**Replacing the Affordable Care Act**

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**Overview**

This updates a 2012 article published in the *Actuarial Review* (the magazine of the Casualty Actuarial Society) suggesting that the Affordable Care Act (ACA) needs to be repealed and replaced rather than fine-tuned. One of its architects revealed that ACA’s flaws were so great that subterfuge was used to sell it to the American public. What’s more, the Supreme Court found the ACA insurance purchasing “mandate” to fail constitutional standards. It did allow ACA to continue for a time using the mild threat of a tax on young people if they don’t volunteer to buy overpriced insurance coverage to help subsidize older and less healthy citizens.

ACA’s proponents have argued that, despite conceding its shortcomings, ACA may be the only alternative to a supposedly failed former system of health insurance in the U.S. This paper will outline a way to improve the old system without ACA’s drawbacks, e.g. forcing some insureds to buy overpriced coverage in order to subsidize others. This new plan can achieve virtually all of the goals of the original ACA to provide guaranteed access to healthcare insurance and to try to bend the cost curve down while providing needed subsidies to some who have affordability problems.

The replacement plan outlined herein actually draws upon time-tested measures in other lines of insurance. It relies on a state-by-state regulated but still competitive market to offer a long-term sustainable system.

**Fundamental Reasons Why the ACA is Not the Real Solution**

First of all, the ACA did not deal adequately with why medical costs were so high and growing fast (see next section). It also tried to impose a single solution to why the uninsured population was large (following section). Lastly it used the mantle of overriding federal rules and mandates to impose on what ought to be an inherently competitive insurance market. Overpricing some insureds to subsidize others creates lack of transparency and ultimately a failure in the free market. A 2,600-page law that even those who voted for it never read, plus 10,000 pages of regulations, is not the way to handle one sixth of the American economy.

The mispricing and subsidy game was tried in Massachusetts auto insurance in the late 1970s and ultimately abandoned by the Massachusetts legislature to return to a system that has worked for decades in other states. Redistributing costs among insurance companies to try to even out the non-actuarial pricing of insureds is not a good role for government. Similar auto insurance experiments had been tried elsewhere beyond Massachusetts (e.g. New Jersey and Michigan), and also abandoned.

Even ACA’s attempt to pay for pre-existing conditions (PEC) was flawed in that the total subsidy anticipated was kept hidden from the public, if it was even calculated. Perhaps it was a leap of faith that overcharging young people and overcharging healthy people could be a sustainable strategy to pay for a major new goal of paying fully for PEC.

**Why Are Medical Costs High and Growing Fast?**

A. Demand is great and growing

 • Everyone wants maximum healthcare – what’s more important than your health and your life?

 • U.S. population is aging and older people need more healthcare.

 • Doctors are motivated to do all they can, with more techniques available and a threat of being sued.

 • Increased affluence allows more inclination to spend on the crucial service of healthcare.

 • Lifestyles today are often not so conducive to good health (little exercise, obesity, alcohol, drugs).

 • Knowledge/awareness programs promote more usage.

B. Supply is not unlimited

 • New technologies are very expensive.

 • Training new doctors is time consuming and expensive.

 • Many uninsureds just use emergency rooms in a crisis, which is more expensive than alternatives, and unrecompensed costs are passed along to others by the hospitals.

 • Medicare fee controls discourage new entrants.

C. Usual price mechanisms to deal with demand/supply issues are not being applied

* Someone else usually pays the bill – the insurer hired by your employer or the government - so customers have little ability or incentive to shop for value.
* Workplace insurance tax deductibility pushes routine procedures into insurance premiums versus allowing large deductibles to keep customer involved in price decisions.

 • Not all the expensive procedures are equally valuable; shopping for value is not very common.

* There is a complex trade-off between early sure costs of annual checkups and expensive diagnostics versus treating more advanced problems later.

D. The tort system creates special problems on costs

 • Defensive medicine to reduce the risk of tort claims is a wasteful add-on to overall costs.

* Medical malpractice liability insurance for some specialties can far exceed $100,000 a year in premiums, driving up doctor and hospital bills.

 • These extra costs often deter practicing in some specialties (e.g. obstetrics) and in some locales.

**Uninsured Population Is Large (But Not Uniform)**

There are at least four very different categories of uninsured:

* Higher Cost/Hard to Price – including those with pre-existing conditions or other life-style problems that could lead to much more need for treatment in the future.
* Rejecting Insurance as Not Worth the Price – The young have other needs to pay for and think their risk is low; the wealthy can self-insure and use other preventive methods to keep real costs down.

 • Chronically Ill and/or Poor – including the homeless.

 • Non-Citizens – in the shadow economy.

Even these four broad categories can be divided further so that the answer can vary greatly from the one-size-fits all solution adopted by ACA which says that everyone must buy a government-specified policy.

**Basic Goals of a New System**

In a new heath insurance system, these are the goals to achieve:

 • Lower overall healthcare costs

 • Offer coverage to those who can’t get health insurance today at a reasonably affordable price

 • Maintain the benefits of a competitive market system -- lower cost, more innovation, increased supply of needed practitioners and more insurers that compete for business by offering low profit margin policies.

