Presidential Candidate Health Care Proposals
By Jeff Adams May 11, 2016

As it appears that Hillary Clinton and Donald Trump will be the party nominees for the November 2016 Presidential Election, it is time to make a more detailed comparison of their policies. In particular, this article analyzes the various points in their health care proposals. At the time of writing of this paper there are slightly less than six months remaining until the election. Candidates may alter their proposals slightly between now and the election but chances are that they will not change significantly.

The following is a brief discussion of our health care system followed by a point by point discussion of the proposals of the two candidates:

Background

An increasing number of people have the opinion that the issues facing our health care system and the resulting effects of these issues on the United States is the biggest problem facing this country today. One of the major reasons for these concerns is that health care costs are eating up a much larger portion of the Federal Budget, causing cutbacks on spending for discretionary items such as defense, scientific and biomedical research, NASA, federal law enforcement, and social programs. Not only do restrictions on spending for defense lessen our national security, less discretionary spending by the Federal government means a reduction in money flowing to state and local governments causing fiscal issues for these governments. In 1990, health care represented 12.5% of Federal expenditures and rose steadily to 26.4% in 2014. As a result of this increase, discretionary spending decreased from 38.6% of total Federal expenditures in 1990 to 31.3% in 2014. A continuation of this trend would cause additional cuts in discretionary spending and stress on the security and infrastructure of the United States.

The Federal Budget is not the only place where rapidly growth in health care costs are causing major problems. In the United States as a whole, health care represented 12.1% of the Gross Domestic Product ("GDP") in 1990 and grew steadily to 17.5% of GDP in 2014. In the early 1990s economists suggested that health care would not increase to over 20% of GDP as this would cause substantial economic issues for the country, yet we are on the brink of that occurring. Employers fund a substantial portion of the cost of health care making it easier for employees to obtain affordable coverage. Since the 1990s, however, employers have been choosing to drop coverage for its employers due to large cost increases and even employers who maintain coverage cover a smaller proportion of the health care cost, thus increasing the uninsured rate. Even employees who are able to retain coverage find that the increased out-of-pocket amounts that they must pay are putting a strain on their economic well-being.

The Affordable Care Act, or ObamaCare, has made it possible for millions of people to obtain affordable health care through premium subsidies and benefit subsidies but tens of millions still remain without coverage. Increases in the cost of health care slowed slightly after the passage of ObamaCare but many analysts are saying that the growth in health care costs is starting to increase again. The 17.5% of GDP that the United States spent on health care is substantially more than the percent spent by any other industrialized country, yet the United States ranks average in quality of care surveys for these same countries. Much of the cost

issue is due to fraud, waste, and abuse. Studies have been done since the 1990s indicating that 25% of all health care costs are fraud, waste, and abuse. This has been increasing over the years and, for the first time, I have seen reports that fraud, waste, and abuse has risen to between 33% and 50% of all health care costs (Aetna posted this on its web site).

Candidate Health Proposals

Listed below are the proposed health care plans for the two presumptive Presidential candidates along with comments and analysis:

Donald Trump - Republican

The Donald Trump health care plan was taken from his web site:

https://www.donaldjtrump.com/positions/healthcare-reform

Here are the components of his plan and accompanying comments:

Completely repeal Obamacare. Our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to.

Analysis: The Republicans have been trying to repeal ObamaCare since the day it was first passed. Although part of the push to repeal is simply party politics, there is the large government versus small government perspectives of the two parties at odds again. The Republicans see ObamaCare as an extension of the massive government Medicare and Medicaid programs that are already draining the government's coffers while the Democrats see ObamaCare as an opportunity to help millions of Americans obtain health insurance and find ways to slow the growth in health care costs.

The individual mandate was put into ObamaCare for a couple reasons. The first is to help alleviate the issue of bad debt and charity, where uninsured or underinsured persons obtain services from providers but then are not able to pay for the services. A substantial portion of these charges are currently charged back to the payers (insurance carriers, health insurance funds, etc.) through government fees or higher provider payments and passed on in the form of higher premiums. The individual mandate would cause less people to be uninsured resulting in less bad debt and charity claims and lower premium rates for the insured. The other reason for the mandate is to encourage younger, healthier individuals to obtain coverage, thus lowering overall premiums. Opponents say that the government should not have the authority to force individuals to purchase health insurance. Proponents claim that persons with insurance should not be forced to subsidize those who do not purchase insurance.

There is probably not a correct answer as to whether to repeal ObamaCare or not but any proposal to repeal ObamaCare must contain components which will reduce the issues of the large number of uninsured individuals and rapidly rising health care costs.

Modify existing law that inhibits the sale of health insurance across state lines. As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up.

Analysis: This is a bad idea. The concept of allowing insurers to sell across state lines is very common in Republican health care proposals. The objective is to avoid state mandates of the states in which the policies are being sold. This would be accomplished by having an insurer "headquartered" in a state with minimal mandates and then having this insurer sell policies in states with substantial mandates. States have very different mandated benefits or rating requirements. Allowing insurers to sell policies across the nation that only have the mandates of the regulations of the states with the least regulation would cause many issues. One issue is that enrollees purchasing coverage would have no security as to what is covered in the benefit package that they purchase. States put in mandated benefits such as maternity, cancer coverage, mental and nervous, women's health benefits, etc., because individuals were purchasing policies and then, after having payment denied for services, realizing that they had no coverage for the specific services that they had performed on them or that there was a lifetime or annual maximum in benefit payments that had been exceeded, resulting in large out-of-pocket expenses for the policyholder, possible financial issues, and even bankruptcy.

Allowing cross-state sale of health care would also allow insurers avoid community-rate requirements in many states. Community rates are rates based on the amount of claims that an entire pool of beneficiaries has and does not allow rates for a group within the pool to be based on claims for only those people in the group being rated. The idea of community-rating is to require rates for good claims experience to be the same as rates for groups with bad claims experience, thus stabilizing rates and rate increases over time. Elimination of this community-rated requirement would not actually lower overall rates, it would allow groups with better-than-average experience in a given year to have lower rates but would then require groups with worse than average experience in a given year to have higher rates. Some of the groups that would get higher rate increases for several could eliminate coverage because the rates could become unaffordable.

Allow individuals to fully deduct health insurance premium payments from their tax returns under the current tax system. Businesses are allowed to take these deductions so why wouldn't Congress allow individuals the same exemptions? As we allow the free market to provide insurance coverage opportunities to companies and individuals, we must also make sure that no one slips through the cracks simply because they cannot afford insurance. We must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it.

Analysis: Allowing individuals to deduct health insurance premiums for income tax purposes is a good proposal, although it does not help with the underlying issues with our health care system. It is not clear whether the medical premium deduction would be subject to the same 10% of adjusted gross income threshold that other medical expenses are. Since the individual may also receive significant assistance from their employer or from government subsidies, the resulting deductible premium amount would theoretically be the individual's contribution to get coverage and not the actual total premium amount. For example, if Joe's company ABC Corporation, purchased coverage from XYZ Insurer for $1,000 a month or $12,000 a year and

Joe had to contribute $200 a month or $2,400 a year to get this coverage then only the $2,400 would be deductible, and possibly only to the extent that the contributions plus all other deductible medical expenses exceeded 10% of adjusted gross premiums. Also, there is the possibility that the individual would not be able to deduct this even if medical expenses plus medical premium exceeded 10% of adjusted gross income if total deductions (charitable deductions, interest, etc.) did not exceed the standard deductible amount. If medical expenses did exceed 10% of Adjusted Gross Income and the individual itemized deductions then they would only receive partial recovery for the health expenses they had to pay. For example, if the individual was in the 15% tax bracket and was able to deduct $1,000 in medical premiums then the savings would be $150 of the $1,000 in expenses.

Allow individuals to use Health Savings Accounts (HSAs). Contributions into HSAs should be tax-free and should be allowed to accumulate. These accounts would become part of the estate of the individual and could be passed on to heirs without fear of any death penalty. These plans should be particularly attractive to young people who are healthy and can afford high-deductible insurance plans. These funds can be used by any member of a family without penalty. The flexibility and security provided by HSAs will be of great benefit to all who participate.

Analysis: This is probably a good idea and should be studied but again does little to help issues facing our health care system. The suggested proposal expands current HSA regulation and would allow individuals to put money away tax-free and use it at any time when out-of-pocket health care costs are incurred. Care would need to be taken in passing this legislation that loopholes would not be opened that would allow individuals to put money into these HSAs for the purpose of avoiding taxes and passing the HSA monies on to heirs who would also not have to pay taxes on the money.

Require price transparency from all healthcare providers, especially doctors and healthcare organizations like clinics and hospitals. Individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure.

Analysis: The idea is a good one and should be studied and then implemented in some proposal that would make it an effective tool for consumers. The idea of transparency is simple, allow patients to see prices of services or drugs before they purchase them, but implementation is complicated.

