

12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage



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Improving America's Health Care System: 12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage

Introduction

Every American should be able to get affordable, comprehensive coverage - regardless of their income, health status, or pre-existing conditions. But hardworking Americans who buy their coverage on the individual market are increasingly finding their premiums are out of reach if they don't qualify for premium subsidies. This population includes families with an income that is more than 400 percent of the federal poverty level (\$47,520 for an individual or \$97,200 for a family of four).¹

Consumers and policymakers at the federal and state levels want solutions. In this paper, we provide several recommendations for actions state and federal policymakers can take to make premiums more affordable. Our recommendations address three issues that drive up premiums for these families:

1. The out-of-control cost of health care services and prescription drugs.
2. Families making over 400 percent of the federal poverty level are the only segment of the American population that don't receive some help with their insurance premiums.
3. Too few healthy people participate in the individual market to balance out the risk.

State and federal policymakers and regulators can take action now to improve premium affordability. Some of these recommendations can be implemented very quickly through regulation, while others require state or federal legislation. While this paper focuses on improving out-of-pocket premium affordability for those who don't qualify for federal support, many of these recommendations will drive down premiums for everyone, reducing the total cost of subsidies and the financial burden they place on taxpayers.

Describing the Challenge

For the 2017 plan year, around 5 million Americans bought comprehensive health coverage without assistance from tax credits, subsidies, or employer contributions that reduce the costs of their premiums.² These hardworking Americans include entrepreneurs, those who have retired before qualifying for Medicare, and workers who do not qualify for employer-provided coverage. This includes 2 percent of those insured in the United States. The Centers for Medicare & Medicaid Services (CMS) reports from 2017 to 2018, the average monthly exchange premium for this market increased from \$471 to \$597.³ The average premium for the least expensive bronze plan for a single 40-year-old rose from \$329 to \$394 from 2017 to 2018.⁴ Increasing health care costs hit these Americans hardest. It's time we brought them some relief.

Evidence is emerging that individual market premiums are becoming more stable.⁵ But in some regions, premiums are too high for many Americans. When families can't afford premiums for comprehensive coverage, some decide to purchase leaner coverage– or even go without coverage at all. That can put their health and financial security at risk.

How are Premiums Set?

To overcome the challenges, it's important to know how premiums are set. The vast majority of dollars spent on premiums go to cover the cost of health care – for example, doctor appointments, hospital visits, and prescription drugs. In fact, health insurance providers are mandated by the federal government to spend at least 80 percent of premiums on health services. The remaining 20 percent must cover the cost of important health insurance provider services like customer service, patient care coordination, collaboration with doctors and hospitals, and fraud prevention.

To set premium costs for consumers, health insurance providers calculate the cost of providing care to all their members in a geographic area. This is why the increasing cost of doctors, hospitals, and prescription drugs is so important. These rising costs play the biggest role in consumers' premium costs.

Premiums aren't affordable for an increasing number of middle-class Americans:

5 million

People bought exchange plans without federal subsidies in 2018.

20%

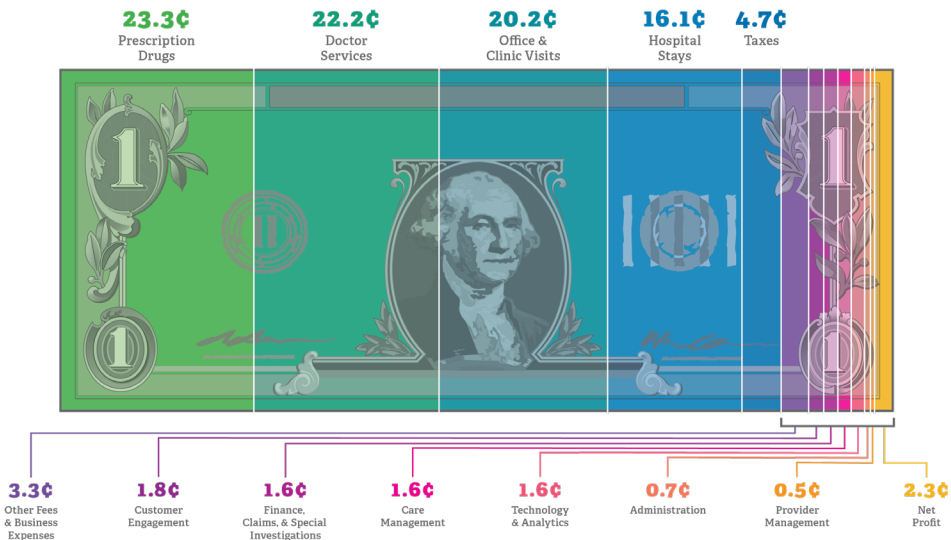
Fewer people covered without subsidies through the exchange from 2016 to 2017.

\$126

Average increase in monthly premium for an exchange plan from 2017-2018.

Where Does the Premium Dollar Go?

Example of a Typical Plan⁶



Three Levers to Lower Premiums

There are three tested and proven methods for driving down the costs of premiums for consumers:



Key to Recommendation Categories

- FR** **FED REG** – Could be achieved through Executive action by proposing new or modifying existing regulation.
- SR** **STATE REG** – Proposal could be enacted at the state level through new regulations in some states.
- FL** **FED LEG** – Proposal requires new Federal Legislation.
- SL** **STATE LEG** – Proposal would require the enactment of state legislation in most states.

