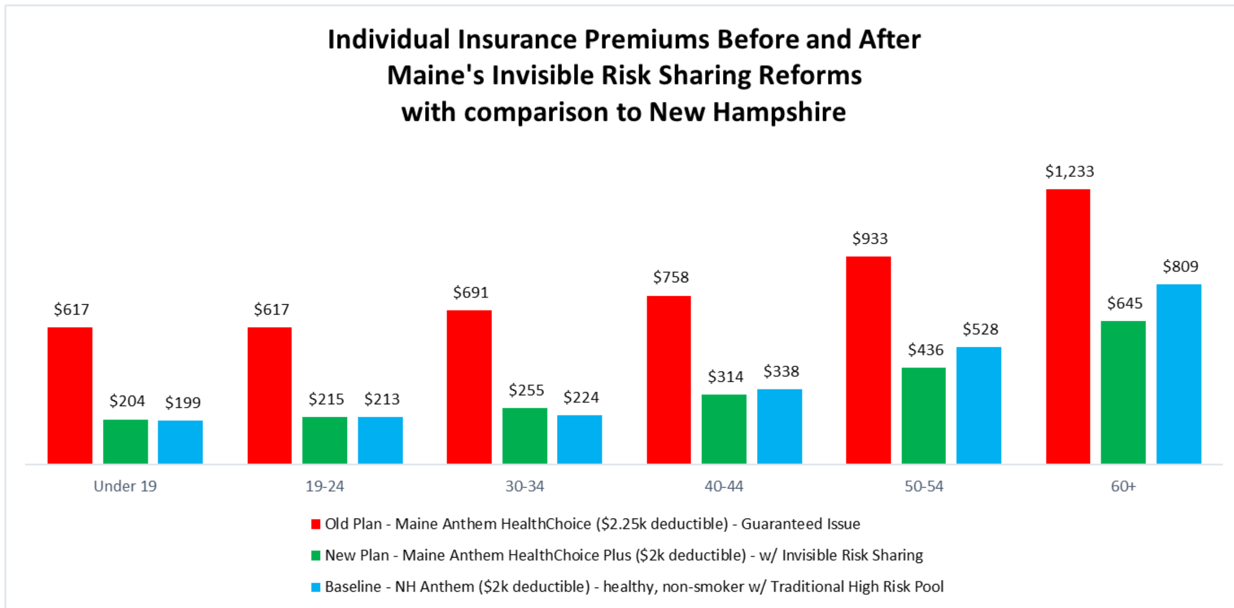
Prior to the ACA, most states segregated those with pre-existing conditions to high risk pools, which sometimes meant higher premiums or fewer benefits for enrollees. However, both Idaho (first) and Maine (later) pioneered a better and more sophisticated approach that lowered premiums without forcing those with pre-existing conditions to buy different plans. It is far more effective than an open-ended reinsurance program that costs more and is not as effective at reducing premiums.

Guarantee issue is a driver of higher premiums because of the open-ended risk and the higher costs it creates for insurers and, ultimately, policyholders by requiring insurers to accept all applicants.

Maine used an invisible risk sharing approach to both limit the risk and cap the cost for those individuals with pre-existing conditions, but did so with no negative impact on those same individuals. With this approach, those with pre-existing conditions are treated the same as everyone else while still having access to the same plans and benefits and most importantly, lower premiums.

In 2012 with invisible risk sharing, Maine dramatically lowered premiums in the individual market (by up to 70 percent) and increased voluntary enrollment with the active carrier (up 13 percent in 18 months). When combined with expanded age rating, this approach lowered annual premium costs by up to $5,000 for someone in their 20s and up to $7,000 for someone in their 60s (Maine was more restrictive than the ACA with 1.5:1 age bands and moved to 3:1.) Individuals could keep their current plans, and only transitioned to new plans if they chose to do so.[ii]

As the chart below shows, the premium impact of Maine's invisible risk sharing meant that those who were healthy or had pre-existing conditions in Maine had the same or lower premiums as healthy, non-smokers in neighboring New Hampshire (which had a traditional high-risk pool at the time).