One reason for the complexity of implementing a transparency proposal is that not only do payers (insurance companies, HMOs, government programs, self-funded plans, etc.) have different payments for the same procedures for the same provider, some payers even have multiple arrangements whereby the payer pays a given provider different amounts depending on the benefit plan in which the patient is enrolled. For example, Insurer ABC may pay Doctor XYZ $75 for a given procedure under its basic plan but only pay that same doctor $65 under its limited network plan that has a much smaller network of physicians. Another complicating factor is that rebates may be offered, as is done with many prescription drugs in the form of coupons that make the price calculation more complex. The “price” of a drug may be $100 but the patient may receive a coupon from the pharmaceutical manufacturer for $10 through the mail, thus reducing the net cost. Eventually there will probably be automated systems to be able to handle all of these complexities but a full system still needs to be

developed.

Another complicating factor is that individuals have different benefit so if Joe Smith and Marty Jones have Insurer ABC and the same $75 procedure performed by Doctor XYZ, Joe Smith may have a $10 copay and have to pay only $10 for that procedure while Marty Jones might have a $1,000 deductible and have to pay the entire $75. Not only does this complicate an automated transparency system, there is no incentive for Joe Smith to switch to Doctor LMN who gets paid only $20 for the procedure and has the same, or better, quality of care. This is because the cost to Joe Smith would be only $10 no matter which doctor he chose. Having a system whereby Joe Smith was given an incentive to switch to a lower cost doctor would lower health care costs. Allowing Joe Smith to sit down with his primary care physician, for example, and look at the costs of the different treatment, provider quality of care scores, and comparative effectiveness analysis for the various treatments available would be extremely useful in lowering cost, raising quality of care, and increasing quality of life.

This is a long way of saying that the transparency is a good start but there must be additional components put into any transparency proposal to make it effective.

Block-grant Medicaid to the states. Nearly every state already offers benefits beyond what is required in the current Medicaid structure. The state governments know their people best and can manage the administration of Medicaid far better without federal overhead. States will have the incentives to seek out and eliminate fraud, waste and abuse to preserve our precious resources.

Analysis: This is probably a good idea, for the reasons stated. The only downside is that it might make it slightly easier for the Federal government to substantially limit Medicaid payments to the states since it would no longer be a "Federal" program. This same negative is actually a positive in the sense that the Federal government would be more able to control Medicaid spending in the Federal Budget.

Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products. Congress will need the courage to step away from the special interests and do what is right for America. Though the pharmaceutical industry is in the private sector, drug companies provide a public service. Allowing* consumers access *to imported, safe and dependable drugs from overseas will bring more options to consumers.

Analysis: This may be a viable option if there was testing done on imported drugs. Allowing individuals to get drugs from any country is a bad idea as many countries do not have regulations that require drugs to be tested to make sure they are safe and that they actually work.

Pharmaceutical manufacturers may sell drugs for a much higher price in the United States than they do in other countries but there are other ways to approach this problem than to have loose restrictions on imported drugs. As long as the new regulation ensures proper testing of the imported drugs then this is a viable option that would lower cost and not lower quality of care.

Hillary Clinton – Democrat

The following web site has a general overview of Hillary Clinton's health care plan:

https://www.hillaryclinton.com/issues/health-care/

The general components it lists are as follows:

1. Defend the Affordable Care Act and build on it to slow the growth of out-of-pocket costs.

Analysis: As stated earlier, there is no correct answer as to whether to repeal or not repeal ObamaCare. Repealing it and submitting a proposal that keeps progress that we have made under ObamaCare such as a lower number of uninsured individuals and a slowing of the growth rate in health care costs. It is probably safer to retain ObamaCare and modify it to make it more effective by adding components that slow the growth in cost while increasing quality of care.

This proposal mentions lowering the growth in out-of-pocket expenses. The best way to do this is to slow the overall growth in health care expenses. Some of the more detailed proposals tend to concentrate more on changing benefits so that the patient would pay less of the claims but that would mean premiums would increase. The premium increase would be paid by a combination of the employer or plan sponsor and the patient.

2. Crack down on rising prescription drug prices and hold drug companies accountable so they get ahead by investing in research, not jacking up costs.

Analysis: I am not really sure that I can improve on this proposal. There is not a lot of detail in it but the idea is a very good idea.

3. Protect women's access to reproductive health care, including contraception and safe, legal abortion.

Analysis: The comment on access to contraceptives may be in response to Donald Trump's proposal for cross-state sale of health care, which would probably substantially lessen the access to contraceptives as many states now mandate contraceptive coverage and the Trump proposal would allow payers to virtually eliminate most mandates.

Additionally, Hillary announced this week that she would support a public option which would allow individuals who are under age 65 and not disabled to buy into Medicare under certain circumstances. It is not clear what these circumstances are and how much these individuals would have to pay for this coverage. Part A premiums for those who currently buy into Medicare Part A is $411 per month. Part B premiums for persons buying into Part B can be as low as $104.90. Generally the target population that has been discussed in the past for allowing Medicare buy-in are persons close to Medicare eligibility age, such as those age 55 to 64. This public option would give these older adults, who are currently not eligible for Medicare, a less expensive option than would otherwise be available but, if it is decided that the premiums will be subsidized then this would drive up both Medicare expenditures and the Federal Budget deficit even higher.

The section below was taken from a previous article I had written in November 2015 when Hillary first released a detailed health care plan. It contains more details than, but is consistent with, the list above, so it is included below along with my comments written in that article:

1. Hillary's plan would modify and add on to Obamacare, not repeal it

Given the alternative proposals currently being presented by presidential candidates, modifying Obamacare seems to make more sense than repealing it and starting from scratch. The key point is that Obamacare must be modified as it has many issues but is still better than the alternatives. Obamacare gives coverage to millions who were previously uninsured. It also has components that may help reduce costs of health care and increase quality of care, but the effectiveness of these components will only be determined over time. One huge weakness of Obamacare is that the cost management components do not do nearly enough to control future increases in health care costs, arguably the biggest problem facing the United States today as funding for defense, infrastructure, education, and other important programs are redirected to cover health care costs. Increasing health care costs will also substantially increase the number of uninsured people in the United States as coverage becomes unaffordable for employers, individuals, Medicare enrollees, and even those with subsidies through the health insurance exchanges. Not repealing Obamacare may be a good thing as long as substantial additional measures are taken to increase quality of care and efficiency in our health care system.

2. The first three sick visits a year would not be subject to the deductible.

This seems like a reasonable approach as it allows individuals to see a doctor if they are sick without having to worry about paying for the visit if the individual has a large deductible. Although it would increase health care costs, it would also help improve the individual's health status. The three visit limit before copays and deductibles apply would help control the cost of excessive doctor visits. Just a note though that the reason that deductibles are so large is that health care costs have been out of control for decades and employers cannot afford the better benefit plans that it used to have for its employees in the past. Hillary's plan does little to help rein in high health care trends.

3. Tax credits up to $2,500 individual and $5,000 family would be given if out-of-pocket health care costs exceeded 5% of income

This is another reasonable approach to offset the cost of health care expenses. Currently, medical expenses exceeding 10% of income are deductible if the individual is itemizing deductions. The tax credit would allow a tax credit for even those who do not itemize deductions.

4. The ability to strengthen or modify "unreasonable" rate increases will be strengthened

I have mixed feelings about this approach but, if used correctly, it can slow the growth in health care costs slightly. In today's environment, an "unreasonable" rate increase is defined as a rate increase that exceeds 10% in a given year. Keep in mind that normal claims cost trends are 10% and higher for many benefits. This means that insurers may need to have rates approved if they are seeking rate increases that only cover normal trend increases. It is

probably a good thing to have somebody looking over the shoulder of the insurance companies and making sure rate calculations are correct and assumptions are reasonable.

The major problem with the strengthened review approach is that under this type of rate review, the rate review authority often arbitrarily cuts back on rate increases, possibly due to political reasons or in the hopes that the insurance company can cut its costs. However, insurance companies use over 80% of the premium dollars to cover claims payments to hospitals, doctors, pharmaceuticals, and other health care vendors. Insurance companies have limited ability to negotiate fee payment schedules with these health care providers and virtually no negotiation leverage with pharmaceutical manufacturers, who can set prescription drug prices at a level of its own choosing. Health insurers can also try to control costs through reduction in the 30% of all health care costs that are fraud, waste, and abuse but this is extremely difficult to do and generally met with cries of "rationing health care" and other arguments that we saw when HMOs became prevalent in the 1980s.

We probably need rate review for large rate increases but there needs to be checks and balances so that we do not see a significantly number of bankruptcies in health insurers as we sometimes see in states where rate review gets political.

5. Pharmaceutical manufacturers would not be able to deduct "marketing" expenses as a business expense

On the surface this might sound like a good idea but its impact would only be higher health care premiums as pharmaceutical manufacturers would just raise the price of its drugs to cover the lost deductions. If there was even limited restrictions on drug prices then elimination of the deduction for marketing expenses might have an impact but the reality is that it would not change the pharmaceutical manufacturers' behavior, just increase drug prices. There needs to be some mechanism put in place to restrict the huge increases in prescription drug prices.

6. A minimum amount of money would be required to be spent by drug manufacturers on research and development.

I cannot really comment on this as I do not know the details of the plan. I think requiring a certain percent of revenue on drug research and development is a good idea. Only requiring a set dollar amount would do little good as it would be a hardship for small pharmaceutical manufacturers and not impact large pharmaceutical manufacturers. A combination of minimum dollar and minimum percent of revenue is also possible.