LEVER 1: REDUCE THE COST OF HEALTH CARE

Evidence over the last decade indicates by nearly every measure, the United States spends more on health care than any other nation in the developed world. In 2017, the United States spent 17.2 percent of its gross domestic product (GDP) on health care. That is the highest of any nation participating in the Organization for Economic Cooperation and Development (OECD)⁷ and almost double the OECD average of 9 percent.⁸ In 2017, the nation spent almost \$10,000 per person on health care – or 250 percent more than the OECD median of \$4,000 per person.⁹ For Americans who pay the full cost of their insurance premiums, these inflated costs are reflected directly in their premiums.

Some approaches aim to move the “cost-of-care” lever and bring premium costs down by simply eliminating coverage for things like prescription drugs, preventive care, or care for pre-existing conditions. While this approach will result in reduced premiums for some people in the short-term, it can expose families to finding themselves underinsured when they need their coverage most.

To provide the kinds of affordable insurance options Americans really want, options that cover preventive care and protect them from financial devastation if they get sick, it is imperative we tackle the real problem - misaligned incentives and sky-high unit prices.

Reduce Surprise Billing

Health insurance providers develop networks that offer consumers access to safe, affordable, high-quality care. Most private insurance providers - and many public programs - offer a variety of network options. When providers choose to participate in networks, coverage is more affordable. When providers choose not to participate in networks - or if they do not meet the requirements for inclusion in a network - these providers may charge whatever they like, sometimes billing amounts far above average rates in the same area. Most out-of-network providers bill patients for any amounts not paid by their health insurance provider. From the provider's perspective this is "balance billing." From the consumer's perspective this is "surprise billing."



Health plans that limit out-of-network coverage are more affordable, because in-network doctors agree to provide care at a set price. To help navigate the options, health insurance providers and exchanges have developed tools for consumers to check if their providers are in-network before purchasing a plan. For routine or non-urgent care, consumers should check if a provider is in-network before seeking services. The issue of "surprise billing" most often arises in two scenarios, despite the best efforts of a consumer to use in-network providers: (1) when individual providers practice at an in-network hospital but don't participate in the network; and (2) when people receive emergency care at an out-of-network facility.

If insurance providers are required to reimburse out-of-network providers at whatever rates they bill, this creates a disincentive for providers to join networks. Unreasonable out-of-network reimbursement rates and balance billing of patients undermines affordability and imposes a "blank check" approach to payment. Laws or regulations establishing specific levels or guidelines for out-of-network reimbursement can protect patients from surprise bills and keep premiums down.

Air ambulances generate some of the most egregious surprise bills related to medical emergencies. The Airline Deregulation Act of 1978 prevents states from exercising the same oversight over air ambulances that they exercise for other emergency medical providers. This allows air ambulance providers—who deliver essential emergency medical services to patients who have no choice—to uncompetitively price gouge health care consumers and insurance providers alike. Anticompetitive behavior increases the cost of such life-saving services and premiums for everyone. Far from unleashing the competitive forces that Congress contemplated would result from deregulation, extending the Airline Deregulation Act to the unique market for these highly-specialized emergency medical service providers prevents states from helping to level the playing field, and fosters unfair business practices and consumer harm.

For individual market plans, federal regulation already addresses reimbursement rates for emergency care received out-of-network¹⁰ and notification requirements for out-of-network services provided at in-network hospitals.¹¹ The current federal requirement specifying reimbursement rates for out-of-network emergency services provides a workable payment benchmark but does not prevent providers from balance billing patients. However, the requirement that health plans notify consumers in advance when they may receive out-of-network services is impractical, because health plans seldom know a member is receiving care until after the care has been provided.

The federal government and states, through legislation and regulation, can take additional steps to: (1) establish regulatory guardrails around health insurance payments to out-of-network providers that provide care at an in-network facility; and (2) protect consumers from surprise bills in emergencies and when care is received at an in-network facility. Any statutory or regulatory approach to the rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts, but instead continues to encourage health plans and providers to enter into mutually beneficial contracts. We recommend actions below to take patients out of the middle of disputes and provide predictable, fair and reasonable reimbursement rates.



Protect patients from surprise bills and prevent unnecessary premium increases related to out-of-network care. For instances when the consumer did not have the opportunity to select an in-network provider, such as emergencies, and the consumer does not have out-of-network benefits defined in their policy, prohibit providers from balance billing patients and set a payment benchmark that clearly defines what the plan is expected to pay the provider for the services rendered. The benchmark should be designed to ensure a reasonable reimbursement rate for providers, while preventing price gouging and excessive consumer bills. Billed rates should never be used as benchmark for out-of-network reimbursement. Providers should be prohibited from billing patients for amounts that exceed the benchmark-based payment.



Update federal statute to allow states to regulate air ambulance providers to prevent egregious bills. Many states have attempted to take action to protect consumers from excessive air ambulance bills, which cost \$50,199 on average in 2016¹², only to find their efforts stymied in the court due to barriers imposed by federal statute. Congress should update the Airline Deregulation Act of 1978 to allow states to regulate their markets.



In the interim, while policies protecting patients from surprise doctor bills are being implemented, require in-network hospitals and other facilities, rather than health plans, to disclose that a patient may be treated by an out-of-network provider in that facility. If out-of-network providers may treat the patient while the patient is receiving care at that facility, require the facility to disclose to the patient that out-of-network provider fees may apply. This requirement, which may not be practical for emergency scenarios, should apply to all procedures and services where treatment is scheduled in advance.

