ACA individual market is a de-facto High Risk insurance pool

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Summary[1]

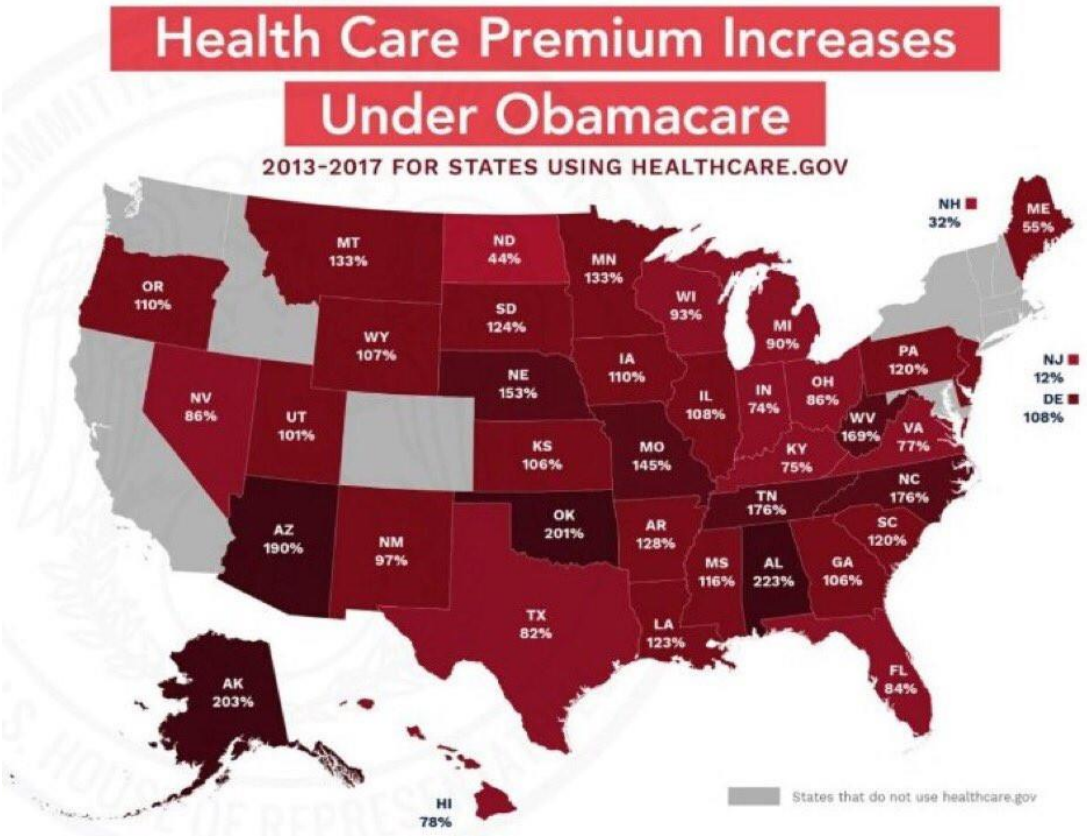
What happened to the pre-ACA 35 state run high risk pool/high cost patients? The ACA merged these patients, plus the high risk patients in the other 15 states that did not have high risk pools - into the small individual market risk pool (Gruber, 2011b, pg 5). Their high costs are shared exclusively with the small individual market consumers.

What happened to the large number of uninsured with pre-existing conditions? An estimated 27% of the uninsured prior to the ACA, had pre-existing conditions. Many or most were merged into the small individual market. By definition, they are higher risk/higher cost patients.

What are the impacts of these changes? The ACA turned the individual market into a de-facto "high risk" and high cost insurance pool. As of 2017, none of this risk (cost) is shared with other insurance market participants. As of 2017, only members of the small individual market pay the costs of insuring these high risk consumers. Consequently, individual market premiums have skyrocketed.

Through 2017, average premiums in the individual market increased by 105% (ASPE HHS, 2017). Two thirds of states saw a doubling of insurance premiums during this time frame. By the start of 2018, our own ACA insurance premiums rose by a cumulative +167% 2014 to 2018 (we have since dropped out of the ACA market).

[1] This paper was written in 2016 and evolved through 2017 and 2018 due to changing market and government policies.

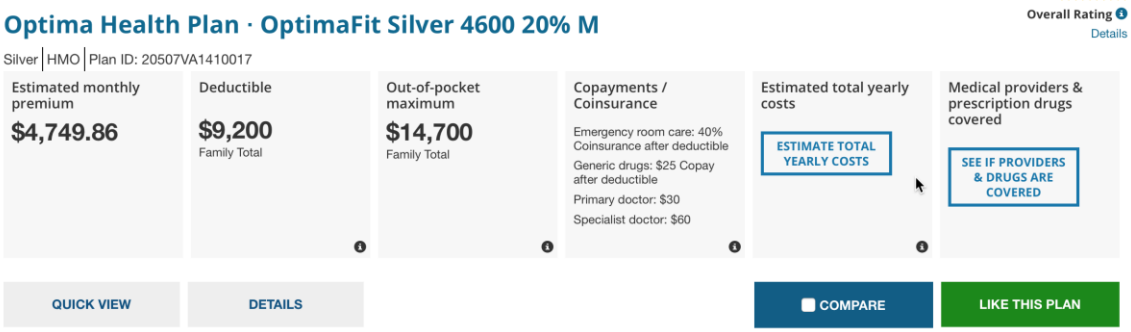


For 2017, average premium hikes of +76% in Oklahoma, +60% in Minnesota and +59% in Tennessee were sought by insurers. Our own 2017 Oregon rate hike was +56%. These prices are unconscionable and unaffordable, leading to the collapse of the unsubsidized individual insurance market.

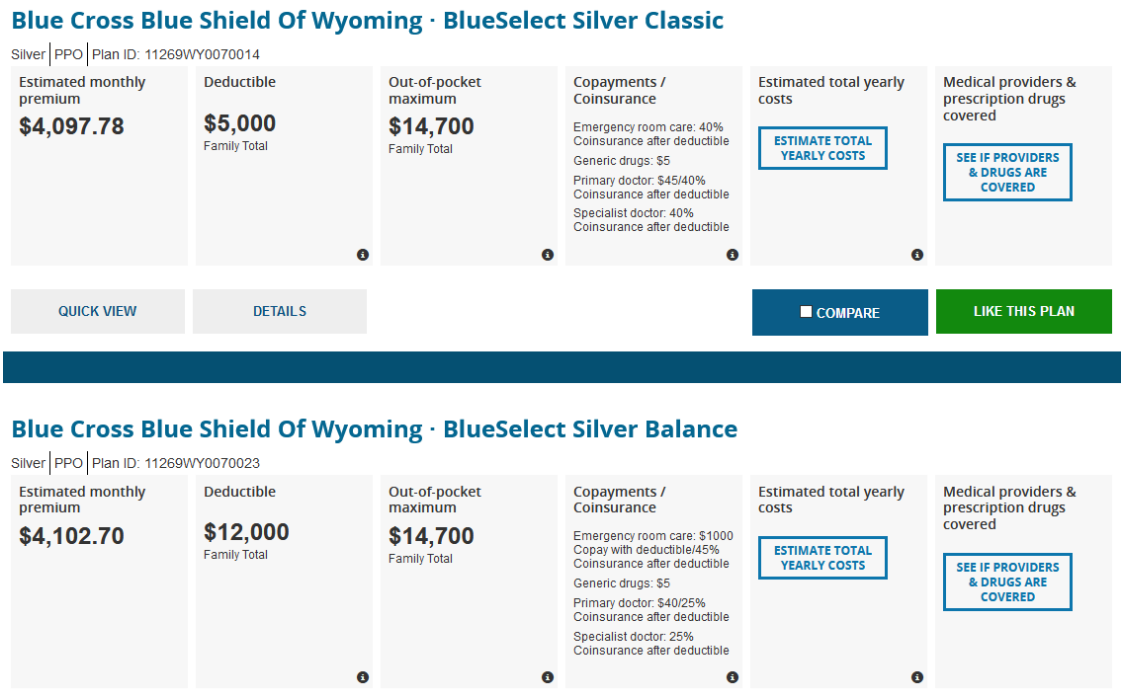
Roughly half the individual market is subsidized and half is not. The subsidized half sees no price increases (government subsidies increase, costs to taxpayers increase) and, all else being equal, pays the same rates as in 2014. The unsubsidized half has seen a doubling and in some cases, a tripling in prices: This market is not sustainable.

The subsidy income level is set regionally as a function of the local poverty income level. <u>It has no connection to actual insurance costs</u>. In 2018, a married 64 year old couple living in Charlottesville, VA with a $65,000 pre-tax income is above the cut off level - yet the cost of the only Silver plan available to them is *$4,749 per month or $57,000 per year*. Clearly this is unaffordable. The problem is the subsidy level is based solely on the poverty level which has no connection to local insurance prices.