Subsidiary goals include:

 • Keep your current coverage if changing employers or even being unemployed for a time

 • Handle the problem of pre-existing conditions

 • Use incentives rather than mandates

 • Recognize that insurance is not a universal solution to all healthcare access problems.

**General Principles and Features of the Solution**

A replacement insurance system, one based on sound insurance principles, can help solve a number of the overall cost and availability problems. Avoid the controversial ACA approach of overpricing insurance for some to subsidize underpriced coverage for others. Also do not hide the true insurance cost in some “community rating” system that ignores relevant information that can identify where cost controls are better than just paying total claims.

Before crafting a solution for more insurance availability, it is important to follow some principles that can ensure a lasting system and that don’t create a new crisis because of unintended consequences:

1. Free market works better:

 a. Avoid government control as much as possible

 b. Don’t require heavy oversight for the system to work

 c. Use private sector efficiencies and innovation

d. Competition keeps prices down.

2. Avoid price controls on Healthcare suppliers and Insurers who offer coverage.

3. Eliminate workplace special tax advantage

 a. Experiment of exclusive tax-advantaged employer-supplied health insurance is outmoded

 b. Level the tax playing field to allow portable, individual policies to flourish.

4. Discourage overutilization

 a. Current system encourages non-crucial usage as “somebody else is paying for it”

 b. Higher deductibles make insureds more involved in service selection and evaluation.

5. Minimize new federal laws, if possible.

6. Model market assistance after successful state plans in auto and homeowners insurance:

 a. Assigned risk plans for hard to quantify risks and hard to place coverage

 b. Catastrophe plans for preexisting conditions.

7. Use premium support - like food stamps (but fixed for bureaucracy).

8. Customize solution by type of uninsured.

9. Encourage tort reform

 a. Several states already do it well

 b. No federal mandate

 c. Use Medicaid block grant extra funds as incentives.

**Solution Using These Principles**

**1. The Free Market Works – Use It**

Any sustainable solution must abandon the notion of intrusive front-end heavy government control that thwarts the efficiency of the competitive market. Successful state programs can be encouraged in other states, but not mandated. The flexibility of Medicaid dollars collected by the federal government can be used as extra block grants to stimulate states to do the right thing.

Another solution is to encourage a low cost policy in every state that would be popular for young people – namely a very high deductible catastrophe type policy. This might only cost $300 or $400 a year, and only kick in for very serious accidents or illnesses. This way hospitals would not be stuck for large bills when a heretofore young “invincible” shows up after a serious accident.

In general, high deductible health insurance policies, such as in Health Savings Accounts (HSAs), promoted in 2003 Federal legislation, were a good idea that may have been discouraged in the ACA.

Having consumers responsible for first dollar spending by year is a good strategy in keeping some costs down. The incentive is that HSA owners can roll over the long-term residual savings into an IRA if they are quite judicious in their overall approach to medical spending.

It is recognized that some health planners decry the absence of promoted annual spending on preventive medicine. However, it is possible to structure even high deductible policies to allow some low cost procedures that have demonstrated prevention qualities.

**2. Price Controls Don’t Work**

Whenever there have been heavy government price controls (either federal, state or local), the supply of products and services drops and innovations cease. Government tries to make decisions it is ill equipped to make, under the mistaken impression that all customers want is the lowest possible price, or sometimes the broadest coverage, without regard to quality or availability.

The mandates, or now taxes, in ACA, for example, would not really have worked in the marketplace, as young, low-cost insureds would not likely accept the overpriced product that its advocates desire.

One option is to pay the tax and self-insure. When, or if, an expensive hospital procedure looms in the near future, they may trust that they can opt in to an insurer that is not allowed to use a pre-existing condition to deny coverage.

Another way is for them to simply gravitate to much lower-priced insurers who don’t have a lot of high-cost and underpriced insureds that need this hidden subsidy. Those lower cost insurers may market selectively via the Internet and will usually not be very visible to the higher-cost insureds such as those with risky conditions or prior illnesses. So the hidden subsidies would not likely have been achieved to try to heavily subsidize the older and less healthy population.

Also trying to require a common coverage that government deems to be the desired product usually means many insureds overpay for some coverages that they don’t want or need.

**State Regulation in a Competitive Market -** The current auto insurance systems in place in most states uses a combined regulatory/competitive market system that could be emulated for health insurance, yet it does not have to impose real price controls in an adverse sense. The origin of state regulation of insurance is as follows.

Public Law 15 (the McCarran-Ferguson Act of 1945) allowed states to regulate insurance prices to enable some collective features (exempt from the Sherman Antitrust Act) in order to encourage competition from smaller insurers who benefit from information published on all insurance. States can regulate rates by monitoring competitive market results or reviewing the rates before they are put in place. States also monitor the financial condition of insurers licensed in their state as insurance is considered a complex and fiduciary product service, which would benefit from regulatory oversight and evaluation.