Curb Inappropriate Third-Party Premium Payments

Third-party payments for drugs or services typically are made for consumers by outside entities, such as health care providers, pharmaceutical companies, foundations, or other entities. Concerns about third-party payments, specifically related to conflicts of interest between a provider's financial interest and a patient's best interests, have generally resulted in the prohibition of these payments in public programs like Medicare and Medicaid. However, there has been less clarity regarding the use of these payments in the individual market.

Health insurance providers have seen a rise in third-party payments from entities steering Medicare and Medicaid-eligible individuals to the individual market. The third-party organizations steering consumers to the individual market, stand to benefit financially through greater reimbursement rates from private health insurance providers.

Steering older and less healthy consumers to the individual market also skews the risk pool to higher-cost individuals, resulting in higher premiums for everyone. This is especially challenging for hardworking Americans who pay for their coverage without any support. Ensuring consumers are enrolled in appropriate coverage designed to best meet their needs, instead of steering them to coverage that results in financial gain for a third-party providing health care services, will help keep costs lower and contribute to a more stable market.

Another type of third-party payment is the growing use of drug coupons and copay cards. Consumers are given discounts on brand-name drugs, encouraging use of those drugs instead of less expensive generics or therapeutic substitutes. Drug makers pass along the whole cost of the drug to insurers, increasing overall costs and driving up premiums. *Health Affairs* has reported drug coupons lead to unnecessary spending by health insurance providers that is then passed on to consumers through higher premiums and more limited coverage options.¹³ Similar to third-party payments, drug coupons are not allowed in Medicare and Medicaid.

Additional Resources:

[How Third-Party Premium Payments Can Harm Consumers and Destabilize Markets](#), May 2018

[AHIP Statement on Third Party Payments](#), December 2016

FR

Reissue rulemaking, under 42 CFR Part 494, to address conditions for coverage for end-stage renal disease third-party payment. In December 2016, HHS published an interim final rule that outlined a narrow set of circumstances in which third-party payments by dialysis facilities would be allowed. Due to ongoing litigation, the effective date for this rule has been delayed indefinitely. Revised rulemaking should retain requirements for dialysis facilities to meet certain conditions in order to receive reimbursement and clarify health insurance providers would not be required to accept third-party payments if those conditions are not met. Specifically, third-party organizations that make premium and cost-sharing payments on behalf of individual market enrollees should be required to report information on funding sources, governance, relationships with provider and pharmaceutical organizations, etc., and attest they meet the requirements set out in such revised rulemaking.

FR

Prohibit direct and indirect premium payments to entities in which the provider has a financial interest. Under its conditions of participation requirements, HHS can prohibit direct or indirect payments by providers as a conflict of interest. Similarly, providers could be considered out of compliance with the conditions of coverage if they do not provide consumers with information on their full coverage options.

FR

Clarify existing guidance under 45 CFR § 156.125 related to insurer acceptance of third-party payments. HHS' long-standing policy is that health insurers may deny any third-party payments that are outside of federal requirements; however, current regulations should be formally amended to include this language.

FR

FL

SR

SL

Do not expand the list of third-party entities from which health insurance providers must accept premium and cost-sharing payments. HHS has identified a limited roster of entities from which health insurance providers must accept third-party payments, including Ryan White and HIV/AIDS programs, Indian tribes, and state and local programs. Expanding this list to include other entities would result in higher premiums and decreased affordability for consumers.

FR

SL

Prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative. HHS and states should take steps to address the increased use of prescription drug coupons and co-pay assistance cards, by prohibiting their use in the private marketplace just as they are prohibited in federal programs. If coupons are allowed for drugs with no less expensive alternatives, the coupons or copay cards should be available to all patients for the entire length of time they need the medication.

Increase Drug Competition

Prescription drug prices are out-of-control and are contributing to unsustainable health care cost growth across the country. In addition to placing strains on the health care system, rising drug prices also place financial burdens on patients who rely on prescription medicines to treat and manage their chronic conditions.

For employer-sponsored coverage, spending on prescription drugs outpaces spending for inpatient hospital care and drug spending continues at a faster rate than overall health care spending and makes up a greater share of total medical expenses.

Bold steps are needed—at both the legislative and regulatory levels—to ensure people have access to affordable medications.

