

# **National Health Reform Agenda: Critical Elements for Assuring Patient/Consumer Access to Coverage and Care**

## **Executive Summary**

Patients/consumers who do not have access to employer- or government-sponsored health insurance or public programs need well-functioning markets, incentives to purchase and maintain coverage and, in some cases, financial support. Changes to the individual insurance market need to be carefully crafted to implement improvements, preserve stability and ensure affordability for patients/consumers. Covered California has been asked to provide a framework that offers principles and critical elements that should be considered for any “reform” effort. The framework that follows is in response to that request. It assumes that any major set of changes to the existing structures would be implemented with a complementary transition plan to prevent the collapse of the individual market and disruption of care for millions of patients/consumers and health care providers serving every community in the United States.

## **Principles for Evaluating Affordable Care Act Reform Proposals**

Clearly articulated principles should serve as guideposts to assess current or proposed changes to health care funding and delivery. Among the potential principles are:

1. Patients/consumers should be empowered to drive change through market forces.
2. Competition must be based on value rather than risk selection.
3. States should have the tools and flexibility to use incentives and market structures to ensure a good enrollment risk mix and the fiscal solvency of health care insurers.
4. Federal financial support mechanisms are critical elements to ensuring the affordability of health coverage for patients/consumers.
5. Consideration of individual patients/consumers’ differences (i.e., income, age, location and other factors) should be reflected in the design and implementation of policies.
6. Disruption of state capacity to deliver Medicaid services and individual and employer commercial insurance markets should be avoided at all costs.

## **Critical Elements for Preserving Stability and Ensuring Affordability in the Individual Market**

The success of any Affordable Care Act reform or replacement proposal will require adoption of some critical elements that work in tandem to ensure that the individual market has a stable and balanced risk pool, and that patients/consumers have effective incentives and adequate resources to purchase and use insurance. These elements include:

1. Federal funding for Medicaid and for subsidies and tax credits for individuals to buy private coverage is critical. Any changes in funding levels or to the type of funding must include multi-year planning horizons for private insurers, states, providers, employers and patients/consumers.
2. States should have substantial autonomy to shape policies for their markets and their patients/consumers.
3. Tax credits should be funded and administered to address patients/consumers’ differing circumstances and to assure a balanced risk mix. Tax credits should be based on income, age and location, and made available to both support monthly premium payment and reduce costs at the point of care.

4. A single common risk pool should be maintained to avoid risk selection and a return to insurance markets with care that is unaffordable or unavailable to many consumers.
5. Significant consequences for not maintaining coverage to achieve maximum enrollment, a sustainable risk pool and improved affordability for all patients/consumers.
6. Coverage should empower patients/consumers, safeguard access to necessary services and assure patients/consumers have meaningful choice of products, plans and providers.
7. Ongoing efforts to rein in underlying health care costs.
8. Clear metrics should be used to measure proposed policies and the ongoing impacts of policies as they are implemented.

As policy makers consider changes to the Affordable Care Act, we have been asked to provide a framework that outlines the elements that are critical to assure that viable coverage options are available to Americans.

### **Critical Element 1: Federal Funding**

**Federal funding for Medicaid and for subsidies and tax credits for individuals to buy private coverage is critical. Any changes in funding levels or to the type of funding must include multi-year planning horizons for private insurers, states, employers and patients/consumers.**

While there is an array of market reform policies, federal funding through states and funding provided directly to patients/consumers in the form of tax credits and cost-sharing reductions serve as the foundation for the coverage expansion. Reduction of federal Medicaid funding and tax credits would cause significant disruptions not only to patients/consumers but also to health care providers, workers, state budgets and local economies more broadly. Rapid changes could lead to collapse of the individual markets in many states, affecting both on- and off-exchange unsubsidized patients/consumers.

If federal funding is not maintained at current levels, a glide path is essential for adapting to and mitigating the impact of any potential shifting of the cost of coverage programs (e.g., Medicaid, the Children's Health Insurance Program [CHIP] and tax credits) to individual patients/consumers. Several mechanisms may be considered for allocating funding to states or administering tax credits, but changes to these should provide for time horizons that allow states, health plans, providers and patients/consumers to adjust.