After the deductible, their cost of insurance plus fees is greater than their annual income – and they still need to pay state and local income and property taxes. Actual screen shot from HealthCare.gov:



This same couple in Laramie, WY in 2018 must pay $49,000 per year for the least cost Silver plan. After taxes, this leaves this couple with $6,000 or $500 per month for all other expenses. Actual screen shot from HealthCare.gov:



Real people with serious health problems are priced out of the market for health insurance and health care. The disconnect between subsidy cut off and actual insurance prices is a major defect in the ACA.

Consolidation and Mergers by Insurers, Health Care Providers and health retailers led to higher prices: But individuals are banned from responding to this with group purchase discounts.

Hospitals merged with medical clinics and doctor's offices to form strong negotiating positions relative to insurers. Drug companies merged and expanded into pharmacy benefits management (PBM). Insurance companies bought PBMs. CVS pharmacy bought a PBM and in 2018 is acquiring the Aetna insurance company; CVS also acquired about

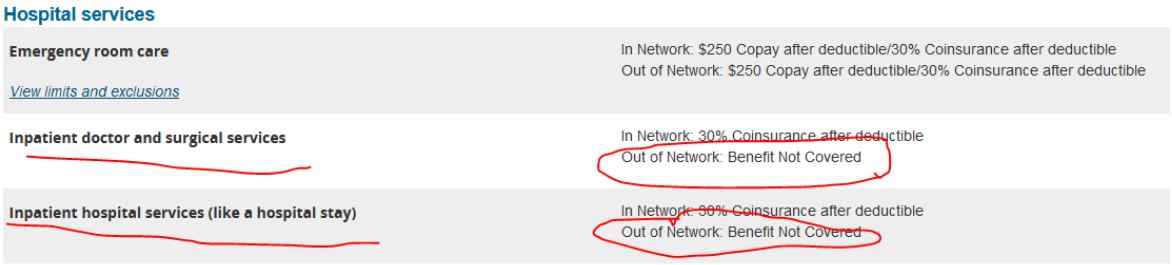
half of the Rite-Aid stores. Post-ACA consolidation by providers has led to higher prices charged (Petris Center, 2018).

Every player in the market merged to negotiate better prices – *except individuals who are prohibited by the ACA from joining volume purchasing associations.*

The ACA prohibited individual consumers from forming volume purchase groups leaving them in the worst position relative to all other market participants. (Starting in 2019, small businesses and sole proprietors will be permitted to use volume purchasing in states that allow this.) That everyone but individuals is permitted merge to increase market power is unfair to individual consumers.

Most ACA policies leave policy holders uninsured for major emergencies while traveling outside their local geographic zone.

Most ACA policies have narrow provider networks, typically restricted to an area of a few counties or possibly a state. Most policies exclude coverage for hospitalization and surgeries "out of network" - which de facto means most ACA policy holders are uninsured for catastrophes while traveling in the United States. Actual policy screen shot from HealthCare.gov - note the words “Out of network: Benefit not covered”:



Hospital services	
Emergency room care View limits and exclusions	In Network: $250 Copay after deductible/30% Coinsurance after deductible Out of Network: $250 Copay after deductible/30% Coinsurance after deductible
Inpatient doctor and surgical services	In Network: 30% Coinsurance after deductible Out of Network: Benefit Not Covered
Inpatient hospital services (like a hospital stay)	In Network: 30% Coinsurance after deductible Out of Network: Benefit Not Covered

Who knew most ACA insured have no meaningful insurance coverage while traveling in most of the United States? In this regard, ACA policies are worse than pre-ACA catastrophic insurance policies.

The Individual Mandate is Moot

The ACA’s “individual mandate” requiring purchase of compliant health insurance policies was moot by 2017. The ACA says if the least cost Bronze plan exceeds about 8% of your annual income, then you are exempt from the mandate. By 2017-2018, a family of 3 earning 1% over the subsidy cutoff income level exceeded this threshold[2] in 47 of 50 cities checked for ACA prices.

[2] In 47 of 50 cities checked by E-Health, a family of three consisting of two 35 year old adults and one child, earning 1% above the subsidy cutoff income level, is exempt due to premiums exceeding 8.16% of annual income. In effect, the ACA killed its own mandate to buy insurance.

See “Affordable Care Act Health Insurance Will be Unaffordable in 2018 for many middle-income American families, E-Health Analysis Shows”. Retrieved from:

By the ACA's own rules, nearly everyone in the unsubsidized market is exempt from the individual mandate. The ACA itself ended the mandate. The political discussion over an individual mandate being essential is nonsensical noise.

As explained later in this paper, Gruber's own research found that the mandate had no impact on signups. More on both of these topics later in this paper.

ACA Implements a Pre-Existing Condition Exclusion Waiting Period

The number of persons impacted by pre-existing conditions is smaller than politicians and media pundits imply. The Health Insurance, Portability and Accountability Act of 1996 prohibited employer-sponsored insurance plans from denying coverage to anyone. About half of U.S. states subsequently adopted their own versions of pre-existing condition protections (see later in this paper). Medicare and Medicaid have no pre-existing condition exclusions. These protections account for the overwhelming majority of persons insured in the U.S. - what was missing was protection for the (small) individual markets not in one of the states that had their own protections.

Prior to the ACA, insurance companies denied coverage to about 250,000 applicants per year[3] in the individual insurance market. Additionally, 226,615 individuals were enrolled in state-run high risk pools[4]. This suggests a baseline of about 500,000 people per year, but to which we should also add in a percentage of the uninsured who had not yet applied for insurance[5]. State-run high risk pools also had their own set of problems and limitations and were costly to states and to those enrolled with premiums typically 150% to 200% higher than standard premiums (from the Kaiser paper on high risk pools) – which is of interest as ACA individual market premiums have gone up about as much as the individual market was turned into a larger high risk insurance pool.

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https://news.ehealthinsurance.com/news/affordable-care-act-health-insurance-will-be-unaffordable-in-2018-for-many-middle-income-american-families-ehealth-analysis-shows

[3] Memorandum, October 12, 2010, House Committee on Energy and Commerce, "Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market", copy of memo retrieved from https://thehill.com/images/stories/blogs/memo1.pdf

[4] State high-risk pool enrollment, Program Features, and Costs. Kaiser Family Foundation. Retrieved from HYPERLINK "https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/"https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/

[5] I personally knew self-employed individuals who did not apply for health insurance because they believed they would not be covered for any insurance. At the time I lived in a state that limited exclusions only to the specific health problem, and only for a specific time period. Lack of knowledge – perhaps caused by a barrage of incorrect political propaganda about pre-existing conditions – prevented them from applying for insurance under the mistaken belief that none was available to them.

The ACA eliminated the worst case pre-existing condition exclusions but retains a waiting period, which is one of the forms of pre-existing condition exclusions used prior to the ACA.

In January, you have no insurance. On February 1st, you are diagnosed with cancer. Under the ACA you are prohibited from signing up for ACA insurance until January 1st of the following year. This is known as a pre-existing condition waiting period. More on this later in this paper.

"Cost sharing reductions" (CSR) payments – given to insurers to reduce deductibles for those earning below 250% of the poverty level are set to automatically expire.

In late 2017, there was much political discussion about eliminating "cost sharing reductions". Left out of the discussion is that CSR payments expire automatically *regardless of politics*. Per Section 1401, (ii) Indexing (I), (II) and (III) once the CSR subsidies exceed 0.504% of GDP, the subsidies change from tracking actual insurance costs to tracking the consumer price index. Since actual insurance costs rise many times faster than the CPI, the low income subsidy program is automatically reduced. ***If the ACA had signed up the original forecast total of 23 million by 2016, the CSR payments would have been cut automatically in 2017 or 2018.***

With the "cost sharing reductions" program in doubt, many states chose to assess a premium surcharge fee (a tax) to all Silver policies purchased on the exchange paid for only by individual market consumers. For subsidized customers this fee is paid by Federal tax payers; unsubsidized individual consumers pay this fee out of pocket to subsidize those with the lowest incomes. *No other insurance market participants pay this fee. The unfairness of this is staggering*.

Solutions

There are solutions to address these serious problems in the ACA. They can be implemented by policy makers at either the State or Federal level to equitably distribute risks to all market participants (as is being done in Alaska) or enlarge the risk pools to distribute the risks to more people (Massachusetts and Vermont allow insurers to combine the individual and small group markets into one risk pool (Arron, Lucia, and Giovannelli, 2016, Norris 2018)). Oregon has passed a state-level re-insurance program, starting in 2019, to address the risk pool problem. The Trump Administration has issued a rule enabling small businesses and sole proprietors to purchase "association" or group volume purchasing to negotiate better prices.

The Cause

The post-ACA "newly insured" in the individual market have greater health expenses (higher risks) than the pre-ACA non-group market due to the design of the ACA.

First, the high risk members of the pre-ACA 35 state run "high risk pools" were moved to the small individual market as the high risk pools were shut down (Luhby, 2017). The ACA redistributed these higher risks *exclusively* to the non-group market; none of this risk was redistributed to the large group, small group or Medicare markets. Similarly, in the 15 states without pre-ACA risk pools, all of those persons were moved to the individual market.