- FR** **Create a robust biosimilars market.** Biosimilars offer great promise in generating cost savings for consumers. Some of the costliest and most widely used biologics have been on the market for decades without biosimilar competition. To achieve this promise, the FDA should finalize regulations that promote a robust competitive market and ensure patients and providers have unbiased information about the benefits of biosimilars. For example, the FDA should provide clarity for all stakeholders and complete the biosimilar approval pathway by finalizing interchangeability policies.
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- FR** **FL** **Reduce federal rules, regulation and red tape to generic entry.** The FDA should provide the necessary resources to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited drug competition. “Pay-for-delay” settlements and “product hopping” should be challenged by the FTC to address patent abuses and anti-competitive tactics. Further, the Inter Partes Review (IPR) process through the U.S. Patent and Trademark Office should be preserved. Additional legislation, via passage of the CREATES Act, is needed to address abuse of patient safety protocols and ensure widespread availability of generic and biosimilar drugs to promote affordability and lower consumers’ out-of-pocket costs.
-
- FL** **Revisit and revise orphan drug incentives.** The Orphan Drug Act incentives are being misapplied. The law’s incentives should only be used by those developing medicines to treat rare diseases, not as a gateway to premium pricing and blockbuster sales beyond orphan indications. In cases of rare diseases for which no effective therapy exists, policymakers should ensure that newly approved drugs are priced in accordance with their value and efficacy.
-
- FR** **FL** **SL** **Publish true R&D costs and explain price setting and price increases.** As part of the FDA approval process, drug manufacturers should be required to disclose information regarding the intended launch price, the use of the drug, and direct and indirect research and development costs. After approval, manufacturers should provide transparency into list price increases. States can also enact state level drug pricing transparency laws. California and Oregon have already done so.
-
- FR** **FL** **Strictly enforce existing regulations on DTC advertising and evaluate DTC advertising impact to develop additional limits.** Direct-to-Consumer (DTC) drug advertising increases premiums by driving consumers to expensive brand name drugs when more clinically appropriate, higher-value treatments may be available. The FTC should enforce existing regulations to ensure drug ads are not misleading. Further assessment is needed of the impacts of the growth in DTC advertising, particularly broadcast advertising, followed by an evaluation of the best approaches for conveying such information to consumers. As part of this assessment, FTC should examine the impact of DTC advertising and point-of-prescribing drug price disclosures on physician prescribing behavior and/or its effects on generic drug availability and utilization. New requirements for DTC advertising should include provisions to promote transparency and accuracy, including requiring that the drug list price be disclosed in any DTC drug advertising in a meaningful manner, as proposed by the Administration and in bipartisan legislation earlier this year.
-
- FR** **FL** **SR** **SL** **Inform patients and physicians on effectiveness and value.** The first step in promoting high-value drugs is to establish a common definition of value. This requires agreed upon standards that account for quality, outcomes, and price. An independent third-party entity, such as the Institute for Clinical and Economic Review (ICER), should take the lead in establishing this definition. To disseminate information on value, increased funding is needed for private and public efforts to provide information to physicians and their patients on the comparative clinical and cost-effectiveness of different treatments, procedures and drugs. These tools can help facilitate appropriate assessments about the value and effectiveness of different treatment approaches, particularly for those with high costs. Findings from independent entities conducting comparative effectiveness reviews, such as ICER, can and should be used to inform decisions around coverage, payment and reimbursement for therapies and drugs.
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- FR** **FL** **SR** **SL** **Reduce regulatory barriers to value-based pricing.** Policymakers should address existing statutory and regulatory requirements that may inhibit the development of pay-for-indication and other value-based strategies in public and private health insurance programs.

Expand the Use of Telehealth

More consumers of all ages are using new technologies like smartphones and expect the convenience these technologies offer. Health insurance providers are responding by offering telehealth services for their members. Telehealth is the use of telecommunications, like video chatting, to support health care evaluation, treatment, and education for a variety of patients. Telehealth has the potential to improve engagement between patients and providers; improve health care maintenance, especially for those with chronic conditions; and avoid unnecessary and costly acute care settings. While particularly useful for those in rural areas, seniors, and others with mobility concerns, telehealth services can make it easier for all patients to access care and connect with specialists from a computer or mobile device.

However, challenges to expansion of telehealth services do exist. Numerous states have enacted laws and regulations governing telehealth for plans operating in the commercial market. The disparities among state requirements related to provider licensure, site- and technology-specific use, and reimbursement and/or payment parity, create many barriers to continued use and expansion of telehealth services.

While telehealth alone will not solve the problem of affordability and access to care, estimates show that it can save more than \$6 billion annually.¹⁴ This will help meaningfully lower overall costs in the health care system.

Additional Resource:

[Telehealth Connects Patients and Doctors in Real Time](#), November 2017

Recommendations

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

-   **Support establishment of multi-state licensure compacts.** In many cases, providers can only offer services in a state where they are licensed. If a patient can only use an in-state doctor, this closes off doctors that would otherwise be available through national provider networks. Allowing multi-state licensure compacts can promote expedited licensure for physicians and/or reciprocity for certain providers applying in multiple states, will increase the number of accessible services, and expand provider networks available to consumers.
-   **Enhance flexibility by not establishing state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use.** Inconsistent state laws and mandates can make providing access to telehealth services difficult for health insurance providers, particularly those that operate in multiple states. State mandates to cover telehealth in specific ways and under specific requirements hinder flexibility to design benefits that meet the needs of consumers.
-    **Designate telehealth as a means of satisfying network adequacy requirements.** Under 45 CFR 156.230, HHS should establish telemedicine as an option to meet federal requirements for network adequacy standards. In a 2016 revised model law, the National Association of Insurance Commissioners included the use of telemedicine as an option to meet network adequacy standards. And, several states have passed laws or updated regulation to incorporate telehealth in their network adequacy requirements. As part of updating standards to allow greater use of telemedicine, states can identify guardrails to ensure telemedicine use is expanded for scenarios for which it is clinically appropriate.
-  **Permit first-dollar coverage of telehealth services in HSA-eligible health plans.** Existing law restricts what care or services a plan may cover pre-deductible in a high-deductible health plan while retaining HSA-eligibility. Telehealth is not only increasingly popular, it is a means of accessing care that is highly affordable for both the plan and the consumer. Permitting plans to cover telehealth services with first-dollar coverage reduces overall costs to the system and allows greater flexibility and affordability for consumers. The approach to expanding HSAs described in the recommendation “Expand HSA Options” is a more comprehensive approach to HSA modernization that would allow for first-dollar coverage of telehealth. As a fallback, Congress should consider a more limited bill to allow first-dollar coverage of telehealth.

