AMERICANS DESERVE NEW HEALTH OPTIONS—AND POLICYMAKERS CAN DELIVER

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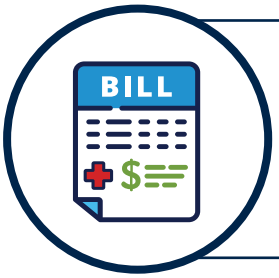
KEY FINDINGS

AN ICHRA-ANCHORED POOL WITH A NEW FEDERAL REINSURANCE PROGRAM WOULD **EMPOWER CONSUMERS**.



SPLITTING THE RISK POOLS WOULD OFFER **25 PERCENT LOWER PREMIUMS**.

A FAMILY OF FOUR COULD **SAVE MORE THAN $6,200 PER YEAR**.

THIS **HEALTH CARE TRANSFORMATION** CAN BE MAXIMIZED WITH OTHER REFORMS.

THE BOTTOM LINE:

HEALTH CARE AFFORDABILITY IS WITHIN REACH.

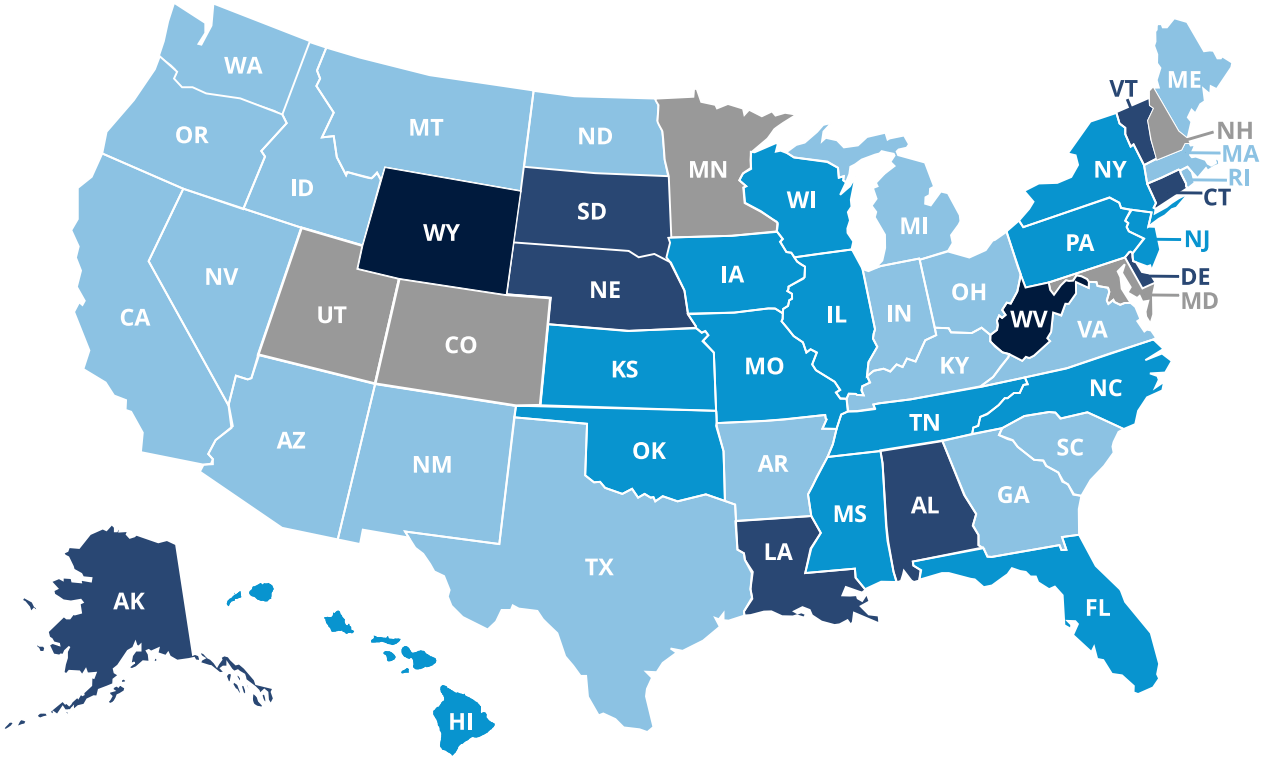
Overview

Affordability of health care remains a top concern for the countless Americans struggling to keep up with the cost of health insurance.[1] Nearly 30 million people are without health insurance entirely, and roughly two-thirds of the uninsured cite insurance costs as the reason for going without insurance.[2-3] For those enrolled in the individual marketplace, affordability can be an almost insurmountable challenge.[4]

One of the main reasons health care continues to be unaffordable is rising insurance premiums. Since ObamaCare was implemented, **premiums on the individual market have more than doubled**.[5-6]

HEALTH INSURANCE PREMIUMS ARE SKY-HIGH NATIONWIDE DUE TO OBAMACARE

Average annual premiums by state in 2022



Source: Centers for Medicare & Medicaid Services

In 2022, **the average premium was more than $6,000 per person, with an out-of-pocket maximum of as much as $9,100**.[7-8] Americans enrolled in this coverage will spend more on health insurance than on gas or groceries in a given year.[9-10] In some states, premiums are even higher—the statewide average premium in West Virginia is nearly $12,000 per year before paying any required out-of-pocket costs for care.[11]

Individual market premiums are through the roof due to the fundamental features of ObamaCare. Several onerous restrictions, such as community rating, benefit mandates, and guaranteed issue requirements, lead to higher costs. Furthermore, low-risk, and therefore lower-cost, enrollees are lumped in the same risk pool as high-risk, higher-cost exchange enrollees—making premiums all the more expensive for lower-risk consumers who are unlikely to receive ObamaCare subsidies.

INDIVIDUAL MARKET PREMIUMS ARE THROUGH THE ROOF DUE TO THE FUNDAMENTAL FEATURES OF OBAMACARE.