7. Prescription drug out-of-pocket maximums would be limited to $3,000 a year.

This would have somewhat minimal impact and ignores the major problem in health care costs. Obamacare already has a total out-of-pocket maximum of $6,500 so if a person in a plan with this $6,500 maximum allowed out-of-pocket had non-drug out-of-pocket expenses of $3,500 then this proposal would have zero cost anyway. In reality, most plans have maximum out-of-pockets less than the $6,500. This maximum drug out-of-pocket would only assist those with drug out-of-pocket expenses over $3,000 but who had limited other medical expenses, which is not a large number of people. This idea would increase premiums very

slightly overall.

This idea also does nothing to help control the total cost of prescription drugs. Health care is arguably the fastest growing sector of our economy and has been so for decades. Prescription drugs are one of the fastest growing components in health care and has been so for decades despite a slowdown in drug costs from around 2005 through 2014. Reducing drug out-of-pocket costs with no other changes would actually increase health care trends and compound the drug cost problem.

8. The sales exclusivity period for biotech drugs would be reduced from twelve years to seven years

This is a reasonable step in order to cut prices on a few particular drugs but its impact overall would not be substantial. Currently, pharmaceutical manufacturers have few restrictions on the prices that they can charge for its drugs so reducing the sales exclusivity period may decrease costs only for those drugs that have been around for eight to twelve years if the manufacturer does not push through a "new-and-improved" drug to replace the drug whose sales exclusivity period is expiring. Pharmaceutical manufacturers will more quickly replace drugs whose sales exclusivity period is ending and pull the old drug off the market, leaving the new drug in an environment with no competition. Again, the key here is that there are no restrictions on how much pharmacy manufacturers can charge for its drug products so the issue of costs during the sales exclusivity period is a subset of the overall problem of absolutely no controls over prescription drug prices.

9. Medicare would be given the ability of negotiating drug prices with pharmaceuticals

Medicare should be given the ability to negotiate drug prices. It would have some, but not a lot, of leverage in negotiations with the pharmaceutical manufacturers. Some type of price restraint on drug prices is imperative. Additionally, these negotiated drug prices would help to serve as a guide for non-Medicare plans as to what drug prices may be reasonable.

Summary

The proposals above have significantly different approaches to health care reform. The voter should judge these proposals based on long-term effects on the growth of health care costs, increase in quality of care, and the resulting number of uninsured individuals. Unfortunately, partisan politics means that many Democrats will support Hillary's plan solely because she is a Democrat and many Republicans will support Donald Trump's plan solely because he is Republican.

Another difficulty with the evaluation of health care reform proposals is that health care represented 17.5% of our economy in 2014 and is increasing steadily each year. That means that any significant proposal may impact that 17.5% of the economy and any change may be resisted by individuals working in the health care sector or who have family working in the health care sector. Thus, emotions tend to run high when such proposals are discussed. For example, a proposal that is made to reduce health care cost increases might be termed a "job-killer". Although it can be argued that this term is accurate, another way to look at it is that the increase in number of jobs in health care would be slowed.

As an example of differences in perceptions making change difficult, I heard a presentation on the Internet that was done by the head of a medical center. He was very proud that he had helped the medical center increase its revenues significantly over the past couple years and that the medical center was to grow 20% in the next couple years and that would be good for the community. To a health actuary's ear that sounded like "Our medical center managed to get substantially more payments out of the insurance carriers, HMOs, and government programs and we expect to get 20% more out of them in the next couple years, exacerbating our health care crisis." In its defense, this medical center did implement a couple program that were designed to reduce costs while maintaining quality of care. This does point out the complexities of medical reform though as the employees of this medical center would be among the first to react emotionally to health care reforms as it would be a threat to job security, income, and financial security for their families.

In the opinion of a growing number of people, if left unabated our health care system will get so large that it will cause a major crisis in the United States within the next 15 years, including possibly the elimination of Medicare for middle-income Americans. If we wait until that happens then we will need to do a complete overhaul of our health care system at that time and that would mean the possible loss of millions of jobs. The alternative is to make incremental changes now that slows the growth of health care, allowing our economy to continue to expand.

General articles regarding health care reform are posted below in order from most recent to earliest posting date:

Objective Analysis of Hillary Clinton's Health Plan
By Jeff Adams November 14, 2015

Hillary Clinton (Democratic Presidential candidate) released her health care plan recently. This is an objective analysis of the components of that plan.

1. Hillary's plan would modify and add on to Obamacare, not repeal it

Given the alternative proposals currently being presented by presidential candidates, modifying Obamacare seems to make more sense than repealing it and starting from scratch. The key point is that Obamacare must be modified as it has many issues but is still better than the alternatives. Obamacare gives coverage to millions who were previously uninsured. It also has components that may help reduce costs of health care and increase quality of care, but the effectiveness of these components will only be determined over time. One huge weakness of Obamacare is that the cost management components do not do nearly enough to control future increases in health care costs, arguably the biggest problem facing the United States today as funding for defense, infrastructure, education, and other important programs are redirected to cover health care costs. Increasing health care costs will also substantially increase the number of uninsured people in the United States as coverage becomes unaffordable for employers, individuals, Medicare enrollees, and even those with subsidies through the health insurance exchanges. Not repealing Obamacare may be a good

thing as long as substantial additional measures are taken to increase quality of care and efficiency in our health care system.

2. The first three sick visits a year would not be subject to the deductible.

This seems like a reasonable approach as it allows individuals to see a doctor if they are sick without having to worry about paying for the visit if the individual has a large deductible. Although it would increase health care costs, it would also help improve the individual's health status. The three visit limit before copays and deductibles apply would help control the cost of excessive doctor visits. Just a note though that the reason that deductibles are so large is that health care costs have been out of control for decades and employers cannot afford the better benefit plans that it used to have for its employees in the past. Hillary's plan does little to help rein in high health care trends.

3. Tax credits up to $2,500 individual and $5,000 family would be given if out-of-pocket health care costs exceeded 5% of income

This is another reasonable approach to offset the cost of health care expenses. Currently, medical expenses exceeding 10% of income are deductible if the individual is itemizing deductions. The tax credit would allow a tax credit for even those who do not itemize deductions.

4. The ability to strengthen or modify "unreasonable" rate increases will be strengthened

I have mixed feelings about this approach but, if used correctly, it can slow the growth in health care costs slightly. In today's environment, an "unreasonable" rate increase is defined as a rate increase that exceeds 10% in a given year. Keep in mind that normal claims cost trends are 10% and higher for many benefits. This means that insurers may need to have rates approved if they are seeking rate increases that only cover normal trend increases. It is probably a good thing to have somebody looking over the shoulder of the insurance companies and making sure rate calculations are correct and assumptions are reasonable.

The major problem with the strengthened review approach is that under this type of rate review, the rate review authority often arbitrarily cuts back on rate increases, possibly due to political reasons or in the hopes that the insurance company can cut its costs. However, insurance companies use over 80% of the premium dollars to cover claims payments to hospitals, doctors, pharmaceuticals, and other health care vendors. Insurance companies have limited ability to negotiate fee payment schedules with these health care providers and virtually no negotiation leverage with pharmaceutical manufacturers, who can set prescription drug prices at a level of its own choosing. Health insurers can also try to control costs through reduction in the 30% of all health care costs that are fraud, waste, and abuse but this is extremely difficult to do and generally met with cries of "rationing health care" and other arguments that we saw when HMOs became prevalent in the 1980s.

We probably need rate review for large rate increases but there needs to be checks and balances so that we do not see a significantly number of bankruptcies in health insurers as we sometimes see in states where rate review gets political.

5. Pharmaceutical manufacturers would not be able to deduct "marketing" expenses as a business expense

On the surface this might sound like a good idea but its impact would only be higher health care premiums as pharmaceutical manufacturers would just raise the price of its drugs to cover the lost deductions. If there was even limited restrictions on drug prices then elimination of the deduction for marketing expenses might have an impact but the reality is that it would not change the pharmaceutical manufacturers' behavior, just increase drug prices. There needs to be some mechanism put in place to restrict the huge increases in prescription drug prices.

6. A minimum amount of money would be required to be spent by drug manufacturers on research and development.

I cannot really comment on this as I do not know the details of the plan. I think requiring a certain percent of revenue on drug research and development is a good idea. Only requiring a set dollar amount would do little good as it would be a hardship for small pharmaceutical manufacturers and not impact large pharmaceutical manufacturers. A combination of minimum dollar and minimum percent of revenue is also possible.

7. Prescription drug out-of-pocket maximums would be limited to $3,000 a year.

This would have somewhat minimal impact and ignores the major problem in health care costs. Obamacare already has a total out-of-pocket maximum of $6,500 so if a person in a plan with this $6,500 maximum allowed out-of-pocket had non-drug out-of-pocket expenses of $3,500 then this proposal would have zero cost anyway. In reality, most plans have maximum out-of-pockets less than the $6,500. This maximum drug out-of-pocket would only assist those with drug out-of-pocket expenses over $3,000 but who had limited other medical expenses, which is not a large number of people. This idea would increase premiums very slightly overall.