Jonathan Gruber, co-architect of the ACA, modeled the impact of merging the high risk insurance pools into the individual market (Gruber, 2011b, page 5). He found that 87% of the market would see an "average premium increase of 41%" due in part to "the merging of the HIRSP population into the Individual Market." HIRSP was Wisconsin's High Insurance Risk Shared Plan. (Actual premium increase would be offset to less than 41% due to other hypothesized savings, said Gruber.)

These very expensive patients were merged into the individual market because there are no longer pre-existing condition exclusions. Regardless of their high expenses, under the ACA they and the other members of their risk pool pay the same rates, based on age and location. However, their high expenses need to be paid for by someone else – which are the other members of the individual risk pools. Thus, insurance prices in the small individual markets doubled or tripled in price because everyone in these small markets shares these risks (or if you prefer "costs", although cost and risk are not identical terms).

Second, the post-ACA individual market added a large group of newly insured who had "pre-existing conditions" pre-ACA. As noted earlier, an estimated 27% of the pre-ACA uninsured had pre-existing conditions. By definition, this group had higher risk and higher costs.

All of this risk (or "cost") was placed into the post ACA individual market, turning the entire nongroup market into a de facto "high risk" insurance pool, resulting in high premium costs, high deductibles, and limited coverage networks – and a poor economic value to much of the market.

In Iowa, a large insurer with a small risk pool sought a 2017 rate hike of +40% *with 1/4th of that due to the costs of a single patient* (Leys, 2016).

> "Medica is promoting the idea of a "virtual high-risk pool" to spread the costs for a handful of patients whose care costs millions of dollars per year. **When explaining the health plan's decision to drop the Iowa market, Wellmark officials mentioned the unusual case of a patient generating more than $1 million per month in claims — an enrollee subsequently described as a 17-year-old with hemophilia.**"
> ....
> "The question, socially, comes back to: Who actually should be helping that individual?" Naylor asked. "Is it a broader pool of people that are insured? Is it the state? Is it the

> federal government? ... **Right now the costs are being borne by the people in the individual market, and that's what's causing part of the issue**." (Snowbeck, 2017)

In Montana, Blue Cross Blue Shield sought a +62% rate hike in 2017, which is not unusual for a small population with small risk pools and a declining number of insurers.

The media and politicians blame high prices on "sicker patients than expected". In fact, this was predicted and caused by the specific design of the ACA itself. There is nothing "unexpected" about this situation. Gruber modeled this impact in his 2011 analysis for the State of Wisconsin (Gruber, 2011, pg 5).

Rapidly increasing rates lead to market drop-outs, which lead to higher rates for a shrinking risk pool, leading to more drop-outs - the "death spiral" of the ACA. ACA exchange Enrollment for 2017 was below that of 2016; the CEO of Aetna told the Wall Street Journal that the ACA likely collapses in 2018 (enrollment has declined further in 2018).

Fairness and equity demand all insured stakeholders share these risks. It is arbitrary that 100% of the pre-ACA high risk pools and high risk newly insured are burdened solely on the members of the small unsubsdized non-group market. This aspect of the ACA is not sustainable.

Background

The ACA sets the individual market as a single "risk pool". "Health insurance issuers must treat all individual enrollees in their plans as a single pool and all enrollees in the small group market as another single pool" (Jost, 2010) and "The Affordable Care Act makes the most dramatic changes to the individual and small-group insurance market, aiming to create: a single health insurance pool in each state" (Baker, 2011).

According to ObamaCareFacts web site[6]:

> "Health insurance issuers would be required to maintain a single statewide risk pool for each of their individual and small employer markets, unless a state chooses to merge the individual and small group pools into one pool. Premiums

[6] https://obamacarefacts.com/obamacare-health-insurance-rules/

The ObamaCareFacts web site is an attempt by some individuals to document information about the Act and its impact in the early years of the ACA. It is not clear that it has continued to be updated. The group notes they do not have specific expertise in the subject matter but have done their best to gather information related to the Act and its provisions. For example, they note that "The primary cause of the insurance premium rate hikes under ObamaCare is the requirement for insurers to cover high-risk consumers." which is true, but they miss that these new risks are concentrated into the small risk pools, which is a key omission in their analysis.

> and annual rate changes would be based on the health risk of the entire pool. This provision prevents insurers from using separate insurance pools within markets to get around the market reforms and to charge people with greater health problems higher premiums by increasing their premiums at higher rates than other, healthier risk pools."

While each insurer has a single pool, the ACA has mechanisms intended to share risks between other insurers individual market pools (mechanisms that ultimately failed) - thus the concept of a single insurance pool in each state.

We now know the *newly* insured have greater costs (higher risks) due to merging the prior "pre existing condition" uninsured and the state run "high risk pools" into a single non-group market place. Post-ACA, the individual market has exclusively absorbed this risk and cost as of 2017.

At that start of the ACA markets, insurers modeled the costs (or risks) of the individual market on the large group risks (Avalere Health, 2016) as they believed the individual market would be similar. But insurers discovered the demographics were different: "The HHS HCC risk adjustment model is developed from data on large employer self-funded commercial claims. This database represents primarily large group market claims and encounter data, *and does not reflect the demographic characteristics of the individual and small group commercial market*" [emphasis added]. **Avalere found the individual market post-ACA has higher risks, lower incomes, is older than the large group market and 30% of such enrollees remain in the market for less than one year.** Part-year enrollees have 18% higher claims - and then drop out.

Blue Cross Blue Shield of North Carolina reported "One in five customers signed up for coverage, paid the first month's premium, used services, and then dropped the plan" (Restrepro, 2015). The costs of these "part time" ACA freeloaders are borne solely by the non-group market.

Wellmark noted utilization of health care services by those with pre-ACA grandfathered plans is less than the new ACA plans (Tibbitts, 2016), which is another way of saying the newly insured have higher risks and costs.

The ACA merged the risks of the newly insured "pre-existing condition" patients into the individual pool and pretended this would not be a problem by assuming vastly larger pools than actually developed post-ACA. The CBO forecast 23 million Exchange customers for 2016 but only 10.4 million signed up.

With the individual market absorbing the pre-ACA high risk pools, a large portion of the uninsured with pre-existing conditions, and enrolling fewer than half the number of people expected, the individual market became a de facto high-risk pool whose prices discourage consumers from participating in the market. "When healthier individuals perceive no economic benefit to purchasing coverage, the insurance

pool becomes increasingly skewed to those with higher expected claims" (American Academy of Actuaries, 2009).

To compensate for the additional risk forced into the individual market, insurers nearly nationwide raised rates by double digit percentages year after year. In Oregon in 2017, insurers sought a weighted average hike of 27%. The year before, they sought an average of 23% and the Oregon Insurance Commissioner approved an even higher 24.4% average rate hike. In September 2016, Providence Health informed us of a rate hike of +56% for 2017; if we stay with them, our total costs to cover ourselves ("Silver") and one adult daughter (in grad school) will come to $19,600 (including $1,200 for dental insurance) for high deductible coverage that used to be called "catastrophic insurance". This is not sustainable and leads to the "death spiral". (Update - we found a legal exemption and dropped out of the ACA markets, and since we are healthy, our dropping out leads to a sicker risk pool for those that remain.)

These exorbitant prices are at odds with the objectives for the Affordable Care Act and the name of the Act itself.

Second*, the majority of Oregon enrollees (60% in 2015) in the individual insurance market *do not receive direct subsidies*.** Avalere (2016) reported that in 2014, only about one-third of the combined exchange and off exchange enrollees received subsidies. The Congressional Budget Office estimated that for 2016, just 45% of the non group market would receive subsidies. Yet HHS/CMMS and the media both use a sleight of hand to report that 70-90% receive subsidies, which is true for policies bought on exchanges but false for the overall individual insurance market (CBO, 2016). ***In the individual market, a majority do not receive a subsidy.

According to CMMS, total Oregon exchange enrollment in 2015 was 113,219 (as of the end of the enrollment period) of which 75% received a subsidy, and 102,232 enrolled directly with unsubsidized private insurance (did not use the exchange) for a total of 215,511 enrollees. (Numbers vary slightly depending on the date obtained and who released them.)

- 84,914 (75% of exchange enrollees) or 39.4% of individual market received subsidies
- 130,597 or *60.6% of all individual market participants received no subsidies*

CMMS claims the average 2016 premium rose by $49/person/month except in the subsidized group the price rose by $1/person/month. Rate hikes for subsidized customers are shifted to taxpayers. Those receiving subsidies are protected from rate hikes and in 2017 paid basically the same rate as they did in 2014. In fact, subsidized customers will pay 2014 rates forever (all else being equal). By comparison, unsubsidized customers have seen rates double and triple from 2014 to 2017.

Exorbitant price hikes crush the majority that receive no subsidies. Unsubsidized consumers absorb 100% of new "high risks" added to the individual market pool by the ACA.