### **Critical Element 2: State Authority and Flexibility**

**States should have substantial autonomy to shape policies for their markets and their patients/consumers.**

Affordable Care Act replacement proposals should be grounded in providing states flexibility and autonomy to organize health care within limited federal standards. With appropriate latitude and continued federal funding, states are well positioned to meet patients/consumers' health care needs by tailoring coverage programs, benefits and market rules to each state's health care market, unique circumstances and approach to reform. At the same time, given the critical role of federal funding and the need for a federal floor in some areas, federal guidelines provide important structure to the market and basic consumer protections. Within the context of state flexibility, states that have successfully implemented the Affordable Care Act should be allowed to keep those elements that work for those states and avoid costly and disruptive changes to their health care markets and patients/consumers.

States should be given the flexibility to opt in to arrangements such as allowing issuers to sell products across state lines or into state compacts. States should be able to preserve current state regulation and policies free from federal pre-emption. States should have the flexibility to take different approaches to assuring market stability, such as through establishing alternate grace-period standards and implementing different approaches to consumer protections and resolving complaints.

### **Critical Element 3: Fund and Administer Tax Credits to Meet Patient/Consumer Needs and Assure a Balanced Risk Mix**

Many patients/consumers need financial help to be able to afford viable health coverage, but the amount and nature of the assistance needed vary by the circumstances of the individual — such as their age, income and where they live. Tax credits should be administered in an efficient manner to bring coverage to as many individuals as possible at the lowest cost. As a complement to public programs, there are important values addressed by providing all patients/consumers who are not eligible for or enrolled in other coverage access to some form of tax credits that allow them to purchase affordable coverage, and to be active consumers in competitive marketplaces to seek the best value.

Proposals to revise the nature and structure of federal tax credits need to recognize that consumers' willingness and ability to afford coverage are tied directly to their personal circumstances.

Patients/consumers care about the net cost of their coverage and the cost to them when they get care. Tax credits that are adjusted based on individuals' circumstances not only promote coverage, but they also directly promote a more balanced risk pool that lowers costs to all patients/consumers. For these reasons, it is important that any tax-credit replacement proposal include the following elements:

- ***Adjust Tax Credits for Patients/Consumers' Income:*** Adjusting tax credits by income is vital because it provides the most cost-effective approach to modifying the financial support based on patient/consumer need. Proposals for “flat” tax credits that vary only by age, but are not adjusted by income, would result in a high-income earner who can afford to purchase insurance receiving the same financial assistance as a low-income earner. In such a structure, tax credits for lower-income individuals would likely be inadequate to support coverage for many patients/consumers, resulting in healthier low-income consumers not enrolling.
- ***Provide Tax Credits Based on Age:*** Having a portion of any tax credit allocated based on age — potentially irrespective of income, or with a higher income threshold than exists under the Affordable Care Act — addresses core equity issues of providing tax-based support to individuals that is otherwise available to all Americans. Having a portion of the tax credit based on age would either lessen the impact on many individuals or assure there is no “cliff” after which some patients/consumers may find coverage unaffordable.
- ***Adjust Tax Credits for Location:*** Health care costs vary significantly by region, both within and between states. This variation is the reason that Medicare payments — both fee-for-service and Medicare Advantage — are adjusted for location. Under the current Affordable Care Act structure, tax credits are benchmarked to the second-lowest-cost Silver plan, which makes tax credits locally adjusted so patients/consumers have consistent purchasing ability regardless of where they live. Adjusting tax credits by region is a critical element, without which many consumers/patients would likely find coverage unaffordable.