After the fact rate regulation works well because the regulators have in place overall profitability measurement by line of insurance and state. If an insurer were earning much higher profits in a state, that regulator could do an expedited full examination of that insurer (most insurers are examined on a regular rotating basis with detailed on site scrutiny). Interim audits are also occasionally done if there is suspicion of unusual activity. If rates were subsequently determined to be excessive, there could even be an order to return premium to insureds. Property/casualty insurance by state is subject to a very high measure much regulatory scrutiny on a routine basis, way more than most products in the U.S. – with very penetrating scrutiny powers, recalling the goal also of regulation to prevent insolvency where by an insurer’s conduct results in not being able to fulfill the future promises from taking the premium in advance of the contract being competed ( a promise to pay in the future for transferring the risk of the insured to the insurer).

Selling freely across state lines is a measure already proposed by some to replace the ACA, but state regulators would be quick to point out that their state insolvency funds would not be available to pay the claims of an insolvent unlicensed insurer. This is true already in the excess and surplus lines market today for complex coverages not readily available in a state. Also, if the solutions espoused in this article were adopted, there would be less need for out-of state access. However, some version of out of state access might be an incentive for individual state legislatures to be more reasonable in allowing innovation. Such a federal law would need to be enacted to change Public Law 15 in place since 1945.

**3. Level the Tax Playing Field: Workplace Versus Individual Policies**

Employer-based health insurance expanded during World War II when wage controls spawned tax deductibility to attract workers by this added benefit. Now the model of working for the same company one’s whole career is an anachronism. Furthermore, health issues may be an impediment to a person even getting a new job if it is viewed as raising the cost of the employer-supplied health plan.

Clearly employer-supplied health insurance should not have exclusive tax deductibility. One solution is to add tax deductibility for individual policies. Individual deductions mostly affect those who are in higher tax brackets using itemized tax returns. Lower economic bracket consumers would have to be handled with some assumptions on insurance purchased and expanded standard deductions. For example, give a higher standard deductible for those who actually purchase a health insurance policy. This would allow individual policies to better compete with group policies. This would also promote many more insurers to compete in market place versus the handful now doing group policies.

Yet tax deductibility still has some perverse incentive to cover trivial medical procedures because of the “35% discount” from corporate tax liability. By lowering overall tax rates and eliminating so called “tax deductions”, it would encourage higher deductible policies and have insureds with more of a stake in the outcome on smaller losses. This avoids the “somebody else is paying for it” syndrome that insulates the consumers from deciding whether each medical procedure is worth it.

Another solution would be to limit the tax deductibility to only the portion of coverage that is basic insurance, i.e., very high deductible coverage.

Employer-supplied coverage is also very limited as to portability. The three-year window of COBRA benefits (mandated by The Consolidated Omnibus Budget Reconciliation Act of 1985) is not even a solution if the employer goes bankrupt or withdraws from the market.

Individual insurance policies (like those in auto and homeowners insurance) have a huge advantage in solving problems of limited consumer choice and isolation from key procedure selection. Individual policies are inherently portable and even can carry guaranteed renewability in the future. If someone develops a subsequent condition after initial underwriting, that can be priced for in the original policy so no extra premium is warranted at renewal. Larger deductibles mean more cost control by insureds paying small bills directly and restoring the buyer/supplier perspective.

For auto insurance, the existence of vigorous competition among auto insurers by state (usually some 100 licensed carriers by state) has produced less than a 4% average overall gross profit margin before tax over the past few decades. This reflects all sources of profit including interest on the prepaid premiums.

Also, have you ever tried to fire your group insurer for poor service? There aren’t very many of them and it is a major upheaval to replace one for the whole sponsoring organization.

**4. Curtail Overutilization**

With more traditional individual policy insurance, higher deductibles, co-pays and coinsurance can usually deal better with the problem of overutilization. Costs tend to be higher when the patient is insulated from payment participation decisions and the costs are paid by somebody else - the employer’s insurer or the government. The latter is also where fraud is a greater potential, because the profit motive is not present.

**HSAs Work Well -** Health Savings Accounts were invented and authorized some ten years ago partially as a means to combat overutilization. With high annual deductibles (e.g $3,000 or so), an insured would be incented to be judicious in having small procedures covered that were not very helpful in maintaining health, as they would be self funded out of an IRA like account established in a back for small claims. The unused portion of those annual bank account infusions would be carried over to the next year for use. In fact, at the end of the HSA period when an insured entered Medicare coverage, all such unused HS funds would convert to an IRA account for use on any expenses needed in retirement, not just medical expenses.

This has vast potential to have the insureds scrutinize more closely their small medical bills during their adult life. No longer would they listen to a medical provider’s billing department saying “What do you care what this procedure costs? You’re not paying for it; your insurer is.”

**5. Minimize Federal Laws If Possible**

Federal mandates are often questionable under the U.S. Constitution. Section 8 of Article I of the Constitution lists the enumerated powers of the federal government. The Tenth Amendment specifies that those powers not so delegated be left to the states or to the people. It’s hard to imagine how mandating health insurance falls under regulating Interstate Commerce. The recent Supreme Court ruling may well have sealed that question off. Similarly federal tort form, however well meaning might be its proposers to save on costs, would hardly fall under regulating interstate commerce.

Taxing powers to provide for the general welfare might leave an opening, which apparently was used in that recent Supreme Court decision. So mandates by federal law are apparently off the table, no matter what the noble goal of federal power espousers.

The most obvious tax change would be to level the playing field for health insurance premium deductions that has been a monopoly for employer-supplied health coverage versus individual policies since the 1940s.