This idea also does nothing to help control the total cost of prescription drugs. Health care is arguably the fastest growing sector of our economy and has been so for decades. Prescription drugs are one of the fastest growing components in health care and has been so for decades despite a slowdown in drug costs from around 2005 through 2014. Reducing drug out-of-pocket costs with no other changes would actually increase health care trends and compound the drug cost problem.

8. The sales exclusivity period for biotech drugs would be reduced from twelve years to seven years

This is a reasonable step in order to cut prices on a few particular drugs but its impact overall would not be substantial. Currently, pharmaceutical manufacturers have few restrictions on the prices that they can charge for its drugs so reducing the sales exclusivity period may decrease costs only for those drugs that have been around for eight to twelve years if the manufacturer does not push through a "new-and-improved" drug to replace the drug whose sales exclusivity period is expiring. Pharmaceutical manufacturers will more quickly replace drugs whose sales exclusivity period is ending and pull the old drug off the market, leaving the new drug in an environment with no competition. Again, the key here is that there are no

restrictions on how much pharmacy manufacturers can charge for its drug products so the issue of costs during the sales exclusivity period is a subset of the overall problem of absolutely no controls over prescription drug prices.

9. Medicare would be given the ability of negotiating drug prices with pharmaceuticals

Medicare should be given the ability to negotiate drug prices. It would have some, but not a lot, of leverage in negotiations with the pharmaceutical manufacturers. Some type of price restraint on drug prices is imperative. Additionally, these negotiated drug prices would help to serve as a guide for non-Medicare plans as to what drug prices may be reasonable.

Summary

Hillary Clinton's health care plan has some decent ideas but falls far short of the type of policy required to help fix our broken health care system. There is little in her plan that addresses the main problems in our health care system, mainly that costs are out of control and have been for many decades. During the next eight years (two presidential yerms), there will be a substantial policy change involving Medicare as during this timeframe the Federal government will not be able to afford increasing Medicare funding to keep up with normal health care trends. The Democrats and Republicans have a different perspective as to how to fix Medicare but both will result in its destruction. The only way to save Medicare is to fix our entire health care system but this needs bipartisan cooperation which is not likely to happen any time soon.

Employer and health insurance exchange coverage will face major issues also due to high trends. More and more employers have been dropping coverage for their employers for decades and this trend will continue. Health insurance exchange premiums will increase substantially and individuals will start to drop coverage due to high premium rates, including those with premium subsidies.

Currently, fixing our health care system is one of the "third-rail" issues as attempts to control cost are cited as job-killing proposals or rationing of health care. I am one of the growing number of people (and have been for many years) that thinks high health care costs are our country's biggest problem. You can read my article **Are Rising Health Care Costs the US' Biggest Problem and Should I care?** for more.

Objective Analysis of Jindal's Health Plan

By Jeff Adams October 16, 2015

Governor Bobby Jindal (Republican from Louisiana) released his health care plan. This article is intended to be an objective analysis of his plan. Due to the politicization of our health care system, any objective article will be disliked by both partisan Democrats and partisan Republicans, and I expect that is true here.

Jindal's Plan

Listed below are the major components of Jindal's plan along with a brief analysis of each:

Full Repeal of Obamacare

Obamacare is, by far, not a perfect solution for our health care system, as it has some rather large issues. If a plan is brought forth that is better than Obamacare then it would be reasonable to repeal Obamacare and replace it with the newer, better plan. Jindal's proposed plan, similar to prior Republican proposals, lacks the elements that would help fix our health care system, such as components that would help control costs while increasing quality of care and provide relief for the tens of millions of uninsured Americans. Jindal's plan is far inferior to Obamacare in improving these key elements. A total repeal of Obamacare would be a step backwards in fixing our broken health care system. The Republicans should, instead, set aside their political agenda and do what is right for the country and work with the Democrats to fix the many issues with Obamacare. The Democrats, in turn, should also set aside politics and work with the Republicans to improve our health care system.

Medicare Premium Support

The Premium Support concept contained in Jindal's plan can be thought of as a defined contribution approach, where the Medicare beneficiary would use the money allotted by the Federal government to offset a portion of the cost of purchasing any available Medicare plan, including the current Medicare fee-for-service plan. This concept has been proposed in response to out-of-control health care costs becoming an increasing portion of the Federal budget. Currently health care comprises approximately

27% of the Federal budget, double what it was a couple decades ago, and cost increases remain out of control. This Premium Support or defined contribution plan would allow the Federal government to rigidly control the cost of the most problematic portion of the Federal budget.

The issue with this approach is that it does not address the major problems with our health care system, which is the out of control cost trends. Jindal's plan requires Medicare beneficiaries to pay a large portion of the premium increases in the future, which will result in Medicare becoming unaffordable for all but the wealthy. An example of the likely scenario is shown below and is based on the following assumptions:

Health care costs have been rising at annual trends substantially exceeding the rate of inflation and the annual growth rate of the United States. Medicare trends have been lower than trends in our overall health care system since the Federal government has control over important portions of the program such as physician and hospital fee schedules. Employer, individual, Exchange, and other commercial coverage trends bear the brunt of suppression of Medicare payments to providers as the providers seek recoupment of the low Medicare fee schedule increases through increases in their commercial fee schedules with insurers as these insurers have much less negotiation leverage than the Federal government. This makes commercial coverage significantly more expensive and cost trends higher. Even with Medicare's lower trends, an annual trend of 6% is probably low, based on historical trends, but not unreasonable for our scenario.
The Premium Support or defined contribution plan is designed to assist in controlling government spending. As such, this government contribution will most likely be increased at the rate of increase in the overall Consumer Price Index, similar to the method used for Social

Security benefit increases and the increases in Premium Subsidies under Obamacare. This means that the increases in Premium Support will be less than 3% annually for the foreseeable future. For the scenario below we will use a 3% increase in Premium Support each year.
The cost of a Senior on Medicare is substantially higher than a person at the average age of, say, 37. Medicare Part A costs can be estimated, very roughly, by the amount of Part A premium for a person who needs to buy into Medicare Part A. The 2015 Part A Premium is $407 per month. The Part B Premium of $147 is designed to be 25% of total Part B costs. Part B costs can be estimated at $147 divided by 25% or $588. Total combined Part A and Part B costs for Medicare would then be $407 + $588 = $995 per month for 2015. We will use $995 as our starting total medical costs or total premium amount for 2015.
Currently individuals pay $147 for Part B and generally get Part A for free. We will use this $147 as the initial Medicare beneficiary cost in 2015 under a premium support program in 2015.
The government Premium Support or defined contribution can then be calculated as the total cost of $995 minus $147 that the Medicare beneficiary will need to pay for coverage in 2015. This means that the government subsidy or Premium Support amount would be $995 - $147 = $848.

Using these assumptions, the table below shows the Premium Support amounts and Medicare beneficiary payments in premiums above and beyond the government contribution:

Year	Total Cost of Health Care	Government Premium Support	Monthly Cost to Senior	Annual Cost to Senior
Annual Increase	6.0%	3.0%		
2015	$ 995	$ 848	$ 147	$ 1,764
2016	$1,055	$ 873	$ 181	$ 2,175
2017	$1,118	$ 900	$ 218	$ 2,620
2018	$1,185	$ 927	$ 258	$ 3,101
2019	$1,256	$ 954	$ 302	$ 3,621
2020	$1,332	$ 983	$ 348	$ 4,182
2021	$1,411	$ 1,013	$ 399	$ 4,786
2022	$1,496	$ 1,043	$ 453	$ 5,438

2023	$1,586	$ 1,074	$ 512	$ 6,140
2024	$1,681	$ 1,106	$ 575	$ 6,895
2025	$1,782	$ 1,140	$ 642	$ 7,707
2026	$1,889	$ 1,174	$ 715	$ 8,580
2027	$2,002	$ 1,209	$ 793	$ 9,517
2028	$2,122	$ 1,245	$ 877	$ 10,523
2029	$2,250	$ 1,283	$ 967	$ 11,603
2030	$2,385	$ 1,321	$ 1,063	$ 12,761
2031	$2,528	$ 1,361	$ 1,167	$ 14,002
2032	$2,679	$ 1,402	$ 1,278	$ 15,332
2033	$2,840	$ 1,444	$ 1,396	$ 16,757
2034	$3,010	$ 1,487	$ 1,523	$ 18,282
2035	$3,191	$ 1,532	$ 1,660	$ 19,914
2036	$3,383	$ 1,578	$ 1,805	$ 21,660
2037	$3,586	$ 1,625	$ 1,961	$ 23,528
2038	$3,801	$ 1,674	$ 2,127	$ 25,525
2039	$4,029	$ 1,724	$ 2,305	$ 27,659
2040	$4,270	$ 1,776	$ 2,495	$ 29,939
2041	$4,527	$ 1,829	$ 2,698	$ 32,374

2042	$4,798	$ 1,884	$ 2,915	$ 34,975
2043	$5,086	$ 1,940	$ 3,146	$ 37,752
2044	$5,391	$ 1,998	$ 3,393	$ 40,715
2045	$5,715	$ 2,058	$ 3,656	$ 43,877
2046	$6,058	$ 2,120	$ 3,938	$ 47,251
2047	$6,421	$ 2,184	$ 4,237	$ 50,849
2048	$6,806	$ 2,249	$ 4,557	$ 54,686
2049	$7,215	$ 2,317	$ 4,898	$ 58,777
2050	$7,648	$ 2,386	$ 5,262	$ 63,138
2051	$8,107	$ 2,458	$ 5,649	$ 67,785
2052	$8,593	$ 2,531	$ 6,061	$ 72,737
2053	$9,108	$ 2,607	$ 6,501	$ 78,013
2054	$9,655	$ 2,686	$ 6,969	$ 83,632
2055	$10,234	$ 2,766	$ 7,468	$ 89,617
2056	$10,848	$ 2,849	$ 7,999	$ 95,990

As the table above indicates, it will only take 13 years for annual Senior contributions to exceed $10,000. This is out of the affordability range of most Seniors. This will result in Seniors dropping coverage.