- ***Tax Credits Must Be Refundable and Advanceable:*** Advanceable tax credits help defray the cost of health insurance for consumers at the point of enrollment and on a real-time basis to pay monthly premiums, promoting broad participation of eligible patients/consumers. If tax credits are not *advanced* to patients/consumers, but instead claimed as a refundable tax credit during tax filing, individuals bear full premium costs upfront — which is financially impossible for many healthy low- and middle-income patients/consumers. Advancing the tax credits provides a positive financial incentive that will improve the risk pool, lowering costs for all patients/consumers and the federal budget.
- ***Tax Credits or Financial Support Need to Reduce Point-of-Care Costs:*** Especially for lower-income individuals, costs at point of care — in the form of out-of-pocket payments for services — can be major impediments to actually using health care services. Under the Affordable Care Act, the cost-sharing reduction (CSR) subsidies directly address this issue by substantially lowering out-of-pocket costs for lower-income individuals. Mechanisms that reduce financial barriers at point of care while assuring patient/consumer responsibility should be part of any new financial support regime. Models could include those similar to current cost-sharing reductions, which require patient responsibility for out-of-pocket expenses that are adjusted by income. Or, states could design and offer income-adjusted and federally funded Health Savings Accounts as a vehicle to support point-of-care costs.
- ***Tax Credits Should Be Indexed to Keep Pace With the Cost of Care:*** Any tax credit needs to have an indexing mechanism such that the financial support keeps pace with the cost of health care.
- ***Risk-Stabilization Funds Should Only Be Used to Lower Premium Cost, and Not Be Contingent on State Matching Funds:*** To the extent that federal risk-stabilization funding is made available to states, the use of such funds should be directly and clearly related to lowering premium costs. States should be provided flexibility in how to use the funding for this purpose. In addition, requirements for state “matching” funds for risk stabilization should be avoided. Considering state budgetary constraints, requirements for a state match will likely result in having to forgo risk-stabilization funding for many states, making the federal support a false promise and leaving many lower-income Americans without affordable coverage.
- ***Administration of Tax Credits Should Allow for State-Based Solutions:*** Federal financial support for tax credits is imperative, but the federal administration should not preclude states from structuring or adjusting tax credits and determining how they are administered — including potential coordination with state Medicaid programs. All state-based administrations should assure that their policies are known by both contracted health plans and patients/consumers in advance.

#### **Critical Element 4: A Single Common Risk Pool**

**A common risk pool should be maintained to avoid risk selection and a return to insurance markets with care that is unaffordable or unavailable to many consumers.**

Maintaining a single risk pool for the individual market ensures that health plans balance their risk mix with healthy and sick individuals from all of their products — and prevents a return of having insurance companies focus on risk selection instead of providing high-value health care. Prior to 2014, insurers segregated high-risk patients/consumers into separate risk pools that experienced substantial annual rate increases. Because a single risk pool requires insurers to consider the cost of all their enrollees, sicker patients/consumers are protected from facing a major premium disadvantage.

To the extent Affordable Care Act replacement proposals no longer require essential health benefits or defined actuarial values (metal tiers), the individual market in many states would likely see the return of low-premium, minimum-benefit plans that would attract younger and healthier consumers. Meanwhile, plans with more-comprehensive benefits or broader networks, or both, would attract higher-risk patients/consumers. To prevent insurers from competing with one another based on risk selection — rather than quality and value delivered to patients/consumers — the following core market instruments are needed:

- **Risk Adjustment:** There is continued need for effective risk-adjustment processes to level the playing field between insurers that attract relatively lower-risk and higher-risk patients/consumers.
- **Guaranteed Issue for All Products:** Continuing the ban on screening based on pre-existing conditions means that guaranteed issue should be required for all products in the individual market. Allowing different rules for different products would likely result in the segregation of sick people into the guaranteed issue products and healthy people to the products that are underwritten.
- **High Risk Funding/Reinsurance:** Mechanisms to provide resources to insurers for high-cost individuals, whose coverage otherwise could imbalance the risk pool, are important. State innovation, with federal support, should promote vehicles that address the financial implications of high-cost chronically ill individuals and those suffering from catastrophic events or conditions.
- **Promote an Efficient Market:** Effective promotion and marketing is vital to maintaining a good risk mix. States should be encouraged and supported in fostering competitive markets, facilitating marketing efforts to encourage the largest enrollment possible and working with plans to help patients/consumers become healthier and less costly. Promoting market competition, effective enrollment and high-value contracting could be supported through state-based exchanges, or by having clear standards for health plans that benefit from federal resources in the form of advanced tax credits.
- **Prohibit Medical Underwriting and Pricing Variation by Health Status:** Medical underwriting imposes substantial administrative costs and encourages health plans to focus on risk selection rather than on assuring patients/consumers are getting the best value and service for their dollar.