Increase Flexibility for Reference Pricing

Reference pricing entails a health insurance provider setting a specific amount they will pay for a covered service. If a person decides to go to a provider that sets a price higher than the reference price, they are responsible for the difference. High-cost procedures that vary widely for reasons unrelated to quality, like joint replacements, provide opportunities for real savings. Many employer-sponsored plans are using or exploring reference pricing, but Department of Labor (DOL) guidance issued in 2014 and 2016 limits the ability of individual market coverage to use this promising tool to reduce costs.¹⁵

Significant savings are possible using reference pricing. A 2013 study found that the California Public Employees' Retirement System saved \$2.8 million dollars in 2011 due to their reference pricing program for knee and hip replacements.¹⁶

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\$2.8 million dollars
in 2011 due to their reference pricing program for knee and hip replacements.

Reference Pricing in Practice, Impact on Savings and Behavior¹⁷

	Procedure(s)	Reference Price (Percentile)	Savings	% of Consumers Switching from Higher to Lower Cost Providers	Reduction in Prices Chared Among High-Priced Providers
CalPERS	Cataract Surgery	66 th	17.9%	8.6%	n.a.
CalPERS	Colonoscopy	66 th	21.0%	17.6%	n.a.
CalPERS	Hip and Knee Replacement	66 th	20.2%	28.5%	34.3%
CalPERS	Arthroscopy: Knee	66 th	17.6%	14.3%	n.a.
CalPERS	Arthroscopy: Shoulder	66 th	17.0%	9.9%	n.a.
Safeway	492 CPT Codes, Lab Services	50 th	20.8%	12.0%	n.a.
Safeway	Diagnostic Lab Testing	60 th	31.9%	25.2%	n.a.
Safeway	Imaging: CT	60 th	12.5%	9.0%	n.a.
Safeway	Imaging: MRI	60 th	10.5%	16.6%	n.a.

Notes: n.a. Not available—study did not explicitly estimate the reduction in prices charged

Recommendation

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

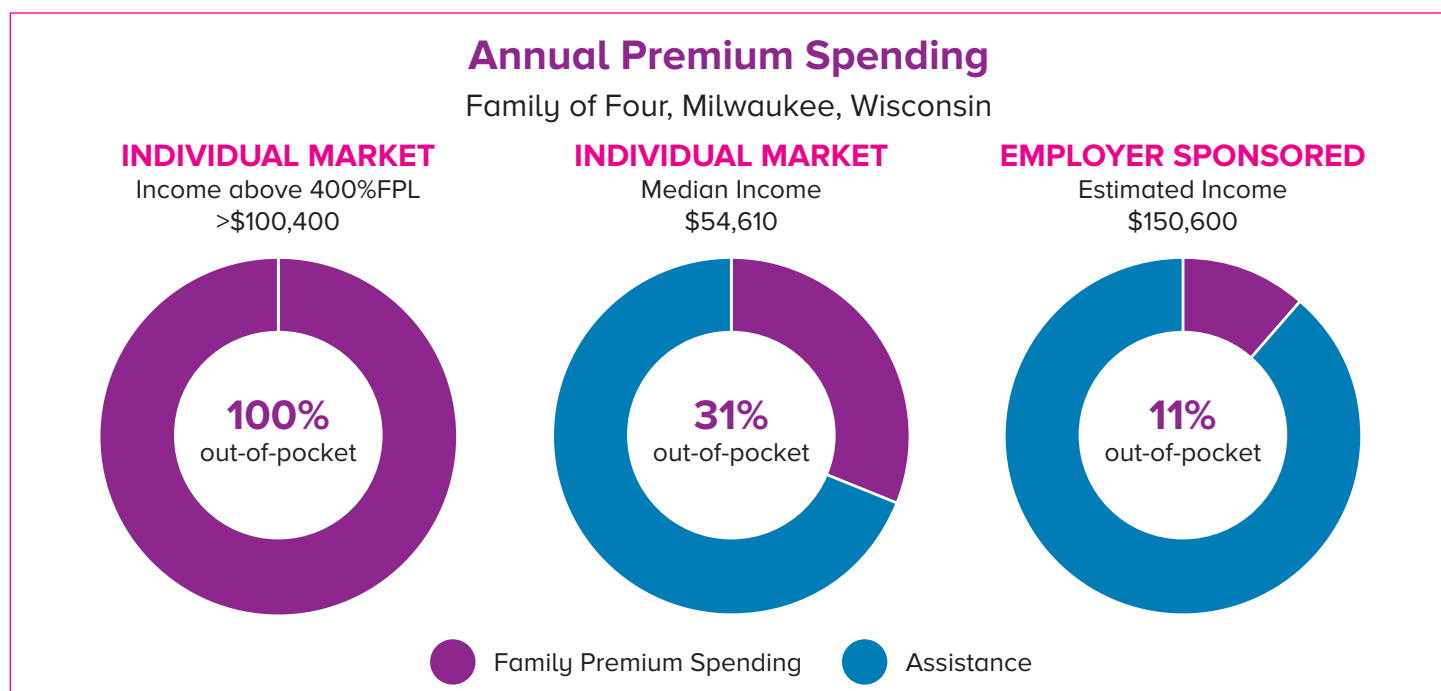
FR

Withdraw “ACA FAQs Part XXI” published October 10, 2014 and “ACA FAQs Part XXXI, Q&A-7” published April 20, 2016. These FAQs can be interpreted to limit reference pricing in individual market plans. Withdrawing the FAQs will provide more flexibility to provide individual market consumers with premium savings similar to those seen in employer-based plans that have implemented reference pricing.