Another desired change is to discourage individual state legislatures from imposing price controls on rating variables for health insurance. This would allow young people to pay their true cost for health coverage at perhaps 15% or 20% of the cost for a 45 year old. Allowing young working adults to also use an HSA may even drop their annual premiums to less than $300.

However, mandating those changes is similarly off the table. Persuasion is the better option, perhaps with higher amounts of Medicaid block grants back to a state that does it. And do the same for meaningful tort reform that is likely to lower the premiums for health coverage that less advantaged citizens (and indeed all citizens) would pay for.

**6. Copy Successes from Auto Insurance Programs**

For risks hard-to-place because of uncertainties and a higher expected loss, but not a catastrophic one, an assigned risk plan like in auto insurance works well. Each of these unplaced risks goes into a system that assigns them randomly to voluntary carriers for that coverage in each state. The assigned carrier collects the right premium for the assessed risk and investigates and pays the claims under the policy.

For all such assigned risks for that insurer, if the premiums collected in total are insufficient, that insurer is entitled to pass the expected loss onto its voluntary insureds in future premiums if it is likely the shortfall will continue in the future. Other voluntary insurers are free to do the same, so losses (translate subsidies”) on the assigned business will not disadvantage insurers competitively.

Auto insurance generally works well this way, as the subsidy (maybe an underpricing of say 20% on the 5% or 10% of the population that needs an assigned risk plan translates to only about a 1% or 2% rise in voluntary market rates to pay for the needs of the assigned risks, and the small surcharge falls rather uniformly on all voluntary insurers and voluntary insureds.

This contemplates that the assigned risk rates are higher than the voluntary rates. States that tried to make the assigned risk rates the same as the best voluntary rates have failed in that utopian dream to prevent the use of underwriting judgment and mandate that private insurers cover everyone who applies.

The above system works well to cover those hard to place risks that are not very catastrophic. For the latter, such as some with pre-existing conditions, some premium support may be utilized to make the insurance more affordable.

**7. Use Premium Support (Not Price Controls) to Solve Affordability Problems**

Other needs in life do not require massive federal government intrusions and price controls in the market place. Periodic government attempts to provide affordable shelter (e.g. housing projects and rent controls) have usually resulted in failures. Milk programs similarly contain a lot of waste and bureaucracy with little real success.

Food stamps, on the other hand, have been a partial aid to affordability without the government trying to control prices. Price controls invariably lead to supply problems (shortages) when competitive markets are short-circuited. Food stamps in theory only go to those who need them without price controls on suppliers.

**Insurance Premium Support**

Similar to the concept offood stamps**,** health insurance overt subsidies could be used as a partial solution to affordability problems for health insurance without intrusive price controls on service providers. (There are several other ways to provide premium support for preexisting conditions which are detailed in the Customized Solutions section below.)

Insurance overt subsidies could be used for those who couldn’t even afford the assigned risk plan rates, but also and especially for pre-existing condition policies offered by specialty insurers, such as for diabetes conditions. The latter might cost two or three times what a non-diabetes policy would. With an overt subsidy, an insured who qualifies might get a substantial amount of the excess premium in support. A more affluent insured who could afford the PEC policy would not get support. This differs from the ACA approach where all PEC insureds get the subsidy even those who don’t need it.

If insurance subsidies are used, this analog to food stamps must correct for abuses of that latter program where the number of recipients has doubled in the last ten years. Government bureaucracy in that program has led to expanded amounts of fraud by those attempting to qualify, with poor incentives to remove the unqualifieds.

One answer may be to outsource management of the program to the private sector, possibly varying by state. Another would be to have the assigned risk insurer to apply to a state agency instead of individuals requesting checks to offset higher premiums. Those subsidy checks tend to keep coming long after the need exists.

The current ACA “solution” to subsidies is clearly the wrong way to approach it. Hiding the extra costs in overpriced coverage to young people and making healthy insureds overpay to cover preexisting conditions which can’t be quantified simply buries the true costs. The result is that society can’t evaluate how much the benefit really costs. With no estimates of the subsidy costs, there is no way to do it partially; ACA appears to be an all or nothing proposition.

Better to have the subsidies transparent. If we can’t afford the full subsidy of preexisting conditions, for example, we can at least decide to cover 75% of them, for example. Bear in mind that this goal is a very generous one, rarely used successfully before on a perceived needed staple.

Auto insurance by state with financial responsibility laws has been a success in offering subsidies via assigned risk plans by state to provide a basic coverage to owners of cars. Some states may even want to try financial responsibility laws for health insurance to make sure people don’t show up in a hospital emergency room with uncovered medical costs that are foisted on the rest of society.

**8. Customize Solutions by Type of Uninsured**

“One size fits all” solutions mostly don’t work. There are many reasons people do not have health insurance today. It is useful to analyze why and craft solutions for each of those major segments. Do not try to solve the whole problem en masse.

**Temporarily Unemployed**

After a short-term continuation of a policy at a high price, the newly unemployed have to shop around for an individual policy in a market that has essentially shriveled because the group health market dominates with the tax deductibility of employer-based plans.

