The Powers Report Podcast

Episode 11

My Ten-Step Replacement Plan for the Affordable Care Act

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Health care is one of the most important issues to Americans in the upcoming election cycle. The majority of Democratic candidates for president have been rallying around a Medicare-for-All idea. Does this mean they've abandoned the Affordable Care Act? In this episode, Powers discusses some of the positive aspects of the ACA, particularly the prohibition of insurers to deny coverage based on pre-existing conditions. She then outlines ten steps that can be pursued to replace the ACA as an alternative to walking away from the program in pursuit of Medicare-for-All.

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Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

If you're a Democrat running for the presidential nomination – and at this point, there are over 20 of them – then you have to have an opinion about Medicare for All. You'll need a response. Are you for a total government take-over? Do you want to eliminate private insurance? Or maybe you just want people to have the option to buy into the current Medicare program?

One of the biggest challenges with positioning yourself on Medicare-for-All is that no one's agreed exactly what it is. But one thing is for sure. It's not the Affordable Care Act. Which brings up an interesting situation for the Democrats. The ACA was the Dems' signature legislation, the Obama-era program that was supposed to provide all Americans will affordable health insurance. It was passed in 2010. Here we are, about a decade later in a different election cycle, and the party has ostensibly abandoned it.

One interpretation of the abandonment, and it's a position I think is legitimate, is that the Democratic candidates don't want to touch the ACA because it didn't come close to fulfilling the promises of bringing affordable health insurance to everyone. About 10% of Americans still don't have health insurance and the insurance that is offered on the marketplace isn't affordable (1).

Now, for those of you who've been listening to this show, you're probably aware that I don't like waste. My professional goal has always been to find the most efficient way to get people the best health care experience possible. In my view, there's nothing more wasteful than campaigning for, lobbying for,

developing and implementing a multi-billion-dollar program and then ditching it less than ten years later for something else. Especially when that something else – Medicare-for-All – is completely financially implausible. So in this podcast, I will talk about how we can leverage selected aspects of the ACA in the development of a replacement plan that is NOT Medicare-for-All.

I've been on the record as an opponent of the ACA. My biggest problem with it is that it took our broken health care system and extended it to everyone. I want solutions that fix the health care system, not ones that make it more bloated and drive up costs.

Now, one would hope that when you have legislation that runs over 2,000 pages long, there'd be something redeeming about it. There are ideas and concepts in the ACA that resonate with Americans. We've spent incredible resources to pursue these initiatives. We need to figure out how we can do these things in a way that isn't so expensive and inefficient.

One of the most popular aspects of the ACA is the inability of insurers to discriminate against potential enrollees based on pre-existing conditions. This makes sense because the main reason for health insurance is to protect people from catastrophic medical costs. If you've had cancer, or you have diabetes, you have higher medical costs than those who don't. You need insurance so you can get access to insurer-negotiated rates so your care can be covered. And of course, you need the balance of the health care pool who does not have those preexisting conditions to contribute funds that subsidize your cost of care.

I think there's an element here, though, that needs to be teased out. And that is that there are pre-existing conditions that we can control, and there are those that we can't. I think the majority of us have some compassion and we'd be willing to fund, at a community level, the health care needs for someone who develops aggressive breast cancer at age 30. No doubt there are genetic elements at play that the individual could not control that lead to such a condition.

The gray part comes when we get to the preventable conditions that are a result of poor choices. Those who smoke, don't exercise and over-eat drive up health care costs for everyone else. Obesity in particular is a preventable condition that is, in my opinion, America's greatest public health threat. 40% of Americans are obese, and the number is rising (2). This condition correlates to pretty much every major chronic disease. And treating these diseases has been a major factor in our high cost of health care. According to the CDC, 90% of health care costs are associated with treating chronic disease and mental health issues (3).

So we now have legislation in place that, while helping those who have been dealt a bad hand, also enables others who have negative health behaviors. Think of it this way: if the law dictates that you'll be covered regardless of your pre-exiting condition, then, for some, there's no incentive to be well. You can act in your worst self-interest because it won't affect the cost of your health care premiums.

So what exactly is a pre-existing condition? The Centers for Medicare and Medicaid Services, CMS, states that a pre-exiting condition is "…a health condition that exists before someone applies for or enrolls in a new health insurance policy." (4) Well…that's kind of broad.

Like, really, broad. CMS estimates that 19 to 50% of non-elderly Americans have some sort of pre-existing condition. I love that range. 19 to 50%. Not 20 to 50%. We have to get precise with the 19. And the headline is that, “Pre-existing Conditions Could Affect 1 in 2 Americans”.

Well, let me clarify that. Pre-existing conditions could affect 1 in 1 Americans.