LEVER 2: BRINGING FINANCIAL PARITY TO THE INDIVIDUAL MARKET

Americans who buy their own health coverage with a household income level above 400 percent of the federal poverty level are the only segment of the population that doesn't receive some help with their insurance premiums. Those who are provided coverage at work see thousands of dollars of savings each year in employer contributions to premiums and tax savings. Those who earn under 400 percent of FPL receive premium subsidies that average out to \$550 per month per recipient for 2018.¹⁸

How Much Premium Assistance do Americans Get for Commercial Coverage? <i>Example: Family Coverage in Wisconsin</i>		
Coverage Type	Monthly Premium Spending	Typical Monthly Assistance
Individual Market – Family of 4¹⁹ Income > 400%FPL	Low: \$848 High: \$1,431	\$0
Individual Market - Family of 4 Median Income: \$54,610 ²⁰	Low: \$848 High: \$1,431	APTC ²¹ : \$786
Employer Sponsored	Average: \$1,634 ²²	Employer Contribution: \$1,172 ²³ Federal Tax Savings: \$214 ²⁴ State Tax Savings: \$97 ²⁵



The most immediate and direct way to help middle-class Americans afford their own coverage is to ensure they have appropriate financial support to do so. Ensuring more equitable treatment of these hardworking Americans can attract healthier people to enroll, improving the risk pool and bringing premiums down for everyone. Below, we recommend approaches to subsidizing premiums.

Provide Tax Parity for Americans who Buy Individual Market Coverage

Section 106 of the Internal Revenue Code excludes health insurance premiums paid through an employer plan from taxable income. This results in substantial tax savings for individuals with employer-provided coverage. In contrast, consumers purchasing individual health insurance coverage must use taxable income to pay their premiums. For consumers earning a household income in excess of 400 percent of the federal poverty level, and who are therefore ineligible for premium tax credits, there are no tax incentives for purchasing health insurance. This is the only segment of the American population that doesn't receive some help with their insurance premiums.

Allowing the cost of health insurance premiums to be deducted from taxable income would create parity between the individual and group markets. If the Code is excluding health insurance coverage from income, that should apply in all markets. Doing so would substantially increase the affordability of coverage for those purchasing insurance on their own.

Recommendation

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

FL

Amend the Internal Revenue Code to allow individual market health insurance premium costs to be deductible for federal income tax purposes for those who do not qualify for premium tax credits.

Individuals and families with gross household incomes over 400 percent of FPL are ineligible for any federal tax assistance. Permitting the cost of health insurance premiums to be deductible from gross income for federal income tax purposes would help millions afford coverage. This would be an “above-the-line” deduction that excludes the premium amount from a taxpayer’s gross income but could be subject to the Pease Limitations that existed in the Internal Revenue Code prior to 2018 that phase out deductions based on income.

Expand HSA Options

Millions of Americans currently use Health Savings Accounts (HSA) to save pre-tax dollars for future health care expenses. As deductibles continue to rise, millions of consumers purchasing coverage through the individual market face challenges in paying for expenses before reaching their deductible, as well as meeting cost-sharing requirements throughout the plan year. As HSA funds are not subject to income taxation, using these funds to pay for expenses allows for consumer dollars to go farther, increasing affordability.

Currently, there are strict limits on what health policies can be paired with an HSA, including a minimum deductible amount and a prohibition on plan coverage of services before an enrollee has met their deductible, except for services or visits that are solely preventive. Allowing more individual market plans to be eligible for pairing with an HSA will give more Americans the ability to save for near-term and long-term health expenses without paying taxes on those savings. Additionally, giving health insurance providers the flexibility to offer coverage of certain services, treatments, or medications necessary to treat chronic health conditions before an enrollee has met their deductible will allow millions of Americans in HSA-eligible plans to better afford essential services.

Recommendation

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

FL

Expand the criteria for health plans to be HSA-eligible, to include all catastrophic and bronze plans.

Both catastrophic and bronze plans typically include high deductibles that allow for more affordable premiums but limit overall affordability when it comes to accessing medical care. One way to give consumers a tax-advantaged means of preparing for future medical costs and having funds to access care is to permit those consumers to save in an HSA. Section 223 of the Internal Revenue Code places strict limits on which plans may be HSA-eligible. A federal bill that would accomplish this (HR 6311) recently passed the House.

Create Reinsurance Programs

A reinsurance program provides payments to health insurance providers enrolling higher risk populations. The program can be funded in a myriad of ways. States have paid for reinsurance programs through: state general funds, utilizing savings within other health care programs, pass through savings, and assessments on carriers, hospitals and provider groups. Ultimately, a federally funded reinsurance program would be ideal to provide premium relief for Americans nationwide.

Reinsurance programs have been implemented in Alaska, Minnesota, and Oregon under 1332 waivers. Applications for reinsurance programs have been approved for Maine, Maryland, New Jersey and Wisconsin. Reinsurance programs have proven to protect against premium increases and can be directed solely to the individual market. This year, within the states enforcing or creating reinsurance programs, premium increases have been up lower due to the reinsurance program.

State 1332 Reinsurance Program Premium Savings as Estimated in Waiver Applications Submitted to CMS

State	Reinsurance Year 1	Reinsurance Premium Impact ²⁶
Alaska	2017	-35%
Minnesota	2018	-20%
Oregon	2018	-7%
Maine	2019	-9%
Maryland	2019	-30%
New Jersey	2019	-15%
Wisconsin	2019	-11%

Additional Resource:

[Kaiser Family Foundation 1332 Tracking](#), August 2018

Recommendations

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

SL

Create/reinitiate state reinsurance programs that are not solely funded by carrier assessments.

