LYFE

Benefits & Insurance Solutions, LLC

Quality Affordable Health Care for All

A PROPOSAL TO REFORM OBAMACARE

Prepared:

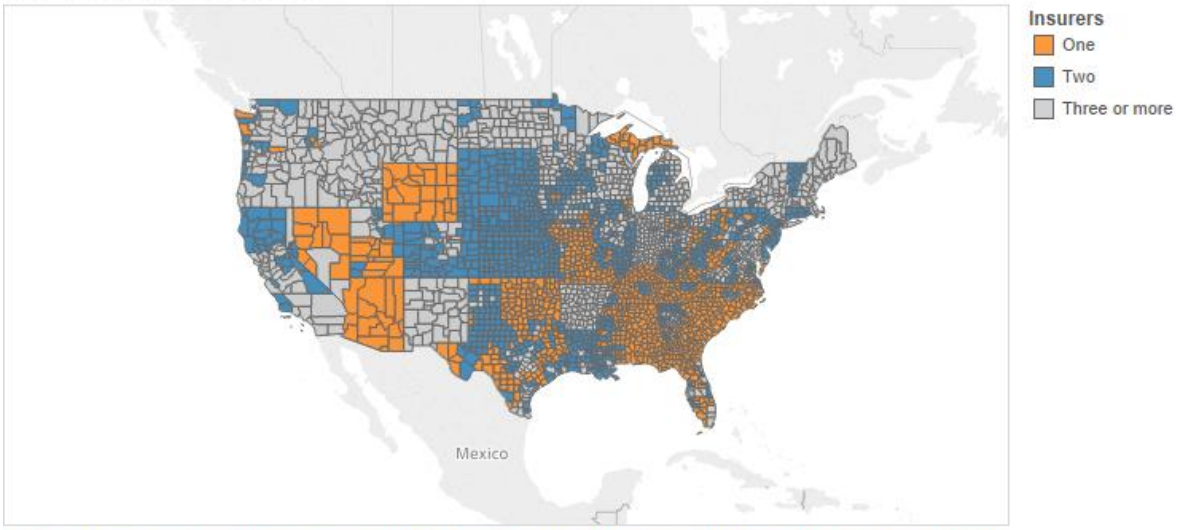
February 6, 2017

David A. Engle
President

Quality Affordable Healthcare Options

Americans want options of high-quality healthcare at an affordable cost. Unfortunately, this is not the case for a many Americans today. According to a Kaiser Family Foundation analysis, 14 states have fewer than three insurance companies providing coverage to 43% of the population. Five of those states, covering a combined total of 1,021 counties, have only one insurer. Obamacare has led to fewer options at a higher cost, reduced coverage, and the beginning of the death spiral of the health insurance industry.

2017 Insurer Participation



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016.
Note: We define the number of insurers in a single county as the number of insurers (grouped by parent company or group affiliation) that offer at least one silver plan in the county. For example, Blue Cross Blue Shield of Arizona offers a catastrophic plan, but no silver plan, in Pima County; we do not consider Blue Cross Blue Shield of Arizona as a second insurer in Pima county.
Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. States that do not use healthcare.gov in 2017 are: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington.

There is a way to stop the death spiral and right the wrongs caused by Obamacare, and do this without causing unnecessary harm to our nation's most vulnerable. This plan is intended to be a starting point of how to reform our failing healthcare industry. My hope is that it gets you thinking, and that you join with me in the conversation about healthcare reform. The more people that are talking and listening to each other's concerns, really listening, the better this new healthcare reform will be.

I would argue that Americans have the right to decide how they want to be insured. It is the responsibility of insurers, in cooperation with the Federal and State governments, to ensure that every American has access to quality care at an affordable cost, regardless of their health condition or past medical history. The states need to be given the authority and flexibility under the new healthcare reform laws to determine if there is a better solution for their residents. States, insurers and providers need to work together to develop and implement new technologies that increase the quality and efficiency of our healthcare system.

