Essential Elements of An Effective ACA Replacement

NOTE. I am not asserting here that this simple outline fully defines the entire replacement system that would be needed. However, I do believe that it summarizes a conceptual approach that will work.

1. All insurance policies must cover the same time period [January 1 to December 31, or some other twelve-month period -- calendar year will be assumed here], and all deadlines for signup must be the same.
2. By the same date each year, all insurance companies must submit electronically to DHHS a database of policies they will offer in the upcoming year, and those lists must contain a small amount of key information such as monthly premium, deductibles that must be met before any reimbursement begins, average co-pay ratio (e.g., 80% / 20%) for all situations where such ratios apply, primary physician visit co-pay, specialist visit co-pay, drug co-pays by "tier", etc. [all of this would be very easy for any company to provide].
3. No insurance company can refuse to issue a policy to anyone based on their health status [e.g., pre-existing conditions]. This would clearly result in most insurance companies attaching astronomically high premiums to some of their policies, putting them out of financial reach for the vast majority of people who would need them. This issue will be addressed in subsequent items in this list. ***NOTE. Even Medicare is denied to people with end-stage renal failure at the time of their initial qualification for coverage. Allowing that criterion for this ACA replacement system should be investigated if elimination of those cases would have a material impact on overall costs***.
4. If there are to be any mandated coverages [maternity, children under 26 can remain as dependents under their parents' policies, abortion, gender change, etc.], **all** insurers who offer those kinds of benefits to **any** policyholders must offer **optional** riders in **all** policies they offer to anyone. One mandated coverage I believe would solve many problems and simplify this [or any] program greatly would be policies that provide catastrophic coverage only. For example: a much-lower-than-average premium; no coverage for anything up to $X, 80% insurance coverage / 20% patient copay from there to $Y, and 100% insurance coverage above $Y [the values of X and Y would have to be worked out, but I expect that values like $2,000 to $3,000 for X and somewhere between $10,000 and $20,000 for Y would result in premiums and "maximum out of pocket" amounts at least as low as any current ACA-enabled policies, maybe lower].
5. A system of incentives for most people [including healthy ones] to enroll in a health insurance plan of their choice [and/or a system of disincentives discouraging non-enrollment] must be included. This is a very complicated component, but **well worth the time and effort that will be required to develop a system that will work** [ineffectiveness in attracting healthy people into the pool of premium payers and a rapidly-declining pool of insurers finding ACA participation profitable were two major factors resulting in the ACA's accelerating pace toward collapse]. There are several conceptual approaches that could be made to work. Here are two that I think are workable:
   a) De-incentivize people from not buying insurance until they have a "big ticket" health issue. Establish a kind of rolling X-year window -- i.e., turn it down, and you have to

wait "X" years before being eligible for the program again. X might be, say, 5; maybe just 3.

b) Provide a graduated scale of eligibility based on age -- e.g., a person in his/her 20s or younger getting insurance **for the first time** is fully eligible for any subsidies that may apply to him/her; one in their 30s is eligible for 85%; one in their 40s for 75%; 50s to Medicare eligibility age, 50%. If a person has had insurance previously but discontinued it [even if more than once], some upward adjustment in these percentages could be made, proportioned to the cumulative number of years they had previously had insurance [similar to how eligibility for Social Security is determined]. Many people would still procrastinate and potentially end up in a bind, but that's a risk they would have chosen to take [i.e., they would have made the decision to spend or save their money in the short to intermediate term rather than "opting in" and thinking of the cost as insurance partly to avail themselves of current benefits and partly to protect themselves from potential future costs much higher than their current premium -- not unlike the thought process that governs decisions people make on whether or not to buy other kinds of insurance].

6. Using statistical techniques [simple "bell curve" logic, standard deviations, etc. -- far less sophisticated than techniques many government agencies use every day], DHHS will identify two groups of "outliers" in the policy database [i.e., policies that fall outside affordability limits set in the preceding year -- see ***Ongoing Refinement*** section below]. One group of outliers will be called the Mandated Coverage Special Handling Pool [MCSHP], and will consist of people who are cost outliers and have applied for mandated coverage. The other group of outliers will be called the Cost Outlier Special Handling Pool [COSHP], and will consist of all other people classified as outliers. For all of these outlier applicants [both groups -- collectively referred to as Special Handling Pools, or SHPs], the following steps would be taken:
   a) The applicable insurance companies would be issued letters of authorization to approve those policies at the average rate of all policies to be issued by that company in that year, with DHHS' guarantee that it will reimburse them for all costs for those policies that are over and above their average costs for all other claims paid during that year.
   b) All SHP applicants will be issued letters from DHHS [or from the companies to which they applied if that is more practical] outlining their options: 1) proceed with enrollment [which would put them in the same status as anyone else who was not put in the SHP, including determination of their qualification for any other governmental financial assistance that may apply to them]; or 2) refuse this offer of government assistance over and above any other assistance for which they may otherwise qualify.
   c) Through dialog with each SHP policyholder who elected to go ahead and enroll, DHHS would: 1) determine whether or not they qualify for any other governmental financial assistance that may apply to them; 2) attempt to identify other coverage options that would provide equivalent or better benefits while lowering the government's projected

costs to support their policy; and 3) implement any decisions resulting from this interaction.