Reinsurance programs have received bipartisan support in many states. However, funding sources can be controversial. General state funds remain the best option but are scarce. If assessments are necessary, they must be shared by a variety of stakeholders that benefit from reinsurance.

FR

Continue expediting review and approval of state 1332 applications seeking to create a reinsurance program.

In 2017 CMS issued guidance to simplify the application process for states seeking 1332 waivers to establish reinsurance programs and approved three new waivers that include reinsurance. By October of 2018, CMS had approved four additional waivers including reinsurance programs.

FL

Create a permanent federal reinsurance program. Establishing a permanent federal reinsurance program will offset some of the costs that come with caring for individuals with complex health conditions who have significant health care needs.

Create State Premium Discount Programs

States can also implement discount programs for state residents who don't qualify for federal premium subsidies. For the 2017 plan year, the state of Minnesota created and funded a premium discount program for Minnesotans who did not qualify for APTC. The program was funded by the state and provided a 25 percent premium discount for unsubsidized individual market enrollees.²⁷

Recommendation

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

SL

Create a state premium discount program for individuals and families earning more than 400 percent of FPL. For the 2017 plan year, the state of Minnesota created and funded a premium discount program for Minnesotans who did not qualify for APTC. The program was funded by the state and provided a 25 percent premium discount for unsubsidized individual market enrollees. States should consider programs if the approach can be funded without imposing fees or assessments that increase the overall cost of coverage.

Repeal the Health Insurance Tax

Allowing the health insurance tax to resume in 2020 will result in higher premiums for consumers. If the tax is not suspended or repealed, individual market health insurance providers will have to factor in the cost of the health insurance tax for 2020 and the tax will contribute \$196 per person annually to the cost of coverage in the individual market. Because the tax is calculated as a percent of premium, the consumers paying the highest premiums already bear the biggest burden.

Additional Resource:

[Legislation to Suspend the Health Insurance Tax Will Help Make Premiums More Affordable](#), August 2018

2019 Savings from HIT Suspension

Individual Coverage	\$230
Small Group, Individual	\$300
Large Group, Individual	\$280
Medicaid	\$160
Medicare Advantage	\$380
Part D	\$17

Source: "Estimated Impact of Suspending the Health Insurance Tax from 2017-2020." Oliver Wyman, December 2015.

2020 Premium Increases due to HIT

Individual Coverage	\$196
Small Group, Individual	\$154
Large Group, Individual	\$158
Medicaid	\$157
Medicare Advantage	\$241
Part D	\$16

Source: "Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later." Oliver Wyman, August 2018.

Recommendation

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

FL

Enact legislation to permanently repeal the Health Insurance Tax. Enactment of this legislation would help deliver more affordable coverage and care as well as lower premiums for millions of Americans—whether they purchase their own coverage on the individual market, obtain coverage through their jobs, or enroll in Medicare Advantage or Medicaid managed care.

LEVER 3: INCREASE ENROLLMENT/IMPROVE THE RISK POOL

The individual health insurance market must operate as a single risk pool under federal law. That means everyone who purchases health insurance in the individual market is grouped together and the cost of their collective health care drives the cost of premiums in each state. A well-balanced risk pool includes both people who do and do not need costly (or complex) health services.

The health of those in the risk pool has a major impact on premium costs. When there are a disproportionate number of unhealthy people covered in a risk pool, health care costs go up because there are fewer healthy people to offset those costs. A well-balanced risk pool keeps premium costs down for everyone and ensures people who need care can get it and people who may need it in the future are protected.

Provide Savings to Consumers who Engage in Wellness Programs

Over the past four decades, wellness programs have become commonplace in many American companies, with most large employers offering some version of a workplace wellness program. For those enrolled, wellness programs help improve overall health and offer opportunities for premium discounts. Thus far, these programs have been limited to the group markets. Increasing the role of wellness programs in the individual market would increase the value of insurance for those who perceive themselves as healthy, attracting more healthy people into the risk pool.

Section 2705 of the Patient Protection and Affordable Care Act (ACA) required the Secretary of Health and Human Services to establish a ten-state demonstration project where health insurance providers would be permitted and funded to develop wellness programs for individual market plans offered on the Marketplace. This was to be established by July 1, 2014, with an option to expand the demonstration to additional states in 2017. No appropriation was made under that section. When wellness programs are included in the individual market as part of the state demonstration project, exchanges in those states may offer health coverage that includes reward/penalty programs that vary people's health insurance costs. The ACA includes a protection that requires these individual market wellness demonstration projects to not result in a decrease of coverage.

Recommendations

KEY:  FED REG  FED LEG  STATE REG  STATE LEG



Implement the 10-state demonstration program for wellness. Congress should fund an appropriation to enable the program. Federal guidance could be issued to provide general implementation parameters.



Preserve flexibility for plans to promote safe, effective, high-value care. Allow individual market health insurance providers to use medical management tools and benefit designs that promote safe, effective, and affordable care. Examples of these tools include but aren't limited to: formulary and provider network designs that tier prescription drugs or providers based on quality and value, and prior authorization that ensures evidence-based care.



Marketing and Outreach

A stable individual market requires broad participation of people who are healthy and sick, young and old. It also requires consumers to enroll for a full plan year and continually maintain 12 months of coverage, as opposed to enrolling only when they need care. Open enrollment provides an annual opportunity for new consumers to enroll in marketplace coverage and allows existing enrollees to reenroll in coverage or choose a different plan that best meets their needs.