These challenges place even greater pressure on taxpayers to subsidize insurance, punish job creators with limited options, and promote government dependency through taxpayer-subsidized coverage. In short, the status quo is unworkable. Fortunately, innovative solutions are available and the costly, burdensome, and flawed structure of ObamaCare is not the only way forward.

New Health Options Market: An ICHRA-anchored pool with a new federal reinsurance program would empower consumers

Federal lawmakers can build on existing policies to advance meaningful reform that drives down premiums. Individual Coverage Health Reimbursement Arrangements (ICHRAs) allow employers to give tax-privileged funds directly to employees to buy their own coverage.[12] Rather than directly managing employee health plans, **ICHRAs give employers an alternative funding mechanism to provide employees with a cash benefit with the same pre-tax preference afforded to traditional employer-sponsored insurance**. **In turn, employees use ICHRAs to purchase a plan on the individual market**. ICHRAs give employees more control over their health insurance benefits and introduce more consumer power into the market.[13]

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The 2020 Economic Report of the President anticipated that younger and healthier workers would be drawn to "the typical individual market coverage of relatively higher deductibles and more limited provider networks due to their lower premiums."[14] But this can only work if premiums are affordable in the individual market. The upward pressure on premiums from the existing, single risk pool structure—where ICHRA users are combined with higher-risk, more expensive exchange enrollees—drives up premiums across the board and makes using ICHRAs to purchase plans in the individual market less attractive.

Because of the differences in risk levels across different enrollees, ICHRAs would be better leveraged if enrollees were not lumped into the same risk pool as exchange enrollees. For example, the average risk score for individual market exchange enrollees is 25 percent higher than those in the small group market—which is where ICHRA beneficiaries would be migrating from.[15] Simply put, forcing both exchange and non-exchange enrollees into a single pool drives up costs for enrollees dealing directly with insurers, even if they are using tax-favored ICHRAs.