Premium rating – A blended strategy

The debate over using community rating vs. experience rating to set health insurance premiums has been a heated debate aimed at the heart of how to adequately calculate premiums so insurance companies are able to continue operating without pricing people out of the market.

Community rating charges all covered individuals in a plan based on the health and demographic profile of a specific geographic region. There are variations of community rating, such as that used by Obamacare, where the community rate is adjusted based on specific demographic factors such as age and tobacco use. This rating method has negative effects on young and healthy individuals, as they are charged higher premiums, causing many of them to choose not to buy insurance.

Experience rating is used to predict future costs based on past claims experience. Insurers estimate what they will pay out in claims based on an insureds medical history, and charge a premium calculated to keep consumers from experiencing a high increase due to future claims. Unhealthy individuals, those with chronic conditions, and seniors will experience higher rates under this method due to the greater likelihood of filing costly claims.

We have all witnessed the negative effects of experience rating used in the pre-Obamacare days where people were denied insurance due to medical history, and we've also experienced the downside of the modified community rating method under Obamacare. This plan proposes using a blended rating system consisting of the benefits of both methods, while minimizing the negative effects of each.

It is important to understand how the modified community rating under Obamacare works. Premiums are calculated based on geographic region, age, and tobacco use, and includes a 3:1 ratio for age band rating. This means that insurers cannot charge seniors more than three times the rate charged to a 21-year-old. Also, insurers can charge tobacco users up to one and a half times the cost for a non-tobacco user of the same age and in the same rating area. To keep the healthcare system intact, insurers need to make sure they are charging enough to cover claims. It's easy to work backwards when calculating rates under this system.

Insurance companies calculate the standard community rating for their coverage area, then adjust it based on age, per the age banding requirements. As people age, the cost of claims increases. Thus, it is important to determine how much seniors need to be charged to cover claims, and continue working backwards through the age bands until you ultimately end up at the rates for young individuals. Because insurers are limited to a 3:1 age band ratio, healthy young individuals, who are not likely to experience a high number of claims, are overcharged for coverage. This has led to an exodus of healthy individuals from the risk pools, choosing to go uninsured and pay the penalty, causing premiums to balloon and more and more healthy people leaving the pools. This circular cycle is what is known as the "death

spiral". It is vital to the success of our healthcare system to get these uninsured, healthy individuals back into the risk pools.

Correcting the death spiral will take some major actions in reforming our healthcare system. If this cycle is being caused by healthy individuals leaving the risk pools, we need to drastically overhaul the way we calculate premiums to effectively reduce the premium for young and healthy individuals, while making sure that we do not price less healthy individuals and seniors out of the market. To accomplish this, the age band ratio needs to be expanded to 5:1, where a 65-year-old cannot be charged more than five times the rate of a 21-year-old. Insurers will also be able to charge tobacco users up to 1.5 times the non-tobacco user rate.

The insurers will calculate the community rating for their coverage areas, and adjust it based on age, per the 5:1 ratio, similar to the modified community rating method currently in use. This will yield the maximum rate than a consumer can be charged for a particular plan, regardless of health status. This will help to lower costs for young and healthy individuals, bringing them back into the risk pool. To eliminate the concern of a higher cost for seniors due to the expanded 5:1 ratio, insurers will be able to utilize experience rating to provide discounts. Insurers will have the freedom to choose what discounts they want to offer, leading to an increase in competitive pricing across carriers. They will also have the ability to request a form of verification, as determined by the insurer, prior to applying a discount to the plan.

Some people will be concerned that this is going to drive healthcare costs up for seniors, however, the current rates insurers charge are based on collecting enough premium from seniors to cover claims. This has been the reason for the large price increases experienced since 2014. I propose that insurers have had enough time to adjust rates due to Obamacare's rating methodology and another large increase to premiums is not necessary, if we can attract healthy individuals back into the risk pool by driving their cost down. Under this plan, a cap on premium increases will be implemented ensuring that seniors do not face a high increase. If insurers want to collect more premiums, they must do it by finding ways to reduce the cost for healthy people, and attract those enrollees. I think we can all agree that the health insurance industry will not sustain another big increase, but if healthy people are not paying into the system, another big increase is inevitable and guaranteed to drive up costs for seniors.