### **Critical Element 5: Strong Incentives to Get and Keep Coverage**

**Strong incentives are necessary to ensure patients/consumers maintain coverage in order to achieve maximum enrollment, a sustainable risk pool and improved affordability for all patients/consumers.**

If the individual shared responsibility penalty is eliminated under a replacement proposal, it will be critical to replace it with other policies that are also effective at promoting enrollment. The individual shared responsibility payment should remain in effect and be enforced until measures to mitigate the impact of its elimination are instated. Incentives could include reinsurance tools (such as formulas to support the costs of high-risk individuals enrolled in the common risk pool), continuous coverage requirements, imposition of waiting periods, auto-enrollment into default coverage, late-enrollment penalties and state-administered tax penalties. Reasonably defined coverage standards are a necessary complement to continuous coverage standards. Until enactment of a replacement law, it is critical that the IRS continue enforcing the individual shared responsibility tax penalty to prevent the collapse of the individual market.

### **Critical Element 6: Define Coverage and Rating Standards**

**Coverage should empower patients/consumers, safeguard access to necessary services and give consumers meaningful choice of products, plans and providers.**

Patients/consumers in the individual market need to know what they are getting, and need products that provide meaningful benefits. Without minimum coverage standards for basic services — such as inpatient and outpatient care, maternity care, mental health care and pharmacy access — patients/consumers with significant health issues may find themselves without coverage or financial protection when they need it, and healthy consumers may exit the market altogether if they do not find products that offer them value.

Policies requiring continuous coverage to benefit from guaranteed issue or avoid a penalty require a definition of minimum coverage standards, otherwise patients/consumers could move from very low-cost/mini-med plans to coverage that is more generous when they become ill or need expensive care. This would make the more comprehensive plans far more expensive, raising costs for most consumers. To mitigate gaming that affects premiums for all consumers and to maintain a common risk pool, issuers need assurances that a consumer's prior coverage meets minimum standards.

Defining common standards also plays a critical role in ensuring the risk pool is well balanced. While the federal definitions for “essential” health benefits and standardized tiers may be subject to being replaced, what follow are elements that should be part of newly framed national standards that each state could then supplement:

- ***Prohibit Annual or Lifetime Caps:*** Protections are needed for the small number of patients/consumers who will face conditions or proven therapies with annual or lifetime costs that can be in the millions of dollars. These sorts of costs are exactly what insurance is meant to cover and are subject to market failure since consumers often do not see the “value” of covering very rare events.
- ***Establish a Floor for Products Eligible for Tax Credits or to Meet Continuous Coverage Requirements:*** Plan designs that have actuarial value (AV) of less than the current Bronze plan

(60 percent AV) would challenge the ability of most consumers to meet access and care needs. Products that are of little or no functional value would run the risk of being avoided by healthy lower-income consumers, leading to a worsening risk pool that would raise costs for all consumers.