Source: Anthem rate filings in Maine and New Hampshire
(Maine Bureau of Insurance, New Hampshire Insurance Department)

We contracted with Milliman to produce an independent actuarial study to show the impact nationally of using invisible risk sharing under a similar structure. That independent study in its entirety is attached to my testimony. Under this model, insurers paid claims for only those individuals with pre-existing conditions which are identified upon application, and insurers cover the first $10,000 of claims per person per year. Insurers contribute 90 percent of premiums collected for those eligible for this risk sharing arrangement, which dramatically lowers the cost of the program (covering 40 percent of costs) and prevents gaming by insurers (dumping more individuals into risk sharing).

Combined with expansion of age brackets, invisible risk sharing would lower individual premiums by up to 31 percent in the individual market for those buying outside of the exchange, without any reduction in benefits or increases in cost-sharing. In addition, these lower premiums would mean up to 2 million more Americans would voluntarily buy individual insurance on their own, without any increase in subsidies. Milliman estimated that the cost of this approach nationally would be between $3-5 billion annually, excluding premium contributions from insurers.[iii]

Furthermore, invisible risk sharing money is only spent to reimburse the actual claims of those with pre-existing conditions or those in the risk sharing program. It is not a general reinsurance subsidy with an unspecific impact on premiums. A good contrast is how Alaska's 1332 reinsurance program reduced a projected premium increase from 42 percent to just a 7 percent increase[iv] whereas the Maine invisible risk sharing alone *reduced* premiums from the baseline by 20 percent or more. In other words, invisible risk sharing gets us a far better bang for our buck, because far fewer resources are needed to reduce premiums even more than under traditional reinsurance or a traditional high-risk pool.

Invisible risk sharing works because, at time of application, it caps the claim costs for insurers to cover those individuals with known pre-existing conditions, removing both the open-ended risk as well as limiting the high claims costs of these individuals. Premiums spike with guarantee issue because of this risk and the high claims

costs it creates. Invisible risk sharing mitigates both, with a targeted approach. Effectively, one can receive the benefit of guarantee issue without experiencing the premium increases guarantee issue would normally create.

We would recommend that the federal government jumpstart the invisible risk sharing program initially and then, after two to three years, transition to the states. This would allow for the fastest and greatest amount of premium relief, while allowing states to customize their approaches over time. Maine started its program just 13 months after the legislation was passed and signed into law. A federal program could begin during 2018, say next fall, and create a special enrollment period for new applicants so that they could immediately reap the benefits of lower premiums, should they choose to do so.

2. Real policy flexibility for states and patients with expanded 1332 waivers

FGA's work in numerous states has revealed bipartisan hesitations about Section 1332 of the Affordable Care Act. As evidence of this, only 8 states even introduced 1332 authorizing legislation this year. There is hesitation due to the cost of the planning process, the higher barriers states must clear before an application will be considered, and the unclear timeframe of waiver approvals as well as the unclear coverage and premium benefits to individuals and families.

Put another way, with the current entry barriers and the structure of 1332s, the legislative "squeeze" necessary to get it done in a state is not worth the policy "juice" produced.

But the individual market is in crisis. There has been a 20 percent drop in those with unsubsidized ACA individual insurance this year, as healthy people drop high cost coverage they determine is not worth it.[v] That unsubsidized individual market is now at least 2 million people smaller than it was pre-ACA.[vi] To put this in perspective, only 4 million IRS returns this year paid the individual mandate penalty.[vii] In addition, since 2013, the number of individuals covered through small businesses has dropped 24 percent, showing that individuals are not simply migrating to group coverage as the economy improves.[viii]

Only 1 in 3 of those with individual insurance are eligible for both Cost Sharing Reductions (CSR) and tax credits. That means 2 in 3 in the individual market face the full brunt of higher deductibles and some, if not all, of the premium increases under the ACA. For the majority of people in the individual market, the battle over CSRs is of little consequence. This does not minimize the CSR impact on those with low incomes, but simply shows that premium relief and flexibility through expanded 1332 waivers would impact vastly more Americans.

To be clear, I do not believe that changes to the current federal guidance is sufficient. Legislative changes are needed in both the entry barriers for states and what policy flexibility states can achieve with a 1332 waiver. The four current statutory entry barriers are too high, and almost mutually exclusive, to allow a state to even apply without that state committing millions or billions of additional taxpayer dollars. Keeping the guardrail of federal budget neutrality makes sense, but reforming the other three is vital.