The numbers in the table would be adjusted based on the year in which this program would be implemented but the results would be the same. The implication here is that Jindal's premium support plan will mean the end of health care coverage for all but the wealthiest Seniors. Even the wealthy Seniors at some point will drop coverage due to the outlandish cost.

Capping medical liability lawsuits

This idea has been thrown around for decades. Its time has come to pass a law limiting malpractice liability. Malpractice liability insurance premiums have become so high in certain fields that physicians have dropped out of the profession, causing a shortage of physicians in those fields. Not only do physicians perform additional procedures due to the current malpractice laws, their fees are substantially inflated as they have to recover the additional cost of malpractice insurance.

Cap Medicaid spending with block grants to states

Jindal's plan would set up block grants to be paid by the Federal government to the states in order to cover the cost of the states' Medicaid program. This would allow the Federal government to have strict control over its Medicaid budget and push the responsibility for keeping Medicaid cost increases onto the states. Another advantage of this plan is that it would allow the states to tailor its Medicaid program to the needs of the residents of its state and to the goals of the state government. The disadvantage is that the states would not have the clout of the Federal government behind the program as sometimes the "bigger hammer" approach actually works in our health care system. The states would also be reliant to give reasonable increases for Medicaid each year.

This approach is not an unreasonable approach although some states, especially the smaller states, may have difficulty keeping a cost-effective Medicaid program with a high quality of care up and running.

No more pre-existing conditions. $100M to states for risky

The reasonableness of removing the pre-existing conditions ban depends on your view of what our health care system should do. I personally do not believe that someone with diabetes, asthma, heart disease, or any other chronic health condition should pay more than another individual solely because of the health condition. Some of Jindal's other ideas to replace the pre-existing condition ban have some merit but are not as effective as leaving the pre-existing condition ban that is currently in place as it would require many individuals to pay substantially more for coverage due to health condition or even leave them uninsured.

Allow individuals to have standard deduction for premium payments

It seems reasonable to give a tax deduction, as Jindal proposes, if an individual has to pay premiums for a health care benefit. It may not help much but at least it is something.

Sale of insurance across state lines

Jindal proposes to allow insurers located in one state to sell insurance in other states without having to follow state mandates of the state in which the insurer is selling its coverage. This is a bad idea that has been put forth for years. The impact would be minimal, even increasing overall health care costs. The main objective of this approach is to avoid the state mandates of the state in which a policy is sold. Insurers would pick the location which would have the least restrictions and mandates and use that as its corporate headquarters. This would allow the company to sell in any state and be subject only to minimal state regulation. It would only take one state to pass even looser laws in an effort to draw insurers to allow insurers to avoid most regulations.

Even ignoring the issue above, the argument for this allowance to cross state lines would not produce the results intended. An insurer in one location trying to sell in another state would not have the leverage to negotiate with the various medical groups and facilities due to a lack of business in that state. Leverage is extremely important for an insurer to be able to negotiate with providers. As a result, these cross-state insurance plans would have worse discounts driving overall health care costs higher and providing more revenue for the providers. The cross-state insurers would target small groups that are in community-rated plans (plans that base premium rates on an overall block of business and not on the individual group). The cross-state insurer would pick off the groups with better experience, leaving a less healthy block of business with the insurer that is actually in the state and following state regulations. As a result, the insurer in the state would have to increase premiums to account for losing groups with better experience. Additionally, individuals purchasing coverage would lose coverage for the benefits that are mandated in the state in which the individual resides

Expanding health savings accounts

It is reasonable to pursue expansion of health care savings account to allow individuals to use more pre-tax dollars to pay for health care costs. An easier way may be to change the tax code and eliminate the 10% threshold currently in the tax law regarding medical expenses. With this change, medical expenses would be tax deductible for individuals if they itemize deductions.

Allow businesses to pool their purchasing power

This may not have substantial impact but it is an idea that would be worthwhile to pursue. This pool of businesses would be trying to obtain better discounts than TPAs or insurers, a scenario that seems unlikely.

Republicans Claim that Democrat's Policies will Destroy Medicare

There is some truth to this claim even though the reason given may not be the actual reason. The reason given by the Republicans is that the Medicare Fund is supposed to be depleted in the future, according to the actuaries who normally perform that study each year. In reality, those studies are very restrictive and do not include additional revenue put into Medicare by the government or by individuals due to Part B premium increases (and Part A premiums if applicable). Historically additional money has been put into Medicare to extend its lifetime, as calculated by the study. This will also happen in the future.

The real issue is that these additional monies are increasing Medicare's portion of the Federal budget at an unsustainable rate. Medicare and Medicaid were 13% of the Federal budget a couple decades ago and now they are 27% of the Federal budget. That means 14% of the budget that was dedicated to programs other than health has been redirected to health care and this will continue into the future. This has, and will, cause many Federal programs to be eliminated or funding to be reduced. It also causes funding to states to be reduced, reducing state programs and reducing funding to local governments. The reduction in local funding will cause a reduction in local programs.

Summary

The solution to the issues with our health care system is to make major changes to our health care system in an effort to increase efficiency and quality of care. These changes must not be piecemeal as a change only affecting Medicare or Medicaid, for example, will cause a shift in cost to our overburdened commercial coverage (employer group, individual coverage, Exchange, etc.)

One third of health care claims are unnecessary as they are either fraud, waste, or abuse. Treatment protocol needs to be developed that would detail the standard treatments for various conditions.

It must be acknowledged by policymakers that each entity in health care is run as a business and not run as a charity. Physicians, hospitals, pharmaceuticals, and other health care vendors try to maximize revenue and reduce their expenses to ensure that the business has enough money to stay in business. Decisions by providers and facilities are often made with the business results in mind and not what is best for the patient. A good example would be if I went into my primary care physician's office and demanded a certain drug, my physician would probably give it to me rather than lose me to a physician down the road. I have often had physicians make this comment to me. There are many very good health care providers who look out for the best interest of their patients and I am lucky to have some of these as my doctors. Policymakers, however, need to make policy based on the entire health care system, which means making policies that make it difficult for those entities most responsible for the 33% fraud, waste, and abuse, including the patients. Unfortunately, this means that the good physicians, hospitals, other providers, and patients suffer due to the acts of the not-so-good elements of our health care system.

There is no quick fix or "silver bullet" for our health care system. Our policymakers need to work together to find solutions that, combined, will help improve our health care system. Using health care as a tool to win the next election is an approach that may be single-handedly the most damaging approach to legitimate health care reform.

Politics and Our Health Care System
By Jeff Adams July 6, 2015

As I read an email from my congressman, I was reminded how little chance our country has of fixing our health care system before it becomes a major catastrophe, which will probably happen in slightly over a decade. Our politicians in both parties are putting their own careers ahead of the well-being of the nation. Misleading media campaigns confuse the public and allow politicians to confuse people and convince them what a catastrophe our lives will be unless we follow that politician's agenda.

The latest email tried to convince me that my congressman was better able to determine what medical treatments and procedures were good for patients than the physician community. Really? It was part of the scare tactics standardly used to show that ObamaCare is the downfall of our society. ObamaCare has many faults but is better than what we had

previously and better than any alternative proposal that I have seen since.

The specific issue brought up by my congressman was the Independent Payment Advisory Board. The email indicated that this board was the root of all evil. In reality, this board was set up in an effort to help fix our broken health care system, specifically Medicare, since our politicians have been unable to work together in a civilized manner. The IPAB will not eliminate necessary care but is designed to lessen the 35% of health care costs that are fraud, waste, and abuse (i.e.-not necessary). Visit the Kaiser Health News web site to read a good story regarding the IPAB. The story is at: http://khn.org/news/ipab-faq/ .

Remember, health care costs need to be brought under control soon. Employers have been dropping coverage for employees over the past couple decades due to increasing costs. Individuals who are not wealthy cannot purchase individual coverage without the government subsidies, which will erode over time if health care costs remain out of control. Chances are that your favorite government programs have already lost all or much of its funding over the past couple decades as health care costs increased from 13% to 27% of the federal budget during that period. In the early 1990s, economists said that health care costs will never exceed 20% of our economy because if it did then our economy would suffer catastrophic issues. Since then health care costs have increased from 12% to over 18% of our economy and our economy has shown signs of fracturing.