***Third,* the ACA included a new benefit for employer provided insurance enabling employees' adult children to receive employer-sponsored insurance up to age 26. This removed a potential group of young, healthy enrollees from the individual market.** HHS estimates 3 million young people receive this benefit-Rep Suzanne Bonamici's office (D-OR) says 6 million received this benefit - regardless, this large group was removed from the nongroup risk pool, shrinking the size of the pool, and in particular, removing potentially millions of "young and healthy". This had the effect of increasing rates in the individual market while decreasing costs for those with employer provided insurance.

***Fourth*, the ACA pools in many states are too small to distribute the risk**. In Iowa, an insurer is seeking a +40% rate hike for 2017 - *because of the extreme costs of treating one patient* (Leys, 2016). In Alaska, 500 very expensive patients made health insurance unaffordable for all in the individual market (Mccaughey, 2017). These examples illustrate the unsustainable concentration of risk into small risk pools.

***Fifth*, the ACA merged the state run "high risk" pools into the individual market, distorting the individual market risk pool**. The pre-ACA "high risk" pools enrolled about 2% of the individual market in 2012 with an average cost per person of $32,108. *But 4.4 percent of this group accounted for the majority of claims paid, averaging $225,000 per patient per year* (Norris, 2015). Let's restate that - the majority of the high risk claims paid averaged $225,000/person/year and this risk - and cost - was thrust onto the individual payers and no one else.

New Mexico is one of the few states still running a high risk insurance pool (as of 2017). Due to state budget problems, New Mexico proposed to move those patients into the ACA individual market but insurers have "warned it could weaken the pool and drive up health premiums for people who are covered individually" (AP, 2017) confirming the problem caused by combining high risk patients into the small individual market risk pools. New Mexico ultimately chose to retain its high risk pool program – but dropped all out of network benefits and required use of "in network" providers only. New Mexico noted that most members of the pool had already migrated to the ACA market policies (New Mexico Medical Insurance Pool, 2017).

Sixth, after millions of Americans received policy cancellations in late 2013 contrary to the "If you like your health plan you can keep your health plan" sales pitch, the Administration issued rules permitting policy holders to retain pre-existing non-ACA policies through 2016. This took an additional group of insured out of the ACA markets, leading to smaller risk pools.

Seventh, the ACA permitted market providers to merge and band together into groups for stronger price negotiation strategies. Hospitals merged, bought local medical clinics,

while pharmacy chains bought each other, pharmacy benefit managers and entire insurance companies. Insurers merged and acquired pharmacy benefit managers. Everyone merged to increase their market power – except for individuals who are prohibited by the ACA from making group volume purchases. Gruber believed his ACA would create a dynamic marketplace of insurers competing for individuals business and volume purchase arrangements were unnecessary. In the real world, however, there is only 1 insurer offering policies in the 55% of counties and just 2 insurers in 75% of counties (as of 2018). Everyone in the health industry merged to increase market power – except individuals who were denied even group purchasing/volume discount arrangements.

The individual market risk pools are too small and the risks too high. Each insurer maintains their own individual market risk pool, per state, and many of these pools are too small to remain viable. There were some mechanisms intended to share risks across the pools between insurance companies but they fell apart (risk corridor payments were slashed) and other components were ended by 2017.

The Minnesota state Insurance Commissioner called the ever rising rates "unsustainable and unfair", noting "that people were being 'crushed by the heavy burden of these costs.'" (Doherty, 2016).

Risk Management

As of 2017, the large, small and Medicare groups take on no additional risk. Only the pre-existing individual market is forced into this high-risk pool. Because of the design of the ACA, ***the risk of the newly insured were not distributed across enough people to moderate the costs***.

In the first 3 years, the ACA included a "risk reinsurance" program that assessed a $63 per year fee on most insured, to redistribute risks of the new individual nongroup market (Aon Hewitt, 2012, Federal Register, 2012, and IRS, 2016). This reinsurance program ended on December 31, 2016 under the mistaken belief that after 3 years, the new ACA individual market risk pools would be large enough to absorb the risks of the high risk/very sick patients and the previously uninsured/pre-existing condition payments.

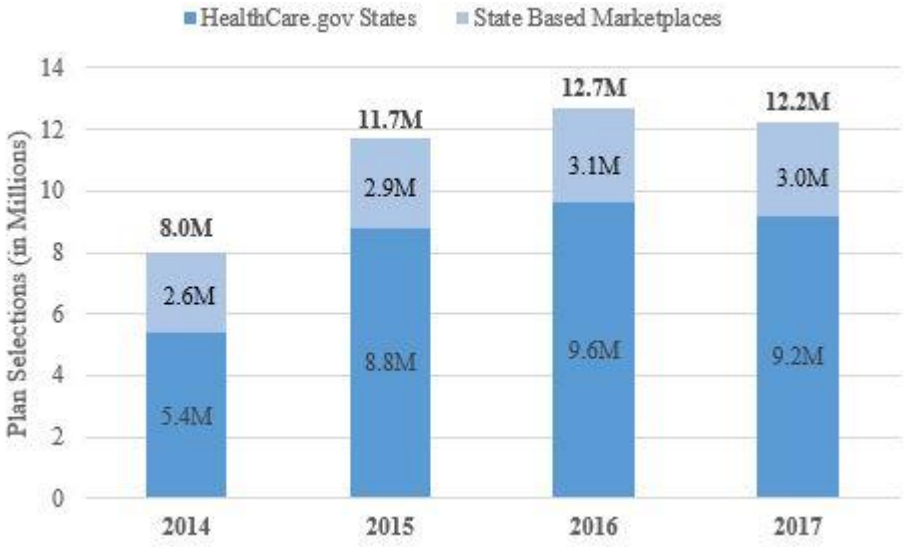
Instead, as of 2017, the individual market risk pool absorbed the high risk pools – but no longer shared the risks with the large and small group markets. Consequently, rates rose at high double digit levels. Rates also rose at a fast rate in prior years, presumably because the $63 per person per year fee was inadequate to distribute the risks of the newly insured combined with the absorption of the 35 state run high risk insurance pools and the high risk uninsured in the other 15 states.

The risks of new sign ups to Medicaid are on taxpayers. Research indicates new Medicaid enrollees *might have a lower risk profile* (Decker, et al, 2016): "They also had lower levels of some risk factors and were in better health (Table 2). The uninsured adults were less likely to be obese and sedentary than [existing] Medicaid enrollees….. The

uninsured adults reported better overall health and fewer functional limitations than Medicaid enrollees…." Other research suggests Medicaid patient costs are higher cost than this. The ACA created a lopsided transfer of risk exclusively to the individual market risk pool.

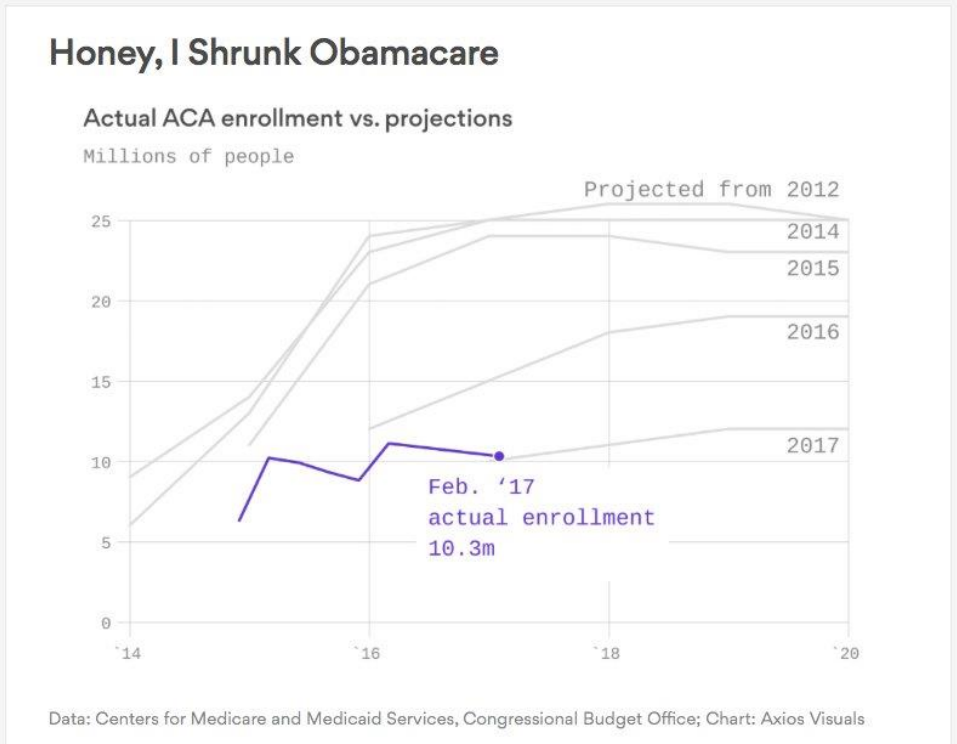
This risk pool was worsened by the ACA's failure to sign up the number of enrollees originally projected. Sign ups in the individual market are at about half the level of what the models projected in 2010 leaving the risk pools too small to be viable long term. The CBO projected 23 million exchange signups by the end of 2016 and 25 million exchange signups (only exchange signups, not including the non-exchange signups) by 2017 (Blumenthal and Collins, 2014). As of March 2017, there was a combined total of 12.2 million signups to ACA exchange policies, down from 12.7 million in 2016 (data from CMMS - CMS, 2017).