If most policies in the future were individual ones, like in auto or homeowners insurance, then a temporary period of unemployment would not be a problem, as the individual policy would simply continue in force. The premium payment might be under stress, but no more than other major expenditures that must be made without a job to fund them. Food and shelter have to be continued. The use of premium support could be extended to this group as well, depending on how much is left from Medicaid block grants.

The existence of individual policies may actually help in the unemployed getting a new job. When health insurance is automatically provided upon employment, then someone with a higher risk or a pre-existing condition may be shunned by a prospective employer for fear of driving up the group health policy’s annual costs.

**Long Term Unemployed**

These likely fall under the Medicaid block grant solution, as they probably never had a group insurance policy, and couldn’t afford an individual policy either.

**Young and Voluntarily Uninsured**

Allocating resources likely drives the choice for these “invincibles”. If not already covered at a large employer, they view health insurance as an option they choose to defer for now, as they are making much less in the early stages of any career, and may prefer other spending options to health insurance.

With a vigorous and full competitive individual policy market, the much lower expected losses for a young adult’s health insurance mean much lower premiums. In contrast to ACA, no one is making them pay a huge subsidy to be with an insurer that is limited in fully recognizing age as a rating criterion. (There should be no forced “community” rating under this new proposed system. It must allow a robust set of risk assessment criteria.)

Some young people may still defer getting an individual health policy, even one with guaranteed renewability and low cost catastrophe coverage. That’s their choice. If they get sick, they will pay for medical services at the point of delivery – at doctor’s offices or emergency rooms. A credit card could well be required before admission.

If a state is concerned that still too many people show up at a hospital demanding “free” health care, an alternative might be to enact mandatory financial responsibility (FR) for its citizens. A state could even legally “mandate” such a concept, even though the federal government cannot. States already mandate FR to car owners before allowing drivers on the highways that might do damage to others. FR can be established by proof of assets or else with a basic liability insurance policy. Car license plate applications help to enforce this by at least asking for FR proof. The result is about 80% to 85% compliance in the U.S.

States could similarly ask for FR proof of all (except for Medicare and Medicaid recipients). This is especially doable for young “invincibles” by using applications for credit cards from banks to require evidence of a catastrophe policy as security for paying back debt. Banks can now even sell such health insurance policies to customers and charge the premium in monthly installments. (Gramm-Leach-Bliley repealed the Glass-Steagall Act of 1933 which heretofore banned banks selling insurance.)

**Wealthy and Self-insured**

Similarly, the well off would not be required to buy a health policy, as they already qualify for FR. Moreover, a much larger individual policy health insurance market could well spur policy options that may appeal to this group – with much higher deductibles – essentially a catastrophe policy, with a continuation of the health savings accounts (HSAs).

**Hard-to-Price** **Risks**

 These are the prime market targets for the new assigned risk plan (ARP). They may have to pay a surcharge over standard policies, but after a few years in an ARP they may provide enough information to return to the regular voluntary market. Before entering the ARP auction, however, a market placement facility may try to find a non-standard insurer that would issue a policy. If so, the insured would then apply for premium support via insurance stamps if affordability were the issue.

**Premiums Unaffordable**

Today this would apply of many who are not covered at work. Like the young who opt out, this group might benefit from new catastrophe policies that are low cost, but don’t cover regular doctor visits. State or local health clinics would benefit this group. Assigned risk plans would not help this group because those premiums are higher than basic policies which they cannot afford.

**Pre-Existing Conditions (PEC)**

An individual policy excluding that condition is presumably easy to obtain. Then a separate policy is envisioned for pooling with other high-risk insurance conditions to be written by specialty carriers in that field at a much higher premium than the regular market. It is still insurance because a pre-existing condition doesn’t usually mean automatic medical bills, just a much higher likelihood. Don’t mix such policies with standard policies because it would raise the premium for everyone else.

For a high-rated PEC policy, the insured can apply for premium support (e.g. insurance stamps). The insurer should not have to subsidize those risks by charging less than the actuarially sound price for assuming the risk. Some of the extra premium may come from a state general revenue source such as a block grant from Medicaid. If the extra-condition is solved by new drugs or new procedures, then that insured could well return to the full standard market for all his health insurance needs.

If a subsequent illness is not clear as to the source, then the regular policy provider and the pre-existing condition policy provider or pool will need to collaborate who is primary on the claim, just as flood and wind insurers do when a hurricane produces storm surge and wind damage both.

For catastrophic type risks, e.g. those with a pre-existing condition that make extraordinarily high future health costs likely, a separate involuntary market mechanism may be needed, similar to a catastrophe wind pool on homeowners insurance. In states with a very high coastal wind exposure to hurricane, there are usually state wind pools to write that coverage alone, so that the voluntary market writes the more vanilla ex-wind coverage.

**The Pool Approach**

The most straightforward solution is to form a pool in each state to cover the preexisting conditions (PEC). The overall results of the pool would be much worse than the non-PEC policies but subsidies from bloc grants of part of Medicaid funds could reduce the amounts, perhaps even supplemented by state sourced subsidies. The net costs would then be charged to each person applying for the PEC coverage. There could be a risk-rating plan on top to reflect lesser PEC conditions allowing for discounts for lower risk presented to the pool. There could even be a means test to further forgive the higher rates for those with lower income situations.