This presents the opportunity for an innovative solution: **Create a separate and parallel risk pool designed to serve employees using ICHRAs and individuals who want to buy plans directly from insurers**. This would open up a parallel, market-driven risk pool with lower premiums. A new "opt-in" pool would enable individuals to migrate to a more affordable plan. Importantly, this new pool would not result in changes to existing benefit mandates, guaranteed issue, or variation in premiums based on health or gender. It would also not force any exchange enrollee in the current risk pool to migrate to the new pool. They can keep their free or highly subsidized plans.

CREATE A SEPARATE AND PARALLEL RISK POOL DESIGNED TO SERVE EMPLOYEES USING ICHRAS AND INDIVIDUALS WHO WANT TO BUY PLANS DIRECTLY FROM INSURERS.

How would the new risk pool be different? Primarily, it would not share one of the mandates that drive up costs in the current risk pool and instead allow premiums based on age to vary with a five-to-one ratio as opposed to the current three-to-one ratio. This would maximize savings for younger Americans with ICHRAs and encourage them to purchase insurance.

Splitting the risk pools would offer 25 percent lower premiums

ObamaCare forces all enrollees into a single risk pool, penalizing lower-risk individuals. Actuarial analyses of splitting the risk pools coupled with a reinsurance program reveal substantial premium savings. Under a separate risk pool financed by employer and employee ICHRA contributions, combined with a low-cost federal reinsurance program, would allow for substantial savings when an individual purchases directly from an insurer instead of the ObamaCare exchange. **Premiums in this new risk pool would be an average of 25 percent lower than premiums on the exchange today**.[16-18] For certain age groups, the premium savings would be even greater.

SPLITTING THE RISK POOLS WOULD SLASH HEALTH CARE PREMIUMS

Example of potential savings for an average silver-level plan

	Age	Status Quo Monthly Premium	Premium Under New Options	Premium Savings	Annual Savings
	30	$392	$244	-37.8%	$1,776
	40	$442	$299	-32.3%	$1,716
	50	$617	$494	-20.0%	$1,476
	60	$938	$850	-9.3%	$1,056

Source: Authors' calculations

The savings to families would be tremendous. Under this proposal, **a family of four could see savings of more than $6,200 per year**—a 36 percent reduction in premiums.[19]

Premiums for a parallel risk pool could be further reduced through a reinsurance program

Reinsurance programs help limit risk by spreading the costs across participating insurers.[20] A reinsurance program would use federal funding to subsidize high-cost claims at a set level to further reduce costs overall. Low- and no-subsidy enrollees paying high premiums in the current, single risk pool ObamaCare exchanges would be able to access lower premium plans, further driving down premiums in the parallel risk pool overall. In 2015, the U.S. Department of Health and Human Services spent approximately $7.8 billion to cover roughly 55 percent of the cost of medical claims between $45,000 and $250,000 through a temporary reinsurance program for the individual market.[21-22] This amounts to a monthly cost averaging nearly $50 per enrollee and reduced premiums between six and 11 percent.[23-24] That reinsurance program for the current risk pool subsequently expired. This new reinsurance program would operate at the same $50 per member, per month level, with a $6 billion annual cap, and would similarly expire once the market stabilizes after a few years.

In summary, codifying existing ICHRA rules, allowing funding of new plans with ICHRAs, creating an exception to ObamaCare's single risk pool requirement and eliminating the three-to-one limit for the new, parallel risk pool, and constructing a reinsurance program would transform the health insurance landscape. **Implementing this proposal would place downward pressure on premiums for millions of Americans, providing much-needed relief for consumers suffering from the high costs brought on by ObamaCare**.

This health care transformation can be maximized with other reforms

A new risk pool structure and reinsurance program would put downward pressure on premiums and bring much-needed relief for consumers. But coupling these changes with additional reforms would maximize the impact. These policies include promoting high-value care by creating flexibility for out-of-network care, disclosing lower cash prices, and codifying commonsense regulatory changes.