High Risk Pools

High risk pools existed in 35 states prior to Obamacare, providing an option for individuals to receive coverage mainly if they had been denied health insurance due to pre-existing medical conditions. Many of these pools had enrollment wait lists due to an enrollment cap. Obamacare funded a temporary high risk pool while the laws were initially being implemented. Many of these high risk pools were underfunded, and still too costly for consumers to afford.

This plan does not call for the use of high risk pools, although the states would have the flexibility to utilize a high risk pool funded solely by the state if they desired. As this plan does not allow for denials due to pre-existing conditions, there is no need for a federal high risk pool to provide coverage for individuals denied for medical conditions. These risk pools were one of the downfalls of the healthcare system prior to Obamacare, and we would be taking a huge step backwards if we went back to them.

A General Accounting Office study determined between 36 million and 122 million (representing between 20-66% of the adult population) reported having a medical condition resulting in a health

insurer restricting coverage. Funding high risks pools that cover up to 66% of the adult population would be a very large expense, costing tax payers billions of dollars. There is a better way of guaranteeing quality coverage for the less healthy population while keeping premiums reasonable for everyone.

Pre-existing conditions

As mentioned above, insurers will not be allowed to deny any consumer on the basis of a pre-existing medical condition. Every American, whether healthy or sick, has the right to quality healthcare, and deserves the peace of mind knowing that they cannot be denied coverage, and their existing coverage cannot be cancelled by the insurer due to a pre-existing condition.

Continuous coverage provisions

Continuously maintaining health insurance is important, and this plan seeks to protect Americans' right to access health insurance due to a qualifying life event. However, it's also important to have protections that safeguard our healthcare system and those purchasing coverage from people that seek to intentionally defraud the system.

Insurers would be permitted to charge more for pre-existing conditions, and impose a waiting period for pre-existing conditions, not to exceed 12 months, if a consumer has a lapse in coverage. The additional charge for pre-existing coverage is to be no more than 1.5 times the regular cost. This protection is in place to stabilize the insurance market by reducing adverse selection of individuals purchasing coverage when they experience claims and then dropping it after the claims have been paid by the insurer.

Continuous coverage protections would apply regardless if existing coverage was obtained through an employer, COBRA, the individual market, Medicaid, or another provider. It is a simple, yet important reform incentivizing Americans for maintaining health coverage.

Open enrollment period

All Americans will be provided a one-time transitional enrollment period during which they can obtain coverage regardless of prior insurance status. During this enrollment period, continuous coverage provisions would apply for every enrollee, granting them coverage for pre-existing conditions with no waiting period.

Consumers would thereafter be provided an annual open enrollment period providing them the opportunity to change plans while maintaining continuous coverage protections.

Minimum Essential Coverage (MEC)

Under Obamacare, individuals are required to have MEC or qualify for an exemption to avoid paying the individual shared responsibility penalty. MEC is defined by the source of coverage under Obamacare, rather than specific benefits that an individual must have. This definition has caused confusion among consumers. Some consumers mistakenly thought there are specific MEC plans that provide only the minimum coverage required to avoid the individual shared responsibility penalty.

I propose that this definition of MEC be replaced by a specific set of benefits, based on the ten essential health benefits specified in Obamacare, combined to form MEC plans. These plans would provide a very basic level of coverage limiting an individual's out-of-pocket expense for major medical events, but

containing higher cost-sharing amounts, and would be used as a base plan upon which a consumer can expand and add additional benefits to form a more comprehensive plan of his/her choosing.