Every single one of us has pre-existing conditions. Why? Because we live in the age of genetic testing. Once any of us takes a genetic test, we’ll find out that we have a proclivity to develop a disease. Something. Probably cancer and heart disease. It doesn’t mean we’re guaranteed to develop these diseases. Interestingly, just because you’ve had cancer once doesn’t mean you’ll definitely get it again. But your odds are greater. And if you have something in your genetic make-up, your odds of developing it are also greater than if you don’t. In the not to future world, this is how we’ll be managing our population. We’ll be taking into account many more risk factors than we do today.

Therefore, this idea that the pre-existing conditions clause as a positive aspect of the ACA is kind of null and void. That’s’ because we’re all wired to develop something. As a result, we have to change our mindset about what health insurance is. It’s not insurance anymore, at least the way the insurance industry has promulgated health insurance. We can’t exclude anyone anymore. What we have is coverage, not insurance.

This may be another underlying reason why Medicare-for-All sounds so attractive. Most of us are uninsurable without the pre-existing conditions clause, so just giving everyone blanket coverage assures that we all get the financial security that health insurance provides.

But there is a better way than chunking the ACA altogether and leaping all the way to Medicare-for-All.

Now, I’d like to see the entire system decentralized, where each of us pays for our own health care based on our own risk profiles. That’s my Longitudinal health care Plan. But that is an idea that’s going to take some time to gain broad acceptance and we need legislative action right now to get people what they need. So here’s what I think we should do.

1. Mandate that the employer-sponsored health insurance subsidy be provided as a cash benefit to employees. This is the cornerstone to making change in the health coverage market and it is imperative that we embrace this idea. Half of all Americans get their insurance through their employer. I think we need to eliminate this program altogether. I’d like the funds employers spend on their employees’ health insurance to be given to the employee so he or she can buy coverage on the open market.

This will require a major change, as the ACA mandates that most employers offer coverage for their employees. In this model, they are providing employees with the financial resources necessary to enable employees can buy the coverage themselves.

Employers should love this idea because it will save them tons of money. Gone will be the expenses associated with negotiating rates with insurance companies and managing employee health insurance

benefits. No more employee wellness programs either. Risk for the high cost of employee insurance gets shifted away from the employer and out into the open market.

And that's where the biggest upside of this idea lies. In 2017, about 12 million people signed up for insurance through the ACA (5). 156 million people got insurance through their employer. The ACA market is characterized by sicker and less wealthy individuals that those covered by employers. When we eliminate employer-sponsored health insurance, all these relatively healthy and wealthy people will flood the market. It will be at least ten times bigger than it is today. All those high costs currently in the ACA market – and some tucked into employer programs – gets spread to millions more people. Rates should subsequently come down considerably.

2. Tax the employer-sponsored health subsidy. Not only do we need to give employees a cash subsidy to buy their own insurance, we need to tax that subsidy. Most people do not realize that the employer-sponsored health insurance subsidy is one of America's greatest entitlements. One estimate identified $280 billion in untaxed income that could be reaped by the government if this benefit were taxed (6). Given our growing deficit and rising interest rates on our debt, America needs all the money we can get.

But more importantly, not taxing the subsidy is unfair. People who don't have their insurance covered by a company not only miss out on the subsidy, they also miss out on the tax benefit. Folks who buy insurance themselves have to do it with money they earn after taxes. Employed individuals get their benefit before taxes.

3. Leave the prohibition against insurers denying coverage due to pre-existing conditions in place. This is the most popular aspect of the ACA. And as noted, we pretty much all have pre-existing conditions. We have to utilize other means to lower rates in the insurance market besides simply eliminating certain people that insurance companies don't want to cover.

4. Bring back the individual mandate. The 2017 Tax Cuts and Jobs Act eliminated the penalty Americans are required to pay if they do not have health insurance. It basically erased the so-called Individual Mandate. The purported reason for eliminating the mandate was that it was a violation of civil liberties. Requiring people to buy expensive ACA-plans was considered by some to be government overreach.

But the real reason the Individual Mandate was eliminated is that it set the stage to potentially over-turn the entire Affordable Care Act. Which is being debated right now.

Back in 2012, the Supreme Court upheld the Individual Mandate on the grounds that Congress was empowered to tax its citizens (*National Federation of Independent Business v. Sebelius*). Now that there's no tax associated with the mandate, some are arguing that the entire law is invalid. In its simplified form, this is the rationale used by 20 state attorneys general when they filed suit deeming the law unconstitutional (7). The Department of Justice has agreed with this idea that the ACA is unconstitutional, so we'll just have to wait and see.

Whatever happens, we need to require Americans to buy health insurance. We all have to buy car insurance in case of an accident. We're not trying to eliminate that insurance requirement. And the

same logic applies to health insurance. All Americans should be required to have some level of insurance, even if it's just for catastrophic care. Individuals who do not have insurance and incur significant health care needs wind up costing other Americans millions of dollars in indirect subsidies. It's simply irresponsible not to have health insurance.