FLEXIBILITY FOR OUT-OF-NETWORK CARE

A major consequence of ObamaCare is the narrowing of provider networks.[25] Narrow networks can often leave patients without a reasonable in-network provider, meaning they are forced to go outside their plan's network to find the care they need. Under current law, out-of-pocket expenses do not count towards in-network deductibles, even if the provider is more affordable. This makes the cost of care even more burdensome for the patient and limits cost savings for the entire insurer network. Patients deserve access to the care they need, regardless of network, especially when out-of-network providers offer low-cost services.

Providing patients with the flexibility to seek out-of-network care by allowing lower cost out-of-network providers to count toward in-network deductibles—something already allowed in Georgia—would not only alleviate the financial burden on patients who have nowhere else to turn, but would also lead to a more competitive system with an incentive to shop based on price.[26]

DISCLOSURE OF LOWER CASH PRICES

Price transparency empowers consumers to shop and leads to lower prices.[27] While price transparency has long been absent from health care, recent reforms—including a pair of price transparency regulations from the Trump administration and the bipartisan No Surprises Act—have helped shift health care in a more market-oriented direction.[28-32] Although these price transparency reforms are a step in the right direction, there is still work to do. In addition to codifying the hospital price transparency and transparency in coverage rules, Congress can go a step further by **giving consumers information about how paying cash could help their bottom line**.

CONGRESS CAN GO A STEP FURTHER BY GIVING CONSUMERS INFORMATION ABOUT HOW PAYING CASH COULD HELP THEIR BOTTOM LINE.

Some goods and services are priced differently depending on the payment method. For example, many gas stations charge customers lower prices if they pay with cash instead of a credit card.[33] This gives consumers the option of choosing a payment method that makes the most sense for them. Health care consumers would benefit from similar knowledge. In some cases, patients could reap substantial savings by paying with cash instead of going through their health coverage. In fact, many hospitals set a lower cash price than what they charge for services paid through an insurance carrier.[34]

These savings opportunities already exist, but patients with insurance are often kept in the dark. The asymmetry of information could be corrected with a simple policy change: **Require hospitals and other health care providers to disclose to patients whether or not a cash charge would be less expensive than their cost-sharing obligation through their health coverage**. Congress previously enacted similar prohibitions against gag clauses for pharmaceuticals.[35-36] This would extend that commonsense policy to health care more broadly. Under this reform, both providers and consumers would benefit. Providers get upfront payment and avoid the hassle of dealing with the middleman insurer and the patient receives the same care for a lower price.

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ASSOCIATION HEALTH PLANS

Association health plans (AHPs) level the playing field for entrepreneurs and businesses by allowing them to band together to purchase health coverage for themselves and their employees at affordable rates.[37] In an effort to confront rising health care costs, President Trump dramatically expanded AHPs by allowing these entities to exist primarily for insurance purposes, branch across different industries, pool from different states, and include self-employed entrepreneurs.[38] By breaking down these barriers to joining AHPs, the Trump administration's interpretation freed these entities from being constrained to the more expensive small group market. These changes were estimated to generate benefits of $8 billion annually.[39] The impact was substantial as millions of Americans gained access to plans that were, on average, 29 percent more affordable.[40-41]

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Unfortunately, the Trump administration's rule was challenged in federal court. Although the Trump administration appealed an initial ruling striking down the rule, it remains in legal limbo as the Biden administration has failed to defend the rule.[42-43] However, Congress can codify the expansion of AHPs to guarantee that these flexibilities are implemented. Similarly, after the Trump administration issued a rule allowing employers to band together to form Association Retirement Plans, Congress codified those policies through the SECURE Act.[44-46]

SHORT-TERM HEALTH PLANS

For decades, consumers have benefited from the availability of short-term health plans in a wide variety of situations, such as when they are between jobs or waiting to be eligible for Medicare.[47] These plans soared in popularity after the enactment of ObamaCare thanks to their comparative affordability, with premiums that are 59 percent less expensive on average.[48-49] Even at similar coverage levels, short-term plans tend to be more affordable than what is available on the ObamaCare exchanges.[50] And, even though they are exempt from onerous ObamaCare mandates, many short-term plans still offer coverage for things like mental health, substance abuse, maternity services, and more, at more affordable rates.[51]