I am an independent voter so I have no political affiliation. I ask that politicians and the public refrain from making our health care system a huge political issue and join together to try to fix our broken system. Failure to do so will lead to catastrophic results in a little over a decade. This is not a Democratic issue. This is not a Republican issue. This is a survival issue.

Choosing an Exchange Benefit Plan
By Jeff Adams September 16, 2013

The Affordable Care Act ("ACA") legislated the establishment of health care Exchanges that would begin offering coverage to Individuals and Small Groups beginning on January 1, 2014, with open enrollment beginning on October 1, 2014. The following narrative describes some of the decisions and decision-processes that an Individual needs to make to determine what plan, if any, the Individual will purchase from the Exchange. I am an actuary, not an Exchange Navigator, so take this narrative in the spirit intended. It is generally good to get different perspectives on issues before deciding what to do. I hope the following is some assistance to those who are considering purchasing coverage on an Exchange. You may wish to consider meeting with a Navigator to discuss the details of your situation, as these Exchange Navigators are professionals designated to assist Individuals looking for Exchange health care coverage..

Exchanges are offered in each state, although an Exchange may be multi-state. Additional information may be obtained by visiting the Exchange's web site. Two of these web sites are listed below:

New York Exchange Web Site

http://www.nystateofhealth.ny.gov/

California Health Insurance Exchange Web Site

http://www.healthexchange.ca.gov/Pages/Default.aspx

You should be able to find the web site for your state by doing a search for your state name and "health insurance exchange" or "health care exchange".

Deciding Whether to Purchase Health Care Coverage From an Exchange?

For individuals and families who are eligible for coverage from the Individual Exchanges due to their inability to obtain affordable coverage (defined as health insurance coverage that costs 9.5% of income or less), deciding whether to purchase coverage can be difficult. Three factors that will greatly influence the decision are:

1. Expected health claims in the next year.

2. The cost of having no health care coverage, including penalties and payments to physicians, hospitals, pharmacies, etc.

3. The cost of having coverage, including payments towards premium and out-of-pocket amounts (deductibles, copays, coinsurance, etc.)

The risk tolerance of an individual or family is also extremely important. Given identical answers to 1, 2, and 3 above, two individuals may choose different options depending on each individual's risk tolerance. An individual who is less risk tolerant is more likely to pay insurance premiums in exchange for the safety net of coverage.

Penalty for Having No Health Coverage

In an effort to encourage individuals to buy health insurance coverage and in conjunction with the creation of Health Insurance Exchanges from which more affordable coverage may be purchased, ACA imposed penalties on individuals who do not have health insurance coverage in 2014. In 2014 this penalty is $95 per member, increasing to $325 per member in 2015, $695 per member in 2016, then increased by inflation each year thereafter. In the rare event that the average premium is less than the calculated per member penalty, the penalty is reduced to the premium amount.

The impact of this penalty is unknown but a congressional budget analysis estimates that six million individuals will pay this penalty rather than purchase health insurance. Currently it is estimated that over 50 million Americans are uninsured. The penalties, expansion of Medicaid in some states, and the income-based Premium Tax Subsidies for many purchasing insurance on the Exchanges will lower the uninsured rate.

Premium Tax Subsidy

The Premium Tax Subsidy is a subsidy given to households whose income is 100% to 400% of the Federal Poverty Level and who are eligible to purchase health insurance coverage from

the Exchange. The 2013 Federal Poverty Level ("FPL") is $11,490 for the head of the household and an additional $4,020 for each additional member of the household. Thus, the FPL for a family of four is $11,490 + 3 x $4,020 or $23,550 and a family of four with income between $23,550 and (400% x $23,550 =) $94,200 who are eligible for coverage on the Exchange may get subsidies.

The level of the subsidy varies by income as a percent of FPL. Eligible households with income at 100% of FPL ($23,550 for a family of four) and who do not have Medicaid will pay 2% of annual income for benchmark plan coverage. Households with income at 400% of FPL ($94,200 for a family of four) will pay 9.5% of income for Benchmark plan coverage. The Benchmark plan has a special meaning here: It is the second-least-expensive Silver plan available in the Exchange. A silver plan is a plan for which an insurer pays roughly 70% of allowable health care costs. An example of a Silver plan might be a $3,000 deductible plan where the member pays 20% of allowed charges above the deductible until the out-of-pocket maximum of $5,000 is reached, after which the member has no additional copayments.

As an example, assume that a family of four has a household income of $47,000 or roughly 200% of FPL. According to ACA, a household with income at 200% of FPL would have to pay approximately 6.3% of income, or 0.063 x $47,000 = $2,961 for Benchmark Silver coverage per year. If the actual Benchmark Silver plan premium family rate is $12,000 per year then the subsidy is $12,000 - $2,961 = $9,039. The household could use this subsidy against a plan of its choice. If the least-expensive Silver plan premium was $11,000 then this household would have to pay $11,000 - $9,039 = $1,961 for that benefit plan.

Cost-Sharing Reductions

Individuals and families with household income between 100% and 250% of FPL also are eligible for additional benefits. Households with income between 200% and 250% of FPL can get increased benefits which are 73% of costs instead of the Silver Benchmark 70%. Households with income from 150% to 200% of FPL get benefits that are 87% of total allowed claims. Households with incomes between 100% and 150% of FPL can get benefits that are approximately 94% of total allowed.

Cost of Coverage Versus the Cost of No Coverage

The decision of whether to purchase coverage from an Individual Exchange or to pay the penalty and take no coverage is dependent on the costs of those two options along with the amount of risk that the individual or household is willing to take.

For individuals or households with income in excess of 400% of FPL, there are no Premium Tax Subsidies to assist with premium payment or Cost-Share Reductions that would increase benefits by decreasing member copayments. The cost of having no coverage for this individual or household is the sum of the penalties for all members that choose not to have coverage plus the entire amount of all health care services that the individual or household incurs. The cost associated with choosing to purchase coverage would be the premium for the plan plus the deductibles, copays, coinsurance, and other out-of-pocket payments required by the plan. The potential policyholder would have to decide whether to buy the security of a

policy or take the risk of having to pay large amounts in claims.

For individuals or households with incomes between 250% and 400% of FPL, the cost of not taking coverage and the benefit plans available are the same as above but households in this income category have premium assistance so that they may not need to pay the entire amount of the premium. These individual or households would be slightly more likely to pay this lower income-based contribution (between 8.0% and 9.5% of income depending on income as a % of FPL) to obtain coverage. This premium could be reduced further if the individual or household chose a Bronze level benefit which has lower level benefits than the Benchmark Silver plan, and presumably lower premiums (remember that the subsidy is based on the Benchmark Silver premium).

For individuals or households with incomes between 100% and 250% of FPL, the cost of not choosing coverage is the same as stated in the prior two income scenarios. Households in the 100% to 250% of FPL income category will also receive the Premium Tax Subsidy described above except that their contribution will only be between 2.0% and 8.0% of income. Persons in this income category will also receive additional benefits in the form of Cost-Share Reduction. For example, benefit plans for those with incomes between 100% to 150% of FPL will be based on the individual or household paying only about 6% of total health care costs (the members are not responsible for the other 94% of claims costs) for covered services. It is expected that most persons in the 100% to 250% income range who are eligible for coverage through the Individual Exchange will choose to purchase coverage.

Which Benefit Plan to Choose

Once an individual or household decides that they will purchase a plan on the Individual Exchange, this potential policyholder will need to decide which benefit plan to purchase. It is recommended that those with incomes between 100% to 250% purchase a Silver plan due to the Cost Share Reductions, as these reductions are only available on Silver plans for most eligible Americans.

In determining which policy to purchase, the prospective policyholder would ensure that the household members' desired doctors, hospitals, and other providers were participating in any plan that might be chosen. The prospective policyholder would then compare the cost and benefits for the plans to determine which fits into the financial and risk tolerance goals of the household.

There are generally four levels of benefits (called metal levels) from which a prospective policyholder can choose: Bronze (60% AV), Silver (70% AV), Gold (80% AV) and Platinum (90% AV). The % AV is the actuarial value or percent of claims incurred for covered services for which the policy issuer (along with government payments) is responsible to pay. For a given issuer, Bronze plans are less expensive than Silver plans, which are less expensive than Gold plans, which are less expensive than Platinum plans. There may be substantial differences in premium between issuers, however, and Bronze plans for one issuer may actually be more expensive than Silver plans from another issuer. Reasons for rating differences between issuers include:

1. Differences in underlying claims costs due to more or less restrictive provider networks,

issuer contracts with providers and hospitals, utilization management practices, differences in claims processing, and administrative cost differences.

2. Differences in issuer-assumed government and other subsidization for plans with sicker member.

3. Since many issuers in the Individual Exchanges do not currently sell policies to individuals they may use substantially different assumptions as to claims levels of the individual population.