As shown in this CMMS chart, enrollment is largely flat from 2015 onwards, and 2017 enrollment is half what was projected for 2017.



The CBO estimated 23 million exchange enrollees (not including off exchange purchasers) in 2016, not the 12.7 million that actually occurred. The following chart compares projections to actual enrollment (enrollment figures differ depending on which month was selected for the chart[7] – enrollment drops throughout the year, reaching a minimum in December):

[7] The reference for this chart was not recorded, unfortunately, but the data point values were cross checked for accuracy. While this paper does contain pages of references and footnote citations, this is a personal paper largely for my own notes, and I do not intend to try and find the reference at this point in time.



Many insurers in Oregon have insufficient pool sizes to remain viable: "…insurers are unlikely to market through an exchange unless they can be assured of enough enrollees to offer a credible insurance risk pool. Small insurance pools, being potentially volatile and susceptible to destabilization by large claims, are problematic for insurers. According to one expert view, a risk pool of at least 100,000 covered lives would probably be necessary to be viable." (Jost, 2010). (Note - *risk corridors* provided a way for insurers to share risk with each other, which sort of handles the small risk pools. However, this proved insufficient in Oregon where numerous insurers left the market prior to 2017.)

Compare Oregon's small risk pool to California with a reported 1.6 million "exchange" enrollees in 2016 (Siepel, 2016) and a forecast for 2017 rate hikes of 8-9%. California has a risk pool at least 10 times greater than that of a small state such as Oregon, distributing risks over a larger group of people. As noted by HealthInsurance.org, "In addition, risk pools are state-based, and smaller risk pools are more prone to premium volatility. If there are 50,000 people in a carrier's risk pool, a $5 million claim is going to have a much greater impact than if there are 500,000 people in the risk pool." (Norris, 2015b).

Various programs, such as "risk corridors" and industry subsidy programs are a mechanism to shift risk across insurers – but the overall costs of the newly high risk patients remain concentrated in the individual market pool. *The ACA transfers the risk within the individual market risk pool* by transferring parts of it between insurance companies - but not to other market participants.

The Subsidy Program Has a Design Defect

The maximum subsidy cut off level is set based on the regional poverty level while premiums are based on age and local health prices.

There is no relationship between the poverty level and age-based rates charged for insurance. This leads to bizarre and non-sustainable scenarios where the ACA expects consumers to pay as much as their entire annual income for "Affordable" insurance.

For 2017, in Flagstaff, Arizona, an age 64 married couple earning $64,000 per year was above the subsidy cutoff income level - but was faced with a monthly insurance premium of $2,994 or nearly $36,000 per year for the benchmark Silver policy with high deductibles (effectively catastrophic insurance coverage).

In 2017, the same couple was charged $30,000 per year in Laramie, Wyoming; in 2018, their Laramie and Cheyenne premiums rose to $49,000 per year. In Charlottesville, VA, their annual insurance costs were $57,000 per year, or $34,000 per year in Asheville, NC. Or $28,000 per year in Bozeman, Montana and Baker City, Oregon or $48,000 per year (as of 2017) in Homer, Alaska (dropping to $40,000 in 2018 after Alaska enacted a state-wide re-insurance program to distribute risks to all insured).

Let's restate that: The ACA requires these couples to pay $28,000 to $57,000 per year in the lower 48, on a *pre-tax income* of $64,000 per year. Do you see a problem here?

For those that get a subsidy, the *subsidy* is increased to adjust for the age rate multiplier. But *the subsidy cut off level does not take age into account and does not change, regardless of the insurance premium cost.* In 2018, some of those above the subsidy cutoff may pay more than 100% of their after tax income for insurance and deductibles before they have received the first dollar of insurance coverage. *In 2019, it is likely that annual insurance premiums in some markets will exceed the subsidy cutoff level.*

A related problem is that per a basic tenet of economics, subsidies cause overall market prices to rise. This leads to higher prices charged for both insurance and actual health care.

The unsubsidized group (the majority) is hit three ways:
(1) the subsidy cut off level is based on regional poverty level but not age-based prices, making their insurance unaffordable,
(2) subsidies raise overall prices charged to the unsubsidized group, and
(3) the individual market group pays all the costs of insuring high risk patients who were merged into this group.

The unsubsidized market segment is much larger than official numbers indicate. Per the official numbers, about half receive a subsidy and half do not. **These numbers leave out the 6.5 million Americans who are paying a "shared responsibility tax penalty" fee for voluntarily choosing to not have insurance.** The unsubsidized plus penalty fee paying group is about 18 million people.

These numbers also leave out the 28 million who have no health insurance - possibly because they cannot afford insurance and have flown "under the radar" of getting caught. The number of people impacted by high insurance premiums under the ACA is measured in the tens of millions, not the "less than 10 million" popularized by media pundits and politicians.

There seems to be an intentional effort to minimize ACA affordability problems by presenting a view that these problems are okay because they only affect "less than 10 million", which is not true.

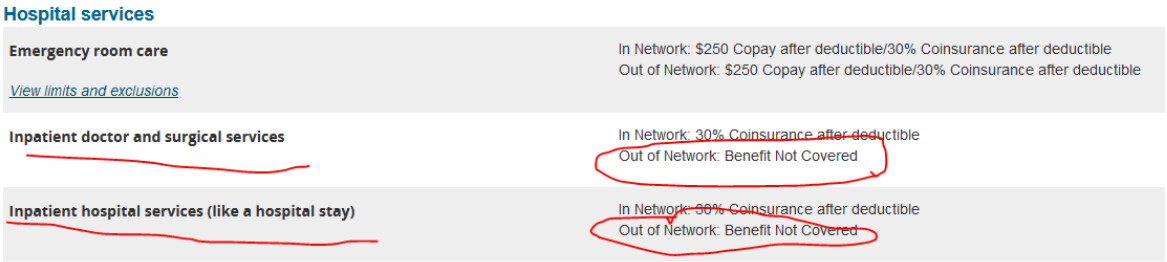
Per comments from the Minnesota Insurance Commissioner and the Director of Oregon's Consumer and Business Affairs, individual market consumers over middle age are either financially ruined or priced out of the market by the Affordable Care Act.

Most ACA policies provide no coverage for catastrophic care when traveling in the U.S.

The majority of policies sold on the Exchange exclude hospitalization and surgery costs for out of network services. ACA policies leave consumers uninsured for potentially catastrophic costs. *In effect, ACA policies are worse than pre-ACA catastrophic insurance policies.*

ACA policies restrict insurance to "in network" providers, which in most cases, are for small geographic zones (as small as a single county). When consumers are traveling outside this small area, most ACA policies provide insurance for an ER visit (after deductible) typically paying just 40% to 50% of costs incurred. ***But most ACA policies provide no benefits for hospitalization or surgery required – for any reason including emergencies - while traveling in the United States.***

The following screen shot of a HealthCare.gov benefits summary page, documents that inpatient services are 100% excluded. The patient must pay the entire bill out of pocket.



Hospital services	
Emergency room care *View limits and exclusions*	In Network: $250 Copay after deductible/30% Coinsurance after deductible Out of Network: $250 Copay after deductible/30% Coinsurance after deductible
Inpatient doctor and surgical services	In Network: 30% Coinsurance after deductible Out of Network: Benefit Not Covered
Inpatient hospital services (like a hospital stay)	In Network: 30% Coinsurance after deductible Out of Network: Benefit Not Covered

Note the keywords "*Out of Network: Benefit not Covered*".

There is no insurance coverage, no re-imbursement for any care other than an ER visit, when required, while traveling in the United States. I checked 33 policies and found 29 excluded hospital or surgery insurance coverage when outside the narrow network provider territory. Only one policy (the most expensive of the 33) provided a national

provider network. Three policies treated this as "out of network" with 50% (or less) benefit coverage and the remainder provided no coverage.

Effectively, the ACA charges high rates for no insurance coverage. This is a stunning defect and failure of the "Affordable" Care Act.

The Cost Sharing Reduction (CSR) Program Has an Expiration Date written in the ACA

The Administration funded a secondary subsidy to health insurers so they can give low deductible policies (e.g. $500 versus $4000 to $8000 for the non-subsidized groups) to those earning below 250% of poverty level. While the subsidy is described in the Act, a Federal Court ruled that Congress never authorized the expenditure of funds for this program. Until October 2017, the Administration funded this without Congressional budget authority. In October 2017, the Trump Administration announced it would no longer fund this program per the Court Order, and turned it back to Congress to properly fund the program.