If greater funds are needed to cover the PECs, then higher deductibles can also be imposed, with a similar sensitivity to the users ability to pay total retained costs.

In this system the total subsidy would be calculated on what the state could afford. The resulting system would not be a bottomless pit with no awareness of the financial commitment. This is in contrast to the ACA where the subsidy amounts are not tracked and which fall unevenly on portions of the insured public. Young people are substantially overcharged and healthy older adults are similarly overcharged to pay for the expensive preexisting conditions as well as other generous extra coverages not needed by the public.

**Individual PEC Pricing Approach**

Another method analogous to auto insurance is to allow the competitive market to actually price individual PECs to focus on separate risks by type of PEC. For example, there might be several specialty insurers measuring diabetes coverage. They would innovate on rating plans that focused on ways to reduce the risk for those with diabetes, based on specialized research. This goes to the purpose of reducing risk not just financing it. Similarly individual insurance stamps could be available based on the actual insured’s ability to pay. Research would then be spurred on how the risk can be reduced, and the insured would be incented to change behavior to reduce his premium.

Again the total amount of subsidy funds would be specified in advance, so that the final financial burden of individual insureds could vary on how much Medicaid block grants were given back to the states.

This latter method of covering PEC via individual rating plan from a specific specialized insurer has the advantage of the insurer’s close attention to the collection of premium accurately and fair payment of claims. The large pool approach has been tried in the past and generally less attention is paid to the fair adjudication of premium payment and claim settlement, so the results tend to be overspending.

**Assigned Risk Approach**

Another way would be to merely assign PEC policies to licensed insurers in a state on a stratified random basis. The assignment would consider the nature of the PEC. A modest PEC, such as prior knee injury which likely needs future correction could be assigned to any insurer. A more serious PEC such as type I diabetes, with perhaps triple the expected loss each year compared to a conventional risk should be carefully apportioned so that one insurer does not get a disproportionate number of these.

The assigned risk insurer might first apply to the state for premium support on these policies to defray its overall claim costs. Then its overall loss on all assigned risks might be reduced to a more manageable 3% to 5% as a percentage of all claim costs. It would then be able to pass this surcharge on to its voluntary insured population uniformly. The goal is that every insurer would have an equal amount of such surcharge so no private insurer would be disadvantaged. Furthermore the public would not likely object to paying a small amount extra (say 3% or even 5%) to subsidize those less healthy.

If the surcharge got to be more than nominal, and if it fell unevenly on different insurers, then problems arise. The state assigned risk plan managers could redistribute some of the inequity among insurers via using year-end dividends and assessments.

The other advantage of the Total Assigned risk approach is that the entire policy for such an insured would be assigned, not just the preexisting condition portion. This lessens the need to coordinate between two insurers as to who is primary on the medical procedure reimbursement.

The advantage of the individual PEC policy approach is that specialty insurers could concentrate on risk control methods by investigating ways to ameliorate the risk long term, and encourage insureds to pursue those remedies. By dissipating the PECs over many insurers, less research is motivated on the particular PEC.

**Chronically Ill**

These persons who are already sick do not have traditional insurance today because medical expenses are not fortuitous but certain. Medicaid support is no doubt the source of available funds today and in any new system. No insurance system can handle this type of risk because their claims are not a risk but a certainty.

**Indigent and/or Homeless**

This population is theoretically already covered by Medicaid today, and may have to continue that method, supplemented by more available community clinics, perhaps funded by charities. This is a difficult problem because their whole lifestyles are not very conducive to promoting healthy conditions. Information on prevention does not translate readily into meaningful reform of their lifestyle. Some incentive system is needed to encourage them to go to these clinics, perhaps bonus food stamps or coupons for home assistance.

**Non-Citizens**

These populations, including undocumented workers (UWs), tend not to have health insurance, unless they work for a large corporation. They tend to use emergency rooms of hospitals as their primary healthcare backstop. Student visitors from another country should carry their own policies, but like young citizens may choose to opt out as they perceive their risk is less. If a state required FR of all who live there, the enforcement rules could apply here on credit cards.

Companies often rely on UWs when there is a current scarcity of workers, without giving them workplace insurance or checking on whether they have their own health insurance. There is no reason why UWs couldn’t buy individual policies under a new health insurance system, but there would be no option use premium support from federally funded Medicaid block grant sources. The assigned risk plans might similarly be precluded from giving them access to extra-subsidized coverage. Under standard insurance policies they would have to pay deductibles and coinsurance just like other customers do.

Hospitals admitting UWs to emergency rooms can and should ask to see their insurance card or FR proof before full admission to help pay for that hospital service. Otherwise they would fall into the indigent or homeless categories to rely on charity or other government programs to handle humanitarian needs.

**9. Tort Reform to Limit Proliferation of Medical Liability Lawsuits**

The fear of lawsuits has spawned the practice of defensive medicine increasing costs by as much as 10%, without really benefiting patients. Spurious lawsuits and outrageous allegations of “pain and suffering” have caused medical malpractice liability insurance (MML) premiums to exceed $100,000 a year for some specialties. This is ironic because the quality of medicine now is so much better than it was in the 1960s when that coverage was about a cheap as auto collision insurance coverage.