4. Not-for-profit health cooperatives receive grants from the federal government.

5. Some issuers may be more aggressive than other issuers in rating.

Due to the insurance company (issuer) uncertainties in determining claims costs and due to management pressures in some cases, some issuers will drop out of the market for financial reasons within a few years. Policyholders will probably not lose coverage in these cases, however, as the other issuers will probably take over these individuals from the failed issuer. Having said that, some prospective policyholders will probably choose familiar issuer names with which they are comfortable will be around and are financially stable.

Some individuals may look at the out-of-pocket maximum as a guide to determining the difference in plan value by metal level, others may use deductibles as a guide. For example, if Issuer A has a Silver plan with a $6,400 out-of-pocket maximum and a Gold plan with a $5,000 out-of-pocket maximum then a potential policyholder may deem the value of the Gold plan over the Silver plan to be ($6,400 - $5,000 =) $1,400. If the premium for the Gold plan is only $600 greater than that of the Silver plan then the policyholder may decide that it is worth paying this additional money for the extra benefit. Others may use the deductible instead of the out-of-pocket in this comparison.

The premium rates will be valid until December 31, 2014. There will generally be rate increases on January 1, 2015 and then again for January 1, 2016. Since there is so much uncertainty there may be wide swings in premium rates between the years as issuers understand more fully the costs that its members are incurring. The policyholders, however, may tend to not worry about future premium increases and base their decisions on the January 1, 2014 premium.

Please feel free to contact me at jeff.adams@health-actuary.com if you have any questions. Navigators in the Exchanges will be your best source of information along with the web site for the Exchange in your state.

Financial Statement Implications for Actuaries From the Affordable Care Act

By Jeff Adams ***July 10, 2013***

The American Academy of Actuaries recently released its White Paper on *Financial Reporting Implications Under the Affordable Care Act*. In case you missed it, a link to the article appears below:

http://www.actuary.org/content/financial-reporting-implications-under-aca

This White Paper is a good summary of some of the financial reporting implications facing actuaries, especially in the first three years after enactment of the Affordable Care Act ("ACA"). Actuaries have spent months trying to determine changes in risk and costs due to ACA in an effort to build them into premium rates. Now that the premium rates for small group and individual have been submitted, actuaries are now expending significantly more effort in analyzing changes in the financial statements due to ACA. Some items are much more difficult to estimate than others. For example, the Risk Adjuster estimate is not known for six months after the end of the calendar year while the temporary reinsurance estimated accrual estimate can be reasonably obtained within a couple months after the end of the calendar year although, as the White Paper points out, there are scenarios where the estimation of the reinsurance recoveries may be inaccurate due to no fault of the actuary doing the estimation.

As the White Paper indicates, the additional accruals and possible increasing magnitude of existing accruals will cause significant volatility in financial statements for health care payors. Even the best actuaries and financial wizards will have difficulties in accurately estimating these accruals. Changes in accrual estimates may need to be booked promptly possibly causing wide swings in underwriting results and problematic comparisons from one payor to another.

Issues with the Premium Tax Subsidy and the Cost-Sharing Reduction may also cause volatility in the financial statement. Persons whose income level changes may have its benefits or Premium Tax Subsidy changed. This could affect the financial statements. Premium Deficiency Reserves may also be required if significant losses are incurred by the issuer's new products.

Please read the White Paper as it contains important information. If you have any comments or questions then you can contact the American Academy of Actuaries or you can contact me and I will try to assist you.

Health Care Reform

By Jeff Adams May 10, 2013

My update on health care reform is that everything is going as expected, and that is not necessarily good. I attended a local Chamber of Commerce meeting on health care reform this morning and confusion still reigns supreme. When the law was initially passed and people were complaining about the fact that the regulation had over 2,000 pages I said: "That is necessary because health care is 17% of our economy and so complicated. Just wait, the government will need to send out over 100,000 pages of instructions before it goes live in 2014." I am thinking that 100,000 pages was a gross understatement.

The Chamber meeting concentrated on the Individual and Small Group exchanges in New York State and the employer penalties for not offering affordable health care. The discussion on employer size is a good example of what has, and will, occur on many topics for a few

years to come. Employers with over 50 employees are required to follow certain provisions regarding offering affordable health care. The Chamber of Commerce discussion on what constitutes an "employee" lasted 20 to 30 minutes. Many questions still remained at the end of the session. The problem is that the original law had a few pages on these requirements, necessarily not including many details due to the size of a document containing all such details for all such health care reform topics. Follow-up documents added more detail but could not possibly discuss all possible scenarios in all locations across the country. For example, one person asked if they could set up a temp service company specifically so that their company did not have to pay for health insurance for its employees who were not full-time all year. I am sure the drafters of the legislation did not think of that scenario or anything like it.

This is just one of many, many topics where details continue to flow from the government on how to implement health care reform, be it from the federal government or state government. All parties involved will continue to be frustrated through implementation and on into its first few years of operation as issues, ignored or not apparent currently, will need to be resolved after implementation.

Furthermore, health care reform does not adequately address two main concerns of our health care system. There are a couple items in the Affordable Care Act ("ACA") that have the potential to lower health care cost increases somewhat but it will not be nearly enough, although better than the other alternative of repealing the law. Also, the uninsured population will decrease significantly initially due to the Premium Tax Subsidy but, as stated in previous articles on this site, the details of ACA will dramatically erode this income-based subsidy over time and people will choose to pay the penalty rather than keeping their health insurance.

So, this article has not said anything new, not a thing that we did not know before. I will end this article with something that one of today's Chamber presenters said, although I paraphrase: Do not ignore health care reform! It will not go away anytime soon. With knowledge of the law you can take advantages of its benefits and avoid some of its pitfalls. Many have chosen to ignore it and will regret it in a year or two.

Health Care Reform

By Jeff Adams March 18, 2013

The Patient Protection and Affordable Care Act was passed in 2010 but much of the legislation will take effect on January 1, 2014. Much of the detail still needs to be ironed out quickly and health care payors and providers are scrambling to decipher the latest releases from the Department of Health and Human Services ("HHS"). Once all the information is released and deciphered the payors and providers must incorporate it into strategic and tactical plans for January 1, 2014 knowing that most of it needs to be in place well before then.

Much ado was made about the original legislation being 2,000 pages long. I said at the time that the law is rewriting one-sixths of our economy so 2,000 pages is extremely small compared to what should be written and that before January 1, 2014 the federal government could release 100,000 pages of materials. I have no way of knowing exactly how many pages

have been released but I am sticking with my previous estimates. HHS seems to be trying very hard to get information from all parties involved before finalizing the pieces of the regulation. To their credit they realize there is no way they can know all of the implications on all parties of 17% of our economy. All parties are invited to comment and, although no law will satisfy everyone,

HHS tries to be fair to the parties affected.

Actuaries working at the issuers (insurance companies) are scrambling to develop and submit rates in March even though not all of the rules have been finalized by the federal government yet. Hospitals and other providers are also scrambling to through the immense amount of work required, including developing Affordable Care Organizations and other provider organizations due to the new law, including different payment types than some providers are used to.

Health insurance Exchanges will start providing benefits as of January 1, 2014 for individuals and small groups, although open enrollment will be in fall 2013. Individuals will be able to purchase coverage through the Individual Exchange if affordable coverage is not available elsewhere for the individual. If an "income tax household" in which an individual resides has income of less than 400% than the Federal Poverty Level ("FPL") then they are able to purchase coverage from the Exchange for a cost of anywhere from 2% to 9.5% of household income, depending on the income level. The federal government will subsidize the difference between the individual contribution and the actual premium. FPL will be roughly $11,450 for the first person plus $4,000 for each additional household member. For example, a family of 4 has an FPL of $23,450, roughly. In addition, a tax household with income of less than 250% of FPL will get additional benefits at no additional cost. Please see my previous article or contact me if you would like more detail.

The major reasons for the legislation are: 1) Decrease the number of uninsured. 2) Increase the quality of care. 3) Make health care more affordable for employers and the public. 4) Assist in controlling government spending on health care by being better able to control Medicare and Medicaid costs.

The number of uninsured will decrease substantially due to the premium subsidies for those with incomes less than 400% of the FPL, although there will still be a large number of uninsured. Increases in the quality of care and decreases in total cost for both the public and private sector are less of a certainty, however. The regulation creates Affordable Care Organizations ("ACO") and the Patient-Centered Research Trust Institute ("PCRTI") in an effort to increase quality of care while decreasing costs. ACOs are hospital and physician organizations that will receive part of its reimbursement based on the quality of care that it gives. PCRTI will develop a list of best practices and treatments for various conditions in an effort to increase effectiveness of treatment and eliminate the costs of poor health related to performance of procedures that are not necessary. It remains to be seen if these will be effective at increasing quality of care and controlling costs.

As a reminder, many people, including me, believe that health care costs are one of the major issues in the US today. I can remember when health care was 11% of the US Gross Domestic Product and 13% of the Federal budget. It is now 17% of our economy and 24% of the

Federal budget, and rising quality. For decades small employers have been dropping coverage because they cannot afford the large increases in premiums.

So what will happen as a result of health care reform? In the words of Max Klinger: "I don't know. If I had all the answers I'd run for God." However, since this column is *The World According to Jeff*, I will take a stab at it.