The controversy over funding this subsidy was a red herring: *Surprisingly, this program has an expiration date defined inside the ACA*. Per Section 1401 (ii) Indexing (I), (II) and (III)[8], once subsidy costs reach 0.504% of GDP, this subsidy is switched from tracking actual insurance prices - to instead track the Consumer Price Index (CPI).

In the first 4 years of the ACA implementation, insurance rates have risen many times faster than the CPI and there is no end in sight to insurance price hikes. Per Section 1401, once the threshold is reached, the subsidies no longer track insurance prices but will track the CPI, which is a fraction of their current level. Literally, the low income subsidy largely expires automatically as required by the ACA Section 1401.

When does this expiration occur? At present, these expenses are about ¼ percent of GDP. If the ACA had enrolled the number originally forecast, we would be at the 0.5% cutoff threshold today and the insurer subsidy would end. But due to only about half that number enrolling, the cut off will not occur for another several years (Bertaut, 2017).

How did this happen? Probably because, as Jonathan Gruber explained at an academic conference panel, "tortured language" was used to get this by "the stupid American voters". This is an example of tortured language inside the ACA that is a time bomb set to explode in the future.

Why didn't Congress authorize funding for the low income subsidy program in the ACA itself?

While the ACA calls for a low income subsidy program, the ACA did not include budget authorization to spend the money. The authorization to spend the money was

[8] https://www.law.cornell.edu/uscode/text/26/36B

intentionally left out of the ACA - and left to an annual appropriation from Congress - in order to improve the CBO scoring of the bill.

If the Act included the appropriation, then the CBO's estimated 10 year costs of the ACA would be greater. By removing the funding from the Act, the CBO could produce a lower estimate of the *authorized* ACA spending costs.

What will happen to the low income subsidy program?

Some states, such as Oregon, assess a premium surcharge (a de facto tax) on all Silver plans sold on the state or Federal "health exchange" for 2018 to raise funds for the low income subsidy program. For those who are subsidized, the extra fee is paid by the Federal government. But unsubsidized individual consumers pay this fee out of pocket, making policies less affordable. *This fee is paid only by unsubsidized individual market consumers and no other insurance market participants. This is clearly unfair to burden only the unsubsidized individual consumers with this cost; no other insured in the group or government programs shares these costs.*

It Gets Worse

Starting in 2017, the risk profile of the individual market may worsen. In 2017, large employers (100+) will be permitted to move their employees to exchanges. If employers with high-risk workers do this (they have a financial incentive to do this) – and those with healthy or young workers do not (they have an incentive to not transfer) - the non-group market will take on more risk (Jost, 2010).

The "Cadillac Tax" was expected to encourage employers to end high benefit plans and move their workers to individually purchased plans on the exchanges. This would increase the size of the risk pools, helping to distribute the new risks (Gruber, 2011). However, Congress deferred implementation of the "Cadillac Tax" to 2020 and many suspect Congress will defer this unpopular tax indefinitely. Thus, the expected increase in exchange enrollees from the Cadillac Tax will not happen.

The Impacts

The CBO originally estimated 23 million exchange signups for 2016; however, only about 10 million were enrolled at the end of 2016. CMMS reported that 9.2 million enrolled by January 31st 2017, which is less than in 2016. In other words, we see the "death spiral" as the healthy drop out of the high priced ACA market.

Providence Health of Oregon said about $1/5^{th}$ of their 29.6% average requested rate hike for 2017 was due to healthy members dropping out, creating a smaller pool of riskier members - which is the definition of the ACA's "death spiral".

ObamaCare policies are prohibitively expensive for those over middle age.

> Currently "rates are unaffordable for many people who don't receive subsidies, especially if they're over 50," said Patrick Allen, director of the Oregon Department of Consumer and Business Affairs. "Even for those with subsidies, access to health has become tougher because of high deductibles and co-payments. (Manning, 2017).

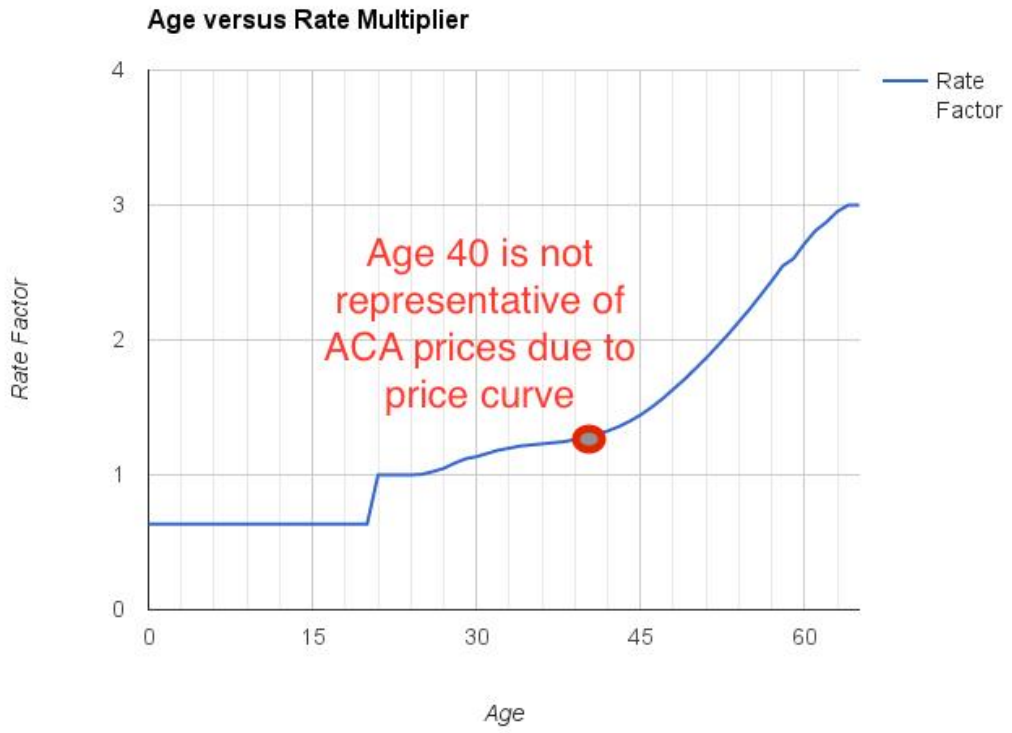
In Wisconsin,

> "I think we're sitting in a market where there is some concern that we're in a death spiral, and the individual market's experience is deteriorating," said deputy insurance commissioner JP Wieske in early October, adding the individual insurance market in Wisconsin has lost $400 million over the last three years. "That's a very significant amount of money to have lost in just the individual market." (Rochester, 2017)

The Department of Health and Human Services misleadingly quotes the "average" price for a 40 year old. While this sounds like an "average", this value is deliberately and intentionally misleading - the rate for a 40 year old is almost the same as that for a 25 year old!

Age 40 is not even the midpoint of the age 21-64 group (43 is). Second, rates are nearly flat from age 21 through age 40; thereafter, rates take a sharp turn upwards. This age rate multiplier chart illustrates the sharp price increases past age 40. (Age rate graph made from the age rate multiplier table in the 2015 Providence Health plan rate filing for Oregon, which is identical to a CMMS produced forecast curve for the ACA.[9])

[9] Massachusetts uniquely sets the age-rate multiplier to a maximum of 2:1 versus 3:1 in other states. This has an effect of increasing rates for younger consumers while decreasing rates for older consumers (Norris, 2018). As of 2018, Massachusetts had the lowest overall average premiums in the United States.



A honest price quote is at the midpoint of the price curve which occurs near age 50 and not the bottom of the price curve. The use of the "age 40" quote is intentionally misleading and should not be used. <u>About 90% of the age based multiplier rate hike occurs after age 40!</u>

Due to these incorrect and misleading low price quotes for age 40, the general public is propagandized into believing ACA costs are far lower than actual market prices. HHS and state insurance agencies deliberately distorted price information to hide the high cost of ACA policies. An arithmetic average of a non-linear distribution is next to meaningless.

In 2015, the Oregon Insurance Commissioner's office agreed with my assessment of this misleading "age 40" metric and began releasing quotes spanning a broad age range (age 21, 40 and age 60).

The ACA's Pre-Existing Condition Waiting Period

The ACA did not fully eliminate pre-existing condition exclusions – instead, it changed them into a waiting period. As described in the introduction to this paper, if you have no insurance in January and are diagnosed as having cancer on February 1, you must wait until the following January 1st to obtain health insurance coverage. That is a simple fact – the ACA implements a pre-existing condition waiting period.

Pre-existing condition exclusions take many forms. These include:

- Denying access to health insurance for all health issues including those unrelated to the preexisting condition
- Denying access to health insurance for the specific preexisting condition, but providing health insurance for other non-preexisting health issues
- Requiring a waiting period before being able to obtain insurance or obtaining insurance for the preexisting condition.

First, the Health Insurance, Portability and Accountability Act of 1996 created pre-existing condition protections for those who had Employer Sponsored Insurance (ESI). Most people are completely unaware of these protections established in 1996.