A base MEC plan must include, at a minimum, the following coverages:

A. Deductible: not to exceed $10,000 per individual, $20,000 per family;
B. Coinsurance: Enrollees would pay 40% of covered expenses after the deductible;
C. Maximum out-of-pocket: $20,000 per individual, $40,000 per family;
D. Preventive care: covered 100%, deductible does not apply;
E. $100 copay for office visits;
F. $200 copay for urgent care;
G. Pharmacy: $50 copay for generics, deductible does not apply. All other prescriptions are subject to the deductible and coinsurance;
H. Diagnostic testing: subject to deductible and coinsurance;
I. Maternity and newborn care: Prenatal care is covered as preventive. Routine in-hospital care of a newborn limited to the first 5 days following birth or when the mother ceases to be an inpatient, whichever occurs first;
J. Ambulance services: ground ambulance service to a hospital for necessary emergency care, subject to deductible and coinsurance;
K. Emergency room: $500 copay, then covered 60% after deductible;
L. Hospital inpatient fees and physician fees: subject to deductible and coinsurance;
M. Mental disorders and substance abuse: subject to deductible and coinsurance. Outpatient doctor visits have a $100 copay per visit;
N. Autism spectrum disorders: subject to deductible and coinsurance. Outpatient applied behavior analysis limited to $50,000 per year, per person;
O. Durable medical equipment: subject to deductible and coinsurance;
P. Home health care: subject to deductible and coinsurance;
Q. Rehabilitation and extended care facility: Limited to 60 days per year for rehabilitation and extended care facility expenses combined;

This plan provides the most basic level of insurance coverage, modeled after catastrophic level plans under Obamacare. Consumers will be able to expand upon this coverage by choosing benefit enhancements.

Benefit Enhancements

Insurers must develop a menu of enhancement options for their plans. Insurers are encouraged to develop their own enhancements to build upon the list below, but these following enhancements must be included as a minimum:

A. Deductible options beginning at $0 and continuing in $250 increments up to $10,000;
B. Coinsurance levels of 60/40, 70/30, 80/20 and 100/0;
C. Maximum out-of-pocket amounts of $5,000, $10,000, $15,000, and $20,000 per individual and $10,000, $20,000, $30,000 and $40,000 per family. The maximum out-of-pocket amount can equal the deductible, but is not to be less than the deductible on any plan.
D. Office visit copay options including $0, $10, $25, $50, $75, $100;
E. Urgent care copay options including $35, $50, $75, $100, $150, and $200;

F. Insurers must provide options for pharmacy benefits, however generics must be covered before deductible, and must have a $50 or less copay. Insurers have the flexibility to maintain their own formulary and categorize medications into their own desired tiers. Insurers must provide options that contain copays for each tier, however, only generics are required to be covered before the deductible. Insurers can offer coverage for other tiers either before or after the deductible, however, insurers are encouraged to offer some prescription enhancements that cover all medications before deductible;
G. Diagnostic testing buy-up that will cover diagnostic testing 100% before deductible;
H. Every insurer must provide an adequate network of providers, however, many insurers have developed multiple narrowed networks. These networks, if offered by an insurer, may be offered as an enhancement option to reduce the premium.

Medicaid Reform

Medicaid is a vital welfare program America's 74 million most vulnerable patients rely on for healthcare, as of November, 2016. More tax dollars are spent on Medicaid benefits than Medicare, and has more enrollees than Medicare. The total amount of Medicaid spending in 2016 surpassed $529 billion, with the federal government subsidizing 92%.

Federal spending on Medicaid is determined by the federal medical assistance percentage (FMAP) rate enacted by the Social Security Act of 1965. This act set a minimum federal matching at 50% and a maximum of 83%, however Obamacare expanded this maximum an additional 23% for CHIP. This allows for some states CHIP program to be 100% subsidized by the federal government.