7. A determination will be made as to income levels [and/or other criteria] at which government assistance should be offered, and what that assistance will be. If such an assistance program is included, it will be implemented through income tax credits [**not** just deductions from income] and a mechanism for providing those credits through payroll withholding credits for employed people or through additions to any unemployment or other [disability, etc.] payments for others. ***NOTE****. **The details of this would have to be worked out in conjunction with changes in the Tax Code that will likely be underway at the same time.***
8. All insurers will submit an annual report to DHHS to include total revenues from policyholders, total reimbursements from government, other revenues, total cost of claims paid [and maybe expenses "incurred but not reported", or IBNR, depending on how long after year-end the report is due], etc. Data for these reports would be readily-available within these organizations, so the reporting [which should be common-format electronic data, not paper] would not be burdensome. A similar reporting requirement for providers might also be advisable if that information would enhance the usefulness of the information obtained from insurers.
9. At some point in the future, when more viable measures of quality are available and more effective ways to incorporate them into insurance policy comparisons have been developed, quality parameters should be integrated into this entire process [attempting to do this now could actually be detrimental without better measures than we have at this time].
10. The above items are operational in nature. Other possibilities for reducing overall healthcare costs that should be investigated would include but not be limited to the following [some of these are controversial; to the extent those controversies are simply driven by "wars among lobbyists", that more fundamental issue will need to be dealt with before meaningful progress can be made]:
    a) Imposition of maximum increases or mandated reductions in a given year. This would have to be purely data-driven, **not** fully controlled by politicians, and some "appeal" process would be necessary.
    b) Removal of state-level boundaries for insurers. Allow the sale of national policies, regional multi-state policies, etc.
    c) Promulgation of Tort Reform. Curb sometimes ridiculous jury awards, but in a way that does not adversely affect accountability. This is much more costly than the awards themselves -- the bigger cost is in "defensive medicine" [tests ordered and procedures performed by providers to avoid potential lawsuits even when they would not, absent the threat of litigation, consider those tests and procedures medically necessary].
    d) Identification of ways to curb "blockbuster" drug costs without thwarting innovation within companies that develop them.
    e) Improvement of capabilities to curb fraud and abuse in all entitlement programs as well as in this new ACA replacement system.

f) Heavy emphasis on fostering improved case management across multiple unaffiliated providers and facilities [physicians' offices, hospitals, assisted living facilities, nursing homes, pharmacies, labs, Durable Medical Equipment sellers, etc.].
g) Heavy emphasis on fostering improved capacity for, and effectiveness in providing, home-based care options.
h) Identification of ways to capitalize on financial and in-kind contributions that can be incorporated into a bigger-than-government system by what Georgia Republican State Congressman Geoff Duncan likes to call the four C's: churches, charities, corporations and citizens [e.g., by allowing businesses and residents to make donations to eligible rural hospitals and claim a state tax credit equal to 70% of the donation].
i) Identification of ways to link healthy behaviors [diet, exercise, smoking cessation, etc.] to reduced costs for individual policyholders [e.g., through premium breaks if they meet certain healthy behavior goals such as those offered by many employers]. This will become more doable as measurement methods and cause/effect evidence increase in sophistication [as they have been doing in recent years]. Successfully establishing these links and implementing the associated cost reductions for policyholders will produce big cost savings for insurers and providers as well, because an increasing percentage of people engaging in healthy behaviors would produce a concomitant decreasing need for treatment of many avoidable conditions [Type 2 diabetes, heart surgeries, joint replacements, stroke surgery and rehabilitation, etc.].
j) Broadening the long-term scope from the get-go on **all** programs associated with the provision of health-related services -- ACA replacement, Medicare, Medicaid, that component of the Veterans Administration, and other programs. The goal, of course, would be to achieve economies of scale and eliminate duplicative and redundant functions [of which there are **many**]. There is a danger that interjecting this thinking up front would result in "paralysis by analysis", so care would have to be taken to avoid getting into the weeds until a workable ACA replacement component can be put in place. However, including this **concept** into planning for the ACA replacement would facilitate making short-term "micro" choices that would be the most consistent with future "macro" decisions that would be needed. There is also a danger that **even mentioning Medicare** in conjunction with development of an ACA replacement would become a highly political issue, but if communication is managed well, that could hopefully be avoided.
k) [Related to the previous item, but important enough to be listed separately since it could be pursued separately, and because the issues over the past few years with the VA healthcare system have resulted in considerable bipartisan support for this item] ... Identification of a way to phase out the healthcare component of the Veterans Administration, moving to a system whereby their benefits are delivered through the same providers used by other citizens. I believe it is highly likely that the government's overall costs could actually be lower in this scenario.
l) Getting rid of dependence on employer-provided health insurance, and trying to move away from the engrained concept that this is a universal expectation [even a mandate

that all employees' salaries / wages would have to be increased by the average of their employer's expense for healthcare coverage at the time would probably "fly" -- it would definitely be supported by most employers].