If the covered individual had at least 12 months of creditable coverage, then a new insurer could not deny coverage for a pre-existing condition. If the individual had insurance for less than 12 months, say 6 months, then the new insurer could establish an exclusion waiting period equal to the number of months less than 12 – i.e. 6 months in this example. After the 6 month waiting period, the new insurer had to cover the pre-existing condition (Cancer.org, 2018). Proponents of the ACA left out that the majority of Americans had pre-existing condition exclusion protections due to HIPAA (the overwhelming majority receive health benefits from ESI, Medicare, Medicaid, VA or other government programs). The Federal law, however, did not address those outside the ESI market – namely, the "individual" market representing between 15 and 30 million potential people (out of a population of 320 million)[10]. Individuals who did not have ESI beforehand could be denied access to insurance.

Second, about half of U.S. states implemented their own pre-existing condition coverage policies after HIPAA was enacted, typically requiring a waiting period for obtaining insurance coverage - and to address the individual market which HIPAA excluded. For example, some implemented state rules similar to HIPAA – if you already had insurance you could change to a different insurer and no pre-existing condition exclusion could be applied. Some enacted a "look back" period – if someone had no treatment during the preceding, say, 6 to 12 months (depending on state), then their condition was not

[10] Kaiser Family Foundation noted that the "individual market" was 15.6 million people in 2014. However, if we count the total potential size of those not receiving ESI/Medicare/Medicaid/Etc benefits, this total was likely 30 to 35 million people (of which many were not eligible to participate in the ACA market subsidy programs due to being in the country illegally). Therefore, the individual market, including those who bought policies and those who did not was probably about 10% of the population. The preexisting condition protections in the ACA were for this population, of which many lived in states that had their own preexisting condition protections. Thus, the preexisting condition protections of the ACA affect up to 10% of the population but perhaps as small as 5%. While this problem needed solving, the ACA itself has been sold using the method of fear of preexisting conditions to the entire population, most of whom were not affected at all. The Kaiser information was retrieved from: https://www.kff.org/health-reform/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/

The journal Health Affairs displays a photo of a chart created for the US Congress noting that the Individual market was 6% or 18 million people (year not given). Retrieved from: https://www.healthaffairs.org/do/10.1377/hblog20170807.061419/full/

considered “pre-existing”. Others chose a “look forward” waiting period – if you had a pre-existing condition, then coverage for that condition would not be provided until, say, 12 months after purchasing insurance.

The goal of a waiting period is to eliminate the “free loader” problem of persons not buying insurance until they develop a health problem.

For example, Washington and Massachusetts initially eliminated all pre-existing condition exclusions and waiting periods. Anyone could sign up for health insurance at any time with the outcome that many people waited until they had a health problem, signed up for insurance, obtained treatment and then dropped coverage. There are anecdotal stories in published papers and the media regarding consumers becoming injured or choosing to have a baby – and then purchasing insurance and dropping coverage immediately after treatment. By 1998, 17 of the 19 insurers in the State of Washington stopped selling individual policies and in1999, every insurer left the Washington state individual market (Gutman, 2017). Washington subsequently passed a law to enact a pre-existing condition waiting period and some insurers returned to the State.

Massachusetts went down an identical path. As insurers tried to remain solvent, they dramatically increased premiums to the point that few could afford them. “RomneyCare”, signed into law in 2006, addressed the market failure that was created by the Massachusetts legislature. Not surprisingly, post-Romneycare, premiums decreased dramatically. This appears to be the source of the false claim made by Obama that the average American family would see a savings of $2,500 per year post ACA. In reality, these premium reductions occurred only in those states that made a mess of their own insurance markets by eliminating pre-existing condition exclusions and allowing "free loaders” to sign up for insurance at any time.

One way to deal with pre-existing conditions is to have an “individual mandate” requiring everyone to have insurance.

The other way is to retain a pre-existing condition waiting period, which the ACA implements, and in fact, is a necessary requirement since not everyone will comply (and does not comply) with the individual mandate.

Even with this waiting period, many people game the system (as described elsewhere in this paper), signing up for coverage starting January 1st and then dropping coverage a few months later after receiving treatment. Other’s stop making payments in November and December due to the “90 day” window for non-payment.

The ACA implemented an “individual mandate” but according to research published in 2016 (co-authored by Gruber), the individual mandate had little to no impact on increasing the purchase of insurance, writing “The individual mandate’s exemptions and penalties had little impact on coverage rates.” (Frean, et al, 2016). In fact, their research found inconsistent results showing the mandate both increasing and decreasing sign ups,

but typically below the level of statistical significance. Hence, they could not find evidence that the mandate increased signups for health insurance.

It appears that the ACA's actual pre-existing condition waiting period worked to reduce free loading, not the individual mandate.

ACA Policies are not equivalent to employer sponsored insurance

Everyone I spoke with during the early years of the ACA debate and eventual implementation believed ACA policies were equivalent to their employer sponsored insurance program.

A common comment has been: "*My ESI costs my employer $20,000 per year so what is wrong with ACA policies costing $20,000 per year?*"

This comment is based on the logical fallacy that ESI and ACA policies are equivalent when they are not close to the same.

Most ESI policies provide:

- Deductibles in the $500 to $1,000 range
- National provider networks
- Cover hospitalization and surgery while traveling in the U.S.
- Cover college age family members away at college
- Extended ESI coverage to family members up to age 26.
- Discounts/rebates for "healthy behaviors"
- Employee costs typically not adjusted for age
- Modest annual price hikes compared to ACA markets (30% versus 100 to 200%)
- Include vision and dental health benefits.

By comparison, most ACA policies feature:

- Deductibles in the $3,000 to $8,000 *per person* range
- Narrow networks as small as a few counties (typical)
- Most policies exclude coverage for hospitalization and surgery while traveling outside one's home area
- Due to narrow networks, no coverage for student family members away at college
- No extended coverage benefits for family members up to age 26. In fact, there are no "family policies" in the ACA (except as a group deductible limit). Each individual has their own policy.
- No discounts/rebates for "healthy behaviors"
- Age rate multiplier increases every year (exponential shaped curve after age 43)
- No vision or dental health benefits
- In my state, we experienced +167% rate hikes from 2014 to 2018 during a period when ESI hikes averaged about 30%.

Poor reporting by the media led most people (who are not in the ACA markets) to believe the ACA was providing "affordable" access to health care, whereas this paper has shown this is false.

Second, for families with parents in their 40s and up, or older married couples, annual premiums for substandard ACA coverage often exceed $20,000 per year – often in the $25,000 to $50,000 range and higher in extreme situations. And remember, this does not include dental and vision coverage, nor other benefits typically present in ESI.

A related problem are the inane comments from ACA co-architects Dr. Gruber and Dr. Emanuel that consumers merely need buy a more inclusive coverage ACA policy: In most markets, no such policies exist at any price - just in case $50,000/year in premiums was not yet high enough. Their flippant commentary acts as propaganda blaming the consume, rather than serious defects in the Act they developed.

ACA Co-Architect: Save Money by Denying Care to Older Patients

The other way to reduce risk and costs is to deny care. Co-architect of the Affordable Care Act, Dr. Ezekiel Emanuel proposed in a 2009 peer reviewed published paper that to reduce costs, health care should be prioritized to "youngest-first, prognosis, lottery, and saving the most lives" and in some situations, health care workers should receive the highest priority for care as they can help others (Persad, Wertheimer, Emanuel, 2009).

Emanuel argues for the reduction of health spending on older people saying we should focus health care resources on those with the greatest capacity to deliver a return to society. He argues we should spend less on infants than on adolescents because society has made an investment in the education of adolescents but has not made an investment in infants. And adolescents have a life ahead of them during which they can contribute to society. Conversely, the elderly have their life behind them and ability to contribute is less, therefore, health spending on the aged should be given a lower priority.

His argument implies that at some age level – say 55 or 60, we should assign a "life value score" to one's remaining life and health care access should be gradually reduced as one ages and their life value score declines. Per Emanuel, this would be based on age grouping and not on individual attributes.

Denying access to health care is similar to taking assets from the elderly[11]. Emanuel's argument could further justify taking assets from the elderly and redistributing them to younger people since younger persons are expected to have a productive life ahead of them. A redistribution does occur *post-death* when assets are distributed to heirs but

[11] We often forget that in the case of Medicare Part A, this has been pre-paid during one's working life. Part A covers hospitalization services. Part B, covering office visits and lab services, and Part D covering prescription drugs, are paid for separately by the Medicare recipient as a separate monthly premium.

Emanuel's slippery slope argues for a government program to redistribute assets prior to death.

Emanuel's emphasis on allocating health resources based on future productive capacity of individuals has hints of Nazism that worked to exterminate undesirables from the population (in this case older people), and is a short step from eugenics.

Solutions

Due to serious ACA defects outlined in this paper, the ACA is not sustainable. Individuals cannot continue to pay insurance premiums that exceed their mortgage, and which rise at double digit percentages, year after year after year.