MML premiums began to jump in the 1970s (ironically right after no fault auto insurance was growing rapidly, and tort lawyers may have feared the loss of revenue from 10 million auto accidents a year). In response California enacted its Medical Injury Compensation Reform Act (MICRA) in 1975, limiting non-economic loss in medical malpractice cases to $250,000 with caps on attorney fees. The result was an actual lowering of medical malpractice liability premiums per capita adjusted for inflation over 25 years: 52% lower compared to an increase in Florida (with no tort reform) of almost 300%.

Wisconsin has a $750,000 cap on general damages, and a state sponsored pool for claims excess of $1 million, where individual doctors can buy the excess coverage.

Other states have contemplated tort reform, but the presence of lawyers in state legislatures has not been conducive to many meaningful results. Not until costs are made known to the public and the deleterious effect on doctors not willing to practice in certain states will legislators begin to deal with this problem more seriously.

States can be encouraged to innovate with tort reform or adopt successful other state models by varying the amount of premium support from the federal government using block grants of Medicaid funds. Federal tort reform may be precluded in the U.S. Constitution’s failure to list that as a federal power.

**Transitioning to a New System**

A replacement health insurance system described herein would no doubt take a few years to fully implement, as it depends on the pace at which individual state legislatures take the initiative to foment an aggressive set of assigned risk plans for health insurance. The National Association of Insurance Commissioners (NAIC) and the National Conference of Insurance Legislators (NCOIL) could help with supporting and crafting model legislation, but they would no doubt wait for U.S. Congress to take action on leveling the playing field on tax deductibility of employer-based group insurance versus individual policies.

There are proposals now to make U.S. corporations more competitive by lowering tax rates and eliminating certain exemptions. Group health insurance could fall in this category. One option short of eliminating it entirely would be to only allow tax deductions for a basic very high limit policy, covering say losses above $3,000 (indexed of course). Then employers would not be incented to offer “Cadillac” policy provisions where employees are covered for small dollar claims.

Realistically, after a change in the employer advantaged status, it will take time for the more than 1,000 insurers In this country to decide to crank up a capacity to handle individual health insurance policies and to rate them using new rating criteria allowed by free market principles. Fortunately this will be on a state-by-state basis, as the federal government no longer appears to have the ability to mandate massive changes here. Also states will need to review any current price controls such as “community rating” laws so that their removal is conducive to a vigorous competitive insurer market.

There may be a need for a step up in actuarial capacity to meet that demand in the U.S. as well. Pricing of individual health insurance policies for over 100 million households has not been needed in the past, as group policies sold through employers have so far met those needs with relatively few insurers supplying the pricing and using large commercial concepts such as experience rating. Having a robust individual risk rating system, such as exists in auto insurance, would be a major expansion of the health insurance pricing challenge, especially when removing the concept of “community rating” where rating variables were not allowed by government fiat. The actuarial profession is up to that challenge.

In 2014 the ACA started mandating preexisting condition (PEC) coverage, in that a non-grandfathered plan insurer (one in existence before 2010) can’t charge extra for it or even deny coverage to someone applying with that PEC. This is a crucial distinction. New individual policy insurers will have to supply highly subsidized coverage for PEC that may risk huge losses if they don’t get their share of insureds who have to overpay to help pay for the subsidy. Will there be many or any such new insurers in 2014?

For grandfathered insurers, they may lose their status of exemption from the PEC mandate if they have reduced coverage sufficiently or raised rates too much. It is not clear who has the authority to cause the loss of such exemption. If an insurer is in danger of losing such exemption and has to risk operating losses from a disadvantaged distribution of underpaying and overpaying insureds, it may consider withdrawing from the market after 2016 when the federal redistribution of premium period is over. In ACA there is a highly complex set of rules for redistribution of costs because the price controls under ACA make for huge risk of adverse selection and therefore financial loss to a private insurer that is disadvantaged by the new rules.

What all of this means is that beginning in 2014 there will be major confusion from underpriced PEC coverage for an independent insurer that may wind up in financial trouble if the federal government fails to bail them out under the new rules.

Since the proposed solution to PEC coverage is vastly different from the contorted mess described above, those consumers who get highly subsidized coverage in 2014 and 2015 and 2016 may need to be alerted that 2017 will likely have a change for them as that is the earliest year that they might have a new system covering them. If they don’t qualify for premium support to cover the difference, they will see a big premium increase for PEC coverage. The good news is that they can more afford it as they have higher income.

For states that do not adopt a new more appropriate system of PEC coverage, they will likely revert to the old system after ACA is repealed, whereby they don’t have PEC coverage. Perhaps they should press their legislators to adopt the new PEC approach along with the other benefits of the new system.

**Winners and Losers**

The ultimate transition to this new system must run the gauntlet of those who perceive they will lose under such a change to the ACA current system and even to the prior employer based coverage system. They in fact are not without resources to lobby against these changes. The following is an estimate of where those current camps are aligned.

First are the clear winners of these major changes, and must be relied upon to withstand the rhetoric of criticism of why we should not make the transition.