Section 1332 could also be of more interest to states if there was a clearer glide path toward timely approval of waiver applications and more policy flexibility. As FGA has noted in Health Affairs, the likely process is cumbersome as Section 1115 waivers, with decades of precedent, take an average of 323 days to win approval. Section 1332 waivers require bilateral approval by Treasury and the Department of Health and Human Services. If states are to change the ACA subsidy structure, the IRS has advised that states may need to waive certain tax provisions altogether and replace them with state-administered tax programs, something almost impossible for the seven states with no state income tax and extremely costly for all other states to do.[ix]

These practical and process concerns demand a simplified set of statutory guardrails, a clearer and fixed timeline path for approval, and more policy flexibility for states.

For those concerned about the types of coverage offered at the state level under a revised 1332 waiver, it is important to remember that states have more than 2,200 mandated provider and coverage benefits on the books.[x]

In short, state policymakers need a greater continuum of individual insurance plans to be allowed if premium relief is going to flow to the vast majority of the individual market and if more individuals and families are going to voluntarily buy insurance outside their employer without new or increased subsidies. The way to empower states to create this more affordable continuum is to give them more policy flexibility in how individual insurance plans are regulated under a revised and expanded 1332 framework. No one should be shut out of the individual market due to health. But evidence from actuaries and families shows that if more affordable range of plans are allowed, then more individuals will buy one that gives them the protection they want at a price they can pay. Policy flexibility for states through a revised 1332 structure is needed to accomplish this.

3. Reducing the cost of health care through transparency and empowering patients

To finish, I want to focus on the root cause of so much of the heart burn and controversy about costly efforts to increase coverage--the underlying cost of health care. There is bipartisan support for greater transparency and consumer protection in health care. This year, the divided legislature in Maine passed into law--with ***unanimous bipartisan support***--PL 232, "An Act to Encourage Maine Consumers to Comparison-shop for Certain Health Care Procedures and to Lower Health Care Costs."[xi]

PL 232 is a first-of-its kind reform. It builds on transparency efforts passed into law in Massachusetts in 2012, and a successful incentive program for state employees in Kentucky and New Hampshire, but also includes an additional key consumer protection for patients facing higher deductibles, narrower insurer networks, and the insurers' typical black box of provider prices.

The reform grants patients the right to shop for the best value care regardless of the network status of a provider. To be clear, this is not "any willing provider," as the patient can only leave an insurer network if the actual cost out of network is below the average in-network price (think of it as a "any competitive provider" patient right).

Let me give you a real-life example of why this matters:

> Jennifer is a single-mother working hard to provide for her two girls and has health insurance from her small employer with a $2,000 deductible. She was recently referred for physical therapy. She had used a physical therapist two years ago that she loved, but when she tried to return to that provider she was told they were now out-of-network and she would need to pay the full cost of any service and none of that cost would apply to her in-network deductible or annual out-of-pocket threshold.
>
> The in-network physical therapist cost $225 an hour, three times more than her previous one at $75 an hour. But Jennifer is stuck paying more and having to go to someone new and unproven. That's not fair and drives up the cost of health care and health insurance for Jennifer and everyone else.

This is not an isolated incident. The number of consumers facing increased cost sharing has spiked. Small business employees who faced $1,000 single-deductibles was just 16 percent in 2006. By 2016, the percentage spiked to 65 percent.[xii]

Increasing health care costs are harming patients, driving up insurance premiums, putting independent providers out-of-business, setting up massive health systems that will be too big to fail, and too often preventing doctors from making the best care decisions with their patients. It is time we sent a life boat to patients and give them the *right to shop*, with the true price transparency and access that allows them to do so. If we want to truly lower health care costs, we must take these steps forward.

With bipartisan leadership, this committee and this Congress can lower premiums for those with pre-existing conditions and everyone else, create a more affordable continuum of health coverage, and actually lower the cost of health care with the three recommendations outlined above.

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[ii] Joel Allumbaugh, Tarren Bragdon, and Josh Archambault, "Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions," Health Affairs (April 2017), http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/

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[x] "State Insurance Mandates and the ACA Essential Benefits Provisions," National Conference of State Legislatures (March 2017), http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

[xi] http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC232.asp

[xii] "2016 Employer Health Benefits Survey," Kaiser Family Foundation (Sept 2016), http://kff.org/report-section/ehbs-2016-summary-of-findings/