Unlike other health insurance markets that have more static populations such as employer-provided coverage or Medicare, the individual market is subject to frequent changes as consumers move in and out of coverage for various reasons, for example due to a permanent move or gaining or losing coverage from another source. Thus, marketing, outreach, and education are critical to ensure all consumers are aware of the open enrollment timelines.

Health insurance providers who participate on the federal exchange are required to pay a user fee of 3.5 percent of premiums. While CMS has not provided transparency into allocation of these funds, the user fee is intended to be used to support marketing and outreach activities, amongst other Federal exchange functions. For the 2018 plan year, CMS announced a reduction in the Federal exchange's marketing and outreach budget (from \$100 million in 2017, or \$11 per enrollee, and \$51 million in 2016, or \$5 per enrollee).

Recommendations

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

SR

Support state-based exchange investments in robust advertising and marketing campaigns, so long as these approaches do not increase premiums. Investments in advertising and marketing should be made without increasing exchange user fees, which would lead to premium increases.

FR

At the option of a state participating in the FFM, transfer a portion of the FFM user fee to the state to conduct outreach, education, and marketing. As CMS evaluates the user fee as the exchange evolves (e.g., with issuers taking on a wider breadth of activities through enhanced direct enrollment) CMS should identify user fees that can be allocated to support state marketing and outreach activities. States that opt to receive these funds may use them to carry out a defined list of marketing and outreach activities, such as support for navigators or other in-person assistance, collaborating with other outreach groups experienced in helping consumers enroll in coverage through the individual market, TV/radio/print advertising, consumer education and enrollment events, or resources for non-English speaking consumers. States that elect to receive user fee funds would be required to provide a plan for how they anticipate using these funds to support open enrollment activities. A commitment by states to promote robust enrollment during the annual open enrollment period could place downward pressure on premiums, increase uptake, and encourage a more balanced risk pool.

Conclusion

State and federal policymakers and regulators can, and should, act now to improve health care coverage affordability for hardworking Americans. Many of the recommendations above can be implemented through the states or federal regulation and could have impacts on premiums as soon as 2020. We look forward to working with policymakers and other stakeholders to make premiums more affordable.

Additional resources on these recommendations and other AHIP approaches to improve health care for Americans can be found at www.ahip.org.

Endnotes

- 1 For 2018. From [Kaiser Family Foundation](#).
- 2 [Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment](#), CMS, July 2 2018
- 3 Ibid, Note that a significant portion of the change in the average monthly premium from 2017 to 2018 is attributable to silver loading to account for the suspension of federal payments to insurers to cover the cost of cost sharing reductions. In most states consumers that chose metal level plans other than silver would have seen a smaller increase.
- 4 CCIO, Health Insurance Exchange Public Use Files found at <https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html>
- 5 <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/16/health-insurance-premiums-are-stabilizing-despite-gop-attacks>
- 6 A full description of methodology and more information on this infographic can be found at <https://www.ahip.org/health-care-dollar/>
- 7 OECD was founded by 18 European nations, the United States and Canada and now consists of 36 countries that span the globe. A list of OECD member countries can be found here. <http://www.oecd.org/about/membersandpartners/#d.en.194378>
- 8 OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/health_glance-2017-en.
- 9 Ibid
- 10 45 CFR 147.138
- 11 45 CFR 156.230
- 12 [Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation](#), Consumers Union, March 2017
- 13 Lara Maggs and Aaron Kesselheim, The Short-Term And Long-Term Outlook Of Drug Coupons, November 12, 2014 <http://healthaffairs.org/blog/2014/11/12/the-short-term-and-long-term-outlook-of-drug-coupons/>
- 14 <https://www.towerswatson.com/en-US/Press/2014/08/current-telemedicine-technology-could-mean-big-savings>
- 15 [ACA FAQs Part XXI \(October 10, 2014\)](#) and [ACA FAQs Part XXXI, Q&A-7 \(April 20, 2016\)](#)
- 16 [Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery](#), James C. Robinson and Timothy T. Brown, Health Affairs, August 3013
- 17 http://www.actuary.org/files/publications/ReferencePricing_11.2018.pdf
- 18 Average 2018 APTC nationwide, from [Marketplace Average Premiums and Average Advanced Premium Tax Credit](#), Kaiser Family Foundation
- 19 2018 premiums found on healthcare.gov for zip code 53207. Based on family members with ages: 40, 35, 13, 8
- 20 Median household income in 2016 based on census data that can be found at <https://www.census.gov/quickfacts/wi>
- 21 APTC is: available for exchange plans only; varies by income level and cost of plans in the area; is not available to those offered affordable employer coverage.
- 22 For 2018 family coverage, from [2018 Health Benefits Survey](#), Kaiser Family Foundation
- 23 Ibid
- 24 Estimate for a family of four with a combined annual income of \$150,600 paying an effective tax rate of 13.1 percent.
- 25 Estimate for a family of four in Wisconsin with a combined annual income of \$150,600 subject to 5.97 percent in state income tax.
- 26 Reinsurance premium impact represents the difference between expected rate increases or decreases with a reinsurance program versus without. It does not represent the total premium change for the year. For example, if premiums would have increased 10 percent without reinsurance and the reinsurance impact is negative 30 percent, premiums would decrease by 20 percent with the reinsurance program. Reinsurance premiums impacts can be found in the state 1332 waiver applications on CCIO's 1332 Waiver page. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html
- 27 [Health Insurance Relief FAQ](#), Minnesota Office of Management and Budget