1. Problems with deadlines will cause the Exchanges to have limited enrollment on January 1, 2014 and, therefore, limited affect on the number of uninsured. Nothing released by HHS indicates this but I think some Exchanges will be allowed to have special enrollment periods during 2014 when Exchanges are fully functional.

2. The regulation will do little in the short term to control Medicaid and Medicare spending. As a result these items will continue to be a budget issue through the next presidential election in 2016. Somewhat random cuts will be made to Medicaid and Medicare in the budget that will, directly or indirectly, reduce payments to providers and increase consumer payments through either higher copays or higher premiums. Effects of health care reform on cost may start to be felt in later years. The impact may be about 5% for services affected by the ACO quality payments. The impact of the research from the PCRTI is totally dependent on the type of research that is actually done by the Institute and what is done with this research.

3. 2014 premium rates for the Individual Exchange that will be submitted by the insurance companies to the state insurance departments for approval will be higher than the federal and state governments are hoping, setting up intense negotiations between the government entity responsible for approving the rates and the issuers.

4. The premium subsidy for the low-income will fade over time as premiums will increase faster than incomes and general CPI. Contributions for those with premium subsidies include the excess of any premium increase over the average increase in US income and general CPI. Insurers do not have a huge incentive to keep premiums down but they do have incentive to deep premiums high enough in this dynamic environment so as to not lose money. Again, an example of how the subsidy works appears in a prior article. In 2017 a reinsurance subsidy to the insurance companies goes away causing them to increase premiums an additional 5% to 8% over 2014 rate levels, that is in addition to normal trend.

5. Republicans and Democrats will fail to agree to any meaningful health care reform between now and 2017, instead sticking to party lines and doing little to control total health care expenditures. Health care will increase to over 18% of GDP by 2017, getting closer to the 20% threshold thought by many in the 1990s to be the magical level at which a major crisis in the US would be so serious it would require major, immediate reform. Not many still adhere to this but there are many of us who consider this to be a crisis even at slightly over 17% of GDP.

6. Health care will be the main issue in the 2016 presidential campaign with the worst possible scenario being a split Congress/Presidency again, leading to nothing meaningful being done.

OK, so that is *The World According to Jeff*. If you have any thoughts or questions please feel free to email me at jeff.adams@health-actuary.com.

Patient-Centered Outcomes Research Institute

By Jeff Adams ***February 19, 2013***

Articles posted on this website have often commented on the need for a reduction in health care costs, both for the financial integrity of the government and for affordability of private health care coverage. One provision in the Patient Protection and Affordable Care Act of 2010 ("ACA") which has promise in helping to control health care costs is the provision establishing the Patient-Centered Outcomes Research Institute ("PCORI"). This institute is a private, non-profit corporation that performs research on comparative outcomes and clinical effectiveness of medical treatments in an effort to provide comparative information to assist patients, clinicians, purchasers, and policy-makers in making informed health care decisions.

PCORI has a 21-member Board of Governors with members from a cross-section of the health care system. Almost half of the Board members are physicians. Other members include consumer advocates, nurses and other providers, payor representatives such as from health insurers, and pharmaceutical, device, or diagnostic manufacturer representatives. ACA also requires Board members to include the Director of the Agency for Healthcare Research and Quality ("AHRQ") and the Director of the National Institute of Health, or their designees. Having such a small proportion of the Board from payors is designed to ensure that results are used to increase quality of care and efficiency and not used predominantly to minimize costs. Members of the Board of Governors and the Methodology Committee, described below, are appointed by the U.S. Government Accountability Office.

A 17-member Methodology Committee has also been established. The committee works to define methodological standards for research. The committee also develops and regularly updates a translation table to guide health care stakeholders towards the best methods for patient-centered outcomes research. More complete descriptions of the Board of Governors and Methodology Committee are available on the PCORI website, PCORI.org.

PCORI is funded by the PCORI Trust Fund. The Fund receives money on a per capita basis from payors based on Medicare, private insurers, and self-insured enrollment. The fee for payors is $1 per capita in 2013 and increasing each year through 2019 by the percent increase in National Health Expenditures. Federal government appropriations are also included in the Fund beginning with $10M in 2010 and increasing to $150M for 2012 through 2019.

Funds from the Trust Fund are used to provide grants for independent comparative studies of health care treatments. The PCORI website indicated on February 19, 2013 that $40.7M in grants had been provided in the past three years. These grants have been given for studies such as a Massachusetts study analyzing the benefits of a collaboration of a hospital and a Patient-Centered Medical Home within an Accountable Care Organization. Other studies analyze treatments for diabetes and depression.

The Office of Communication and Knowledge Transfer of AHRQ is required to broadly communicate the results of the studies sponsored by PCORI. PCORI cannot mandate

reimbursement or benefits based on the information received from the studies. Medicare also cannot determine payments or benefits based solely on these studies. Instead, these studies are designed to be just another tool that will be available for patients, clinicians, purchasers, and policy-makers to help determine the best treatment plans.

Like many elements of ACA, the actual impact of PCORI will not be known for a few years. It will take years to complete the few studies already receiving funded by PCORI grants. Future grants will continue to provide information that can be used to help stakeholders determine the most appropriate treatment protocol in order to increase quality of care and efficiency. Like other proposals to improve our health care delivery system, this is not a Silver Bullet, just another tool to help in getting us where we would like to go in modifying our health care system. Depending on its effectiveness, a very rough guess is that PCORI could save 5% to 15% in a mature state.

Subsidized Premiums for Exchanges in 2014
By Jeff Adams

As part of the ACA, health insurance exchanges will offer health policies to individuals. There will be subsidies available to these individuals if their household income is less than 400% of the Federal Poverty Level ("FPL") and they do not qualify for health care coverage through another source. Persons will either need to have some form of health care coverage (employer-based, government, individual, etc.) or pay a penalty. The purpose of this narrative is to describe the government premium subsidy for individuals with incomes less than 400% of FPL.

Persons with household income between 100% and 400% of FPL eligible for coverage through the Exchange may get a subsidy on premium payment to coverage through their regional exchange. In order to get this subsidy these persons must not be eligible for coverage through any other source (employer-based, government coverage, coverage through a family member, etc.) .

The FPL is set by the federal government and is based on the number of persons in the household. There is an FPL for the continental United States, an FPL for Alaska, and an FPL for Hawaii. For example, in 2014 the FPL for states other than Alaska and Hawaii may be $11,450 for the first individual and $4,000 for each additional household member. That would mean the FPL for a three-person household in 2014 would be $19,450 ($11,450 + 2 x $4,000). A three-person household that submits an income tax filing totaling $58,350 would have Income as a Percent of FPL of 300% ($58,350 / $19,450 x 100%).

Once income as a % of FPL has been calculated, the following table will be used to determine the % of the household income that the household will have to pay for the Benchmark plan set of benefits, which will be described later:

Income as % of FPL	**Contribution as % of Income**

100%	2.0%
133%	3.0%
150%	4.0%
200%	6.3%
250%	8.0%
300%	9.5%
400%	9.5%

As an example, the three-person household would be able to purchase a Benchmark set of benefits in 2014 for $5,543.25 ($58,350 times 9.5%) since the household income is 300% of FPL. If the income as % of FPL does not appear in the table above then the contribution % would be a linear interpolation of the values in the table (275% would result in contributions as a % of income of 8.75%).

The Benchmark set of benefits to which a policyholder would be entitled for the contribution described above would vary by exchange but would be the second least expensive Silver plan offered in the appropriate regional exchange. The ACA dictates that a Silver plan must pay for approximately 70% of eligible expenses. Eligible expenses are defined by the Federal government and are called Essential Health Benefits. A sample of what a Silver plan might look like is a $3,000 deductible, 30% policyholder copay, and a $6,250 out-of-pocket maximum.

Additionally, households eligible for the subsidy whose income are less than 250% of FPL are entitled to benefit plans richer than the Benchmark plan described above. Specifically, the regulation describes these increases through the use of the Actuarial Value table below:

Range of Income as % of FPL		**Actuarial**
Minimum	**Maximum**	**Value**
100%	149.9%	94%
150%	199.9%	87%
200%	249.9%	73%

250%	400%	70%

As an example, a household with income at 150% of FPL would be entitled to a benefit plan which paid approximately 94% of eligible charges if they were to contribute 4.0% of their household income.

After 2014 and through 2018, policyholders will be responsible for the contributions calculated via the formula above but will also be responsible for the difference between the % increase in premiums for the Benchmark plan for each of those years and the % increase in a national income index for that particular year. Thus, the policyholder will have to pay additional amounts if health care costs increase more than national average incomes in 2015 through 2018. Similarly, after 2018 policyholders will need to pay any increases in health care costs greater than the general United States Consumer Price Index increases. These possible additional policyholder contributions give added importance to implementing controls to restrain out-of-control health care cost increases in future years.

A publicly available subsidy calculator has been published by the Kaiser Foundation and can be found at:

http://healthreform.kff.org/Subsidycalculator.aspx

Adams Actuarial LLC also has a more detailed subsidy calculator. If you have any questions or comments please feel to contact Adams Actuarial LLC.