- **Require Transparency to Facilitate Consumer Choice:** Plans should be required to make clear and prominent disclosures to consumers of what is *not* covered and the benefit design features that promote or discourage access. Transparency requirements should include description of coverage issues, such as the nature of the deductible (how big it is and what is and is not covered by the deductible), coverage for prescription drugs, any limitations to coverage, and the scope of outpatient and inpatient care.
- **No Product or Rating Differences by Gender:** The policy of gender-neutral rating has been effectively adopted by all health plans and implemented effectively. Returning to different products and pricing based on sex or gender would be a return to health plans doing product design for risk selection and not providing high-value care.
- **Allow State Variation of Age Bands:** Currently, the Affordable Care Act establishes a national standard that prohibits health plans or states from having product pricing that is greater than three-to-one based on a patient/consumer's age. Increasing this "age band" would result in lower costs for younger individuals, but potentially much higher costs for older individuals. States should have the ability to adjust the age band up from the national standard of three-to-one to five-to-one.
- **Allow State Ability to Define "Essential" Benefits for Its Market Above a National Floor:** Currently, the Affordable Care Act establishes national standards for essential health benefits. While there will be a need for a national floor for some benefits to assure valid continuous coverage, states should have the ability establish standards for essential coverage above that defined by the national floor.

## **Critical Element 7: Address Underlying Health Care Costs**

When health care costs grow at a faster rate than increases in the gross domestic product, coverage is less affordable and poses a greater financial burden on individuals, families and employers. While a variety of factors contribute to health spending, including technological advancements (e.g., increased diagnostic imaging), prices (e.g., unit costs), and specialty drugs (e.g., biologics), there is no single panacea for mitigating cost growth. In turn, public and commercial payers have deployed a variety of cost containment strategies, ranging from market-based approaches, regulatory oversight and delivery system improvements.

Any reform proposal will need to directly address underlying health care costs to prevent dampening its intended policy goals for coverage and affordability. All payers should be engaged to pay for value and minimize payment for wasteful, inefficient and non-patient-centered care. What follows is a non-exhaustive, high-level list of potential approaches for consideration:

- **Transitioning From Fee-for-Service to Fee-for Value:** Payments should hold providers accountable for cost, quality and outcomes, e.g., the Quality Payment Program authorized under the Medicare Access and CHIP Reauthorization Act of 2015.
- **Delivery System Reforms:** Improve care, outcomes and per capita spending through better integration and coordination of care, e.g., bundled payments, accountable care organizations and health homes.
- **Price and Quality Information Transparency:** Encourage competition by allowing consumers to meaningfully compare providers and services based on value, e.g., public transparency portals or all-payers claims databases.
- **Antitrust Enforcement:** Improve market efficiency by blocking mergers and acquisitions that reduce competition.
- **Multi-Payer Strategies:** Align financial incentives across multiple payers to ensure that high-value care is rewarded consistently, e.g., all-payer rate setting or statewide global caps on health spending.

### **Critical Element 8: Common Metrics**

**Clear metrics should be used to measure proposed policies and the ongoing impacts of policies as they are implemented.**

Assessing proposed “repair” and “replace” policies requires a set of common metrics to measure their likely impact. Having common metrics that are used nationally will facilitate cross-state learnings and the ability to share lessons to improve affordability and the delivery of care across the country. In establishing measures, care should be taken to minimize the burden of collection on plans and providers. In addition, data collection should not unintentionally reinforce fee-for-service payment systems over other payment systems or particular kinds of contracting structures. What follow are metrics around which there should be national standards and infrastructure to measure, collect and share:

- Coverage through each major market segment (e.g., employer, individual market and public programs).
- The financial impact on the federal and state budgets, employers, providers and the overall economic health of the nation and local communities.
- Measures of total cost of care, reflecting affordability for patients/consumers (to both premium and out-of-pocket costs for covered and non-covered benefits).
- Patients/consumers’ access to plans and providers.
- Measures specific to patients/consumers with different health statuses (e.g., those with chronic conditions, high-cost cancers or those who are relatively healthy) and measures that address health disparities.
- Quality and efficiency of the delivery system.

*This document was developed in response to requests from policy makers for information that will inform discussions regarding how to build on and improve reforms that have transformed millions of consumers' lives and insurance markets throughout the nation. If you have comments or questions, feel free to contact Peter Lee at [peter.lee@covered.ca.gov](mailto:peter.lee@covered.ca.gov).*