5. Eliminate the Ten Essential Benefits requirement. One of the biggest beefs with the ACA is that it created bloated insurance coverage because it mandated that a certain level of services be covered in all plans. Such an approach did not allow insurers to customize offerings to individuals and it forced people to buy into coverage they didn't need or didn't want. That has to stop.

When the market becomes significantly larger, then we will need much more variety in plan options. Some people may buy more robust plans because they have higher health care costs because of some pre-existing conditions. Some people may just want the security and perceived luxury of plans with lots of benefits. But we can't force everyone to buy things they don't want.

We also need to remember that those with significant health issues have options. There should be an incentive for Americans to improve their health by engaging in better health behaviors so their health care costs aren't so high. We need to see more of us become more accountable for our health. We need to stop designing a health care market that caters to poor behavior and design one that caters to good behavior.

The key is not to punish those who are sick because they're sick. We need to better understand who these folks are so they can get better directed care. Which means we should…

6. Remove individuals who have recurring, high cost medical needs from the general insurance pool. About 5% of Americans account for half our health care costs (8). One reason insurers set rates so high is out of concern that very high cost individuals may sign up for their plans. If these individuals are managed separately, rates for the general population should go down.

Funding for very sick, high cost individuals should be provided by the individuals themselves and through public funding. They should be managed through a system that accommodates their special needs, not rolled in with everyone else and shifted around, year-over-year. Such an approach cannot take a longitudinal perspective on their health and give them the more personalized care needed to help address major health care needs.

7. Require insurers to offer terms of three years, not one. Insurers rely on healthy members to offset the costs of unhealthy members. Even when we remove the very sick from the general pool, each of us is going to have several expensive medical incidents in our lifetimes. They may be one-offs, like a torn ACL from a ski accident. Or we may develop an autoimmune disease that could periodically flare up.

One of the problems of encouraging individuals to switch insurance each year is that it raises the risk that any one insurer will enroll an individual with a serious health condition for any particular year. Assuming such a scenario happens, that same individual who was very sick one year – like if they had the torn ACL – may have very low health care costs the next few years. If that member switches insurers,

the new insurer gets all the upside of covering the member with low health care costs, but none of the downside that the initial insurer sustained.

If insurers were required to offer plans with longer terms, they should be lowering their risk that any one individual in their plan is going to have continuous health problems. They may be hit with one year's worth of costs, but then costs for the rest of the period should be low. Requiring longer terms for plans should then lower rates.

8. Require employers to offer part-time employees a prorated insurance benefit. When employers begin offering a cash subsidy to employees to buy insurance, the employer is acknowledging their responsibility to help pay for health care costs. That responsibility extends to all workers, whether they are full time or not. As a result, part time employees should receive a prorated health subsidy from their employer.

As noted earlier, the elimination of employer-sponsored health insurance programs will save employers money. Lots of it. Some of it should be used to fund the health care needs of their part-time workers too.

Now consider that many people with part-time jobs work multiple part-time jobs. If these individuals could cobble together subsidies from each of their employers, they'd be able to buy insurance on the open market. That sets the stage for a host of other changes like…

9. Reevaluate the Medicaid expansion program. Part of the ACA provided the option for states to expand the Medicaid program. The federal government agreed to pay for the majority of costs associated with the expansion. However, a good portion of states rejected the expansion. As of how it's somewhere between 15 and 20 states that have not expanded Medicaid (9). One reason why is that most states have some sort of balanced budget provision or expectation. That means that when Medicaid costs are added, other things need to get pushed out so their budgets can stay in equilibrium. That means cuts have to go to education, pension, infrastructure. Many states don't want to make that trade-off.

Given the changes proposed, more people should be able to afford their own health insurance. The part-time employer subsidy could be an absolute boon for some current Medicaid enrollees. They'd be able to buy into a private plan, giving them more freedom and better access to care than what is often available through Medicaid.

10**. Eliminate government sponsored subsidies for health insurance premiums**. Today, the majority of buyers on ACA exchanges get the cost of their premiums subsidized by the government and it costs the government about $55 billion (10). What's even more concerning is that it now costs more to pay for an individual's ACA subsidy than it does to fund a Medicaid enrollee (11). It's just not a sensible program. With all the changes I've proposed, there should be more options, cheaper insurance and subsidies provided to all working Americans via their employer to help buy insurance. We need to move towards the elimination of subsidies that the government provides. If people can't afford insurance, they need to be in Medicaid.

So there you have it. Ten ways that we can redesign the American health care system. These ideas highlight popular aspects of the ACA while allowing more choice for Americans. No system is perfect. But an approach that leverages the power of the market, as opposed to a centralized government-run system enables more adaptability and flexibility. The government will need to monitor rates and terms, but an increase in transparency in the purchase of health insurance should change how Americans view health coverage – for the better. Using funds so we can buy the plans we want should encourage us to be more responsible financially and behaviorally, helping as all to be as healthy as we can be.

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