Recognizing the value that consumers see in short-term plans, the Trump administration reversed the restrictions from the Obama administration that arbitrarily and dramatically shortened the duration of these popular plans.[52-53] An analysis of this change estimated an annual benefit to consumers of $8 billion.[54] Since then, consumers in states that fully permit short-term plans have benefited from the increased choice and competition.[55] In these states, exchange enrollment is higher, there are more insurers selling exchange plans, and exchange premiums are lower.[56] Unfortunately, access to these more affordable and flexible health coverage options is under threat by the Biden administration.[57] Congressional action to codify the Trump-era rules would stop the ping-ponging of definitions between presidential administrations and protect the popular coverage options that the Biden administration is threatening to take away.[58]

RECOGNIZING THE VALUE THAT CONSUMERS SEE IN SHORT-TERM PLANS, THE TRUMP ADMINISTRATION REVERSED THE RESTRICTIONS FROM THE OBAMA ADMINISTRATION.

THE BOTTOM LINE: Health care affordability is within reach.

Health insurance premiums are increasingly unaffordable thanks to ObamaCare. Reforms that stem the tide and put downward pressure on premiums would provide much-needed relief for consumers. Unlike President Obama's false promise, this proposal does not outlaw existing options.[59] If Americans like their current plan, they can keep it. Congress should act to open up new pathways for consumers to select quality coverage options that they can obtain at a lower cost.

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APPENDIX: STATEWIDE AVERAGE PREMIUMS IN 2022

STATE	STATEWIDE AVERAGE MONTHLY PREMIUM	STATEWIDE AVERAGE ANNUAL PREMIUM
Alabama	$662	$7,942
Alaska	$636	$7,636
Arizona	$477	$5,720
Arkansas	$429	$5,146
California	$495	$5,937
Colorado	$392	$4,703
Connecticut	$651	$7,813
Delaware	$604	$7,253
District of Columbia	$512	$6,147
Florida	$524	$6,294
Georgia	$453	$5,439
Hawaii	$528	$6,340
Idaho	$442	$5,305
Illinois	$552	$6,624
Indiana	$486	$5,830
Iowa	$574	$6,892
Kansas	$540	$6,481
Kentucky	$499	$5,992
Louisiana	$653	$7,837
Maine	$473	$5,677
Maryland	$377	$4,528
Massachusetts	$494*	$5,931
Michigan	$438	$5,253
Minnesota	$414	$4,962
Mississippi	$524	$6,287
Missouri	$542	$6,500
Montana	$493	$5,911
Nebraska	$611	$7,326
Nevada	$441	$5,293
New Hampshire	$389	$4,670
New Jersey	$535	$6,419
New Mexico	$453	$5,442
New York	$554	$6,653
North Carolina	$545	$6,536
North Dakota	$448	$5,372
Ohio	$497	$5,965
Oklahoma	$527	$6,326
Oregon	$491	$5,887
Pennsylvania	$509	$6,112
Rhode Island	$427	$5,126
South Carolina	$497	$5,970
South Dakota	$593	$7,111
Tennessee	$528	$6,332
Texas	$477	$5,724
Utah	$359	$4,310
Vermont	$615	$7,377
Virginia	$495	$5,943
Washington	$462	$5,546
West Virginia	$978	$11,738
Wisconsin	$539	$6,465
Wyoming	$732	$8,784

Source: Centers for Medicare & Medicaid Services

** Merged individual and small group premiums. See footnote 24 in the Summary Report on Permanent Risk Adjustment Transfers for the 2022 Benefit Year, https://www.cms.gov/files/document/summary-report-permanent-risk-adjustment-transfers-2022-benefit-year.pdf.*

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17. Savings relative to the status quo range from 25 percent with no small group market migration to 34 percent with complete small group market migration.
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