I am a proponent of the Medicaid reform included in a healthcare reform proposal released by the Health Care Reform Task Force entitled A Better Way. This proposal calls for the states to have an option to choose either a per capita allotment or a block grant to fund its Medicaid program, states are given more flexibility to design its Medicaid program, and states, plans and providers are incentivized for managing and innovating its State's Medicaid program.

I further add onto these reform proposals by including a transitional relief period for beneficiaries that lose eligibility under Medicaid and must transition to a commercial insurance plan. Many individuals that lose Medicaid eligibility face a big sticker shock when moving to the commercial market. A portion of these individuals decide to go uninsured because they cannot afford the large increase in cost to insure themselves or their families. In an effort to further incentivize individuals to better their lives and leave the Medicaid program, I propose a 24-month transition during which a person's base MEC portion of their commercial insurance premium will be subsidized according to a graded benefit schedule. States will have the flexibility to determine if they want to expand beyond only subsidizing the base MEC portion and include any benefit enhancements.

States will be able to subsidize 96% of the premium for the first month of enrollment in a commercial plan. This transitional relief subsidy will decrease 4% per month until it is completely phased out and the consumer is paying 100% of the commercial insurance premium.

Medicare Reform

Medicare is another vital program relied upon by millions of enrollees. Medicare needs to undergo massive reforms if it is to withstand the test of time for future generations. This program was raided of

over $800 billion and is not facing insolvency by 2026. I believe that the Medicare reform laid out in A Better Way is a structurally sound plan for strengthening Medicare.

Many of the Obamacare reform policies need to be repealed in order to stabilize the Medicare market. This plan calls for the repeal of IPAB, CMMI, the ban on physician-owned hospitals, and repealing the Bay State Boondoggle. This plan also calls for new reforms for Medicare Advantage value-based insurance design, Medigap reform, combining Medicare Parts A and B, protecting the patient-doctor relationship, uncompensated care, and Medicare Advantage and fee-for-service performance parity, as well as premium support payment on a new Medicare Exchange.

Conclusion

With the passage of the Affordable Care Act, we have been faced with ever-increasing premiums, and reductions in coverage. This plan is unsustainable and will end up driving more and more insurers out of the market. With reduced competition in the market, the prices will continue to skyrocket at a break neck pace as the pool of insured becomes more and more unhealthy year after year.

Medical expenses rank as the number one cause of bankruptcy in America, and will continue to drive more and more people into bankruptcy as access to health insurance becomes too expensive. The number of Americans living with treatable conditions will rise as enrollment in health insurance declines. This will lead to more medical expenses down the road when these treatable conditions worsen and an uninsured person is forced to seek care.

Medicaid enrollments have been on the rise, mainly due to the expansion of Medicaid in many states. Our current system incentivizes individuals to stay in the Medicaid program or, in some circumstances, to leave full-time employment in an effort to qualify for Medicaid benefits. This leads to less people in the workforce, less tax revenue for states and federal governments, and increased spending on Medicaid benefits. This system is unsustainable and must be corrected.

Medicare is facing an ever-shortening lifespan. Benefits are being cut, funding is being cut, enrollment continues to rise. As of 2010, there were only 2.9 workers for every one Social Security retiree. Medicare is underfunded and consistently raided to fund other programs. Reforms are needed to secure this program, reduce fraud, waste and abuse, and expand the lifespan of Medicare. It is a difficult process to accomplish, but necessary, nonetheless.

Healthy individuals coming back to the market, getting people back to work transitioning from Medicaid to the commercial market is a vital aspect to the success of the healthcare system. Quality healthcare reform that benefits all of us is possible but it will take some thinking outside the box to accomplish it.

Americans want options when it comes to healthcare. They deserve to be able to choose what coverage they feel is necessary for them. This plan will allow for people to have choices. This plan allows for insurance companies to have greater flexibility to better price plans while maintaining Americans' right to not be denied. This plan strengthens the Medicare and Medicaid market of the most vulnerable among us.

It's time for us to set aside our differences and work together to come up with a plan that works for all of us.