**Winners**

*Consumers of healthcare* – By bending the cost curve down, and making it easy to get coverage for all American citizens, their only hesitancy will be whether they truly believe this is possible.

*Employers* – will be able to concentrate more on their core business, instead of huge problems wrestling with “mandated’ coverage that increasingly chews up more of their benefit package to attract employees. Smaller employers especially simply provide an allowance to each employee to purchase health coverage from the open market that has portability guaranteed should the employee ever leave. Furthermore the guaranteed access to coverage outside the employer would lessen the temptation to ponder if a prospective employee has a preexisting condition that would make the overall company health pool uncompetitively more expensive.

*Providers of healthcare* – overwhelming majority of hospitals and doctors – Being able to charge their true costs and being reimbursed fairly for their efforts by an expanded insurance coverage system at a lower cost will be a huge benefit. A small amount of procedures won’t be done because the consumer doesn’t think they are worth it. Many procedures that are only defensive medicine are only a distraction to them, and they can concentrate on where the real diagnosis takes them.

Hospitals especially will benefit from fewer procedures that are uncovered, especially in new FR law states, where most emergency procedures and follow-ups will likely have a catastrophe policy with high coverage limits. So having to reallocate expensive cases (e.g. $500,000 trauma cases) to regular other patients’ bills will make for more economic decisions on staffing and pricing of procedures.

*Insurance agents* of multiline casualty and property insurers bring value via access to many more insurers that provide individual policies that are portable. The large shift from employer-based coverage to individual coverage may mean that individuals need agents for advice and help in placement.

The ultimate coverage shift from group to individual insurer could also create a market even larger than the current personal auto insurance market. Health insurance premiums on average have been more than $4,000 per person, while individual cars are generally insured for $1,000 or less a year.

This added volume would in turn attract more insurers and more agents to service the market – making for even more competition and better service and lower prices.

*Casualty insurers* will pick up some of the market from group health insurers because their pricing staff is already expert in predictive modeling techniques to price small volumes of data. Life insurers similarly will want to compete, even if they have not been active in the health insurance market. There may well be some new entrants, such as hospital and doctor groups applying for an insurer license in a state.

*Individual state regulators of insurance* – will have an enhanced role in monitoring competition and the reasonableness of pricing individual health insurance. They may have to expand their staff size and expertise in this new state regulatory role of monitoring new insurers entering the field.

**Losers**

*Group health insurers* – They could easily lose half their business, as many employers will no longer feel the need to concoct complex group health plans.

*Group health insurer brokers* – Similarly huge commissions will disappear if an employer decides to just allocate a fixed financial benefit for all employees to buy outside coverage.

*Employer benefits consulting firms* – This is a mixed result. The huge travail that large employers will undergo from the ACE will disappear and so will the need for advice from consultants on how to deal with it. Conversely those same firms usually have casualty actuarial consulting practices that will benefit from providing advice on predictive modeling for the many new insurers that will jump in the very large individual policy market. Some of the health practice actuaries will also pick up projects of pricing individual polices, but the techniques are very different than for group policies.

*Plaintiff lawyer tort specialists* – If new tort reform of medical malpractice liability is introduced to many states, the contingent fees from speculative cases could shrink markedly.

*Defense lawyers for tort cases* – Their caseload would correspondingly diminish if a meaningful limit were imposed on the general damages from doctor or hospital liability cases in many more states.

**What Happens to ACA in the Interim?**

The straightforward answer is to repeal it in the same legislation or contingent on one that enables the tax equalization between employer-based health insurance coverage and individual policies.

The last resort is to suspend all future staggered features of ACA until states enact their answer to providing guaranteed access to health insurance on a more affordable basis. This should also officially remove all mandates in ACA and all subsidies to health insurers.

Any insurer in 2014 that had to accept a PEC policyholder at an underpriced rate would apply for special premium support relief from Medicaid funds for the excess charges not allowed. Parents who had post 21 year olds included on their policy could keep that coverage, as there likely was an extra premium charge allowed.

Lifetime limits removed on any policy would not likely have come into play yet, so no adjustment need be applied so far. In the future, insurers might be encouraged to offer such riders, but should not be prohibited from charging the appropriate amount. So far only very large group insurers likely had such limitations applied. For smaller individual insurers, their own reinsurance capacity should be looked at to see if it affects their potential solvency. It should be their call as to whether they want to play in that high-risk arena. Some insurers may specialize in this area, and consumers that want to pay the higher premium would be able to gravitate towards those insurers. Generally state insolvency funds would offer the final protection, should one of those carriers fail, and the liquidation costs would be passed back to the solvent insurers in an equitable manner.

**Final Perspective on Costs**

In reality, with something as vital as one’s health, it may be that 15% or 20% of GDP is the right portion to spend. Many would rather have another 20 years of higher quality of life than a 3D 80-inch TV. Most Americans would not trade our medical care facilities for those of other countries where rationing, waits for MRIs and earlier death from preventable outcomes are more accepted.

Health care might well deserve to be the third most costly item in one’s annual budget behind shelter and food. The main problem then becomes the need for wider availability of insurance to spread out those costs over time, so that one-year variations don’t break the bank. If a new replacement healthcare insurance system can actually help to bend the cost curve down, even better.

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