The ACA's non-subsidized rates are so high because this tiny group and only this tiny group is required subsidize the costs of care for the pre-ACA high risk consumers, a group whose costs were so high that 35 states ran taxpayer funded programs to subsidize their costs. By dumping these costs onto the tiny individual market exclusively, the ACA turned the individual market into a high cost, high risk pool that few can afford. The unfairness of this is obvious.

But there are potential solutions that must be considered by policy makers for the ACA to survive – doing nothing is not a solution.

1. Equitably redistribute the risks of the newly insured to all insurance participants, not just the individual market. This is the approach the State of Alaska took (Summers, 2016) after all but one insurer dropped out of the market. Alaska created a single, statewide risk pool through a re-insurance program. Before Alaska did this, rates rose by 40% each of the past two years and were expected to rise by +60% for 2017. After fixing the risk pool problem, the rate hike for 2017 came in at 9.8% (Hale, 2016, and Dorsey, 2016) and at the time of this writing in mid-2017, *Alaska will see a - 22% rate reduction for 2018.* Oregon passed a state law that will implement a re-insurance program starting with 2019. See also (7) below regarding Nevada's proposed "Medicaid for All" program.

2. Reintroduce the expiring reinsurance program, with revised fees per insured that are reflective of the actual market risks now identified in the nongroup market.

3. Allow insurers to combine their individual and small group risk pools; this is permitted by the ACA and is done in Massachusetts and Vermont (Arron, Lucia, and Giovannelli, 2016, Norris 2018).

4. Allow insurers to merge risk pools across state lines to enlarge their risk pools.

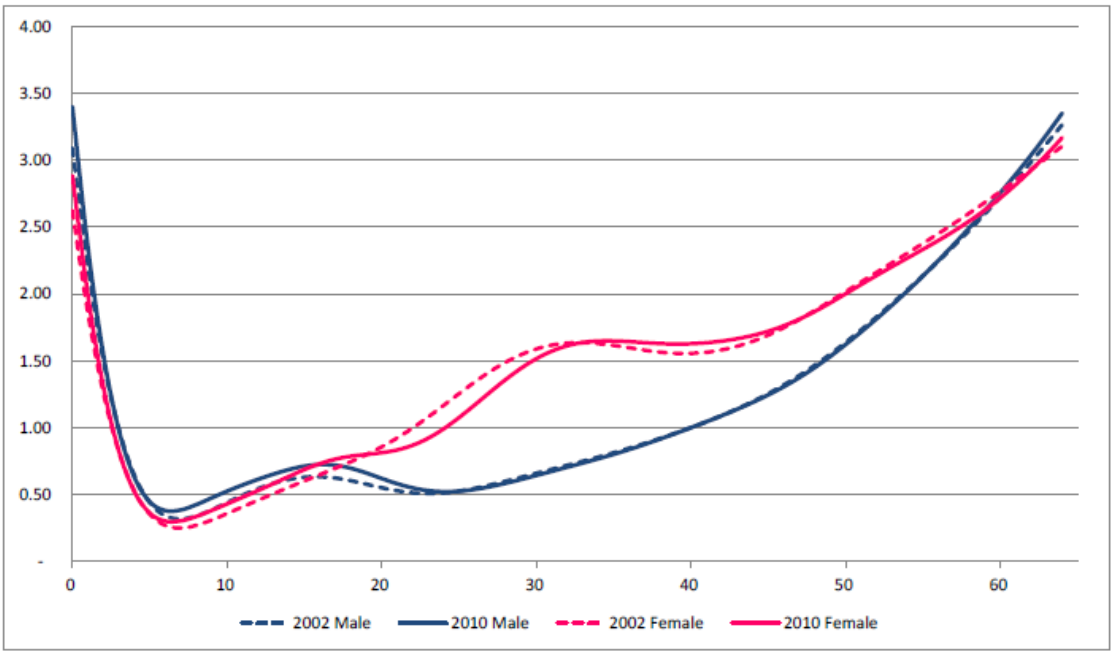
5. Some advocate restoring taxpayer funded "high risk pools", paid for by all insurance stakeholders. This would distribute costs to all taxpayers - but policy experts say it is likely less effective than providing a statewide re-insurance

program.

6. Permit individual market participants to buy the "risk management" insurance they need, rather than expansive insurance for risks they cannot have-I cannot get pregnant but the ACA requires that men purchase maternity insurance for themselves.

   How did this happen? According to the Society of Actuaries, women's health costs are greater than men's health costs from age 18 through approximately age 60, after which men are slightly greater than women but die 7 years younger (Yamamoto, 2013) such that overall men's health costs, on average, are less than women.

Commercial Aging Curve (Chart 1)



Congress did not want to discriminate against women by charging higher rates for "women's health" issues so chose instead to discriminate against men:
(1) Congress required men to purchase insurance for "women's health" issues they do not have such as pregnancy.
(2) HHS require "free" or "essential" women's health services but lists zero "free" or "essential" men-specific preventative health services (HHS, PHS).

Consequently, men pay more for less value. Congress opposes discrimination based on female gender but favors discrimination based on male gender and age.

A possible solution is to provide a broader range of policies that are matched to purchaser tolerance for risk. We do this now with the poorly implemented concept

of Bronze through Platinum but this provides an inadequate set of risk choices to match bona fide consumer needs. Insurance policy offerings must be driven by consumers, not insurance companies or politicians. This idea was partially included in the Senate's 2017 "bipartisan" proposed solution which introduced a new Copper plan.

7. Enlarge the risk pools by moving more lives into the individual markets. Hypothetically, moving all 22 million local, state and federal workers to the exchanges would quickly enlarge the risk pools.

   The State of Nevada legislature passed a 2017 bill that would create a "Medicaid for All" program (the bill was vetoed by the Governor noting that the bill lacked analysis of costs). This would potentially address the small risk pool problem by creating a single large pool.

   Medicaid for All is similar to Medicare for All - neither is likely to achieve the nirvana that proponents claim - but they do address the risk pool problem. Further, whereas Medicare for All puts insurers out of business, Medicaid for All does not which makes it politically palatable.

   The majority of state Medicaid programs are managed by private insurance companies under contract to the States. *Consequently, insurers are less likely to object to a "Medicaid for All" scheme - unlike Medicare for All which puts the insurers out of business. About 75% of Medicaid patients are managed by outsourced third parties and not directly by the government* .

8. (7) suggests that State-level experimentation may lead to innovative solutions. The Federal government is in a deadlock or stalemate where genuine problems of the ACA are politically unsolvable. *When one party unilaterally passes a bill with fatal defects and then leaves it to the unilateral opposition party to fix the problems, the problem is politically unsolvable*. Because of this, States can and are playing a key role in fixing serious problems in the ACA.

9. Adopt a "single payer" scheme that uses one nationwide risk pool or a single payer state-wide risk pool that encompass all market participants. New Hampshire, Vermont, Colorado, Maryland and California considered state run single payer models but ruled them out as unaffordable. This does not mean single payer cannot work – only that specific single payer plans did not work out.

   Ultimately, the math and reality of market participants must work for single payer to be adopted.

   Oregon has a multi-year study underway to investigate an Oregon run single payer model.

   Medicare for All

   Many politicians discuss a "Medicare for All" concept. The proposal, however, is nebulous and has multiple definitions of features and costs depending on who is describing it[12]. Lacking a consistent and agreed upon definition of Medicare-for-All, the following discussion is based on the text of H.R. 676.

   Sen. Sanders has proposed a "Medicare for All" that covers everything (medical, dental, vision, prescriptions, and more without any direct costs to the consumer - no co-pays, no deductibles) and would be more generous than any health system in the world - but lacks details on funding. Several analyses project costs in the tens of trillions over 10 years while other says the costs would be offset by pay cuts in the health care sector, reduced expenses on billing and payments including laying off insurance industry and medical office billing staff, and the end of employer sponsored insurance.

   The most recent analysis (Blahous, 2018) estimates a 10-year cost of $32 Trillion (in line with other analyses of Medicare-for-All), and at least a doubling of all Federal taxes (summarized by Graboyes, 2018, with a link to the analysis report). Others interpret the Blahous study as saying Medicare-for-All would save $2

[12] Two New York Times columnists, in an October 19, 2018 opinion column note that many of the people who say they support single payer or Medicare-for-All have numerous definitions of what they support depending on who is doing the talking. There is no consistent and clear definition. They suggest that details will be left out until at least 2020. See https://www.nytimes.com/2018/10/19/opinion/sunday/medicare-single-payer-health-care.html

Trillion over ten years.

Considering the highly erroneous analysis and false claims made for the ACA, it is likely that all estimates for costs and savings due to Medicare-for-All are bogus.

Medicare-for-All has no relation to Medicare other than a common name

Medicare-for-All covers everything – health, dental, vision, prescriptions with no co-pays, no deductibles, no premiums.

Compare this to Medicare.

Medicare has co-pays and deductibles, does not cover dental or vision services[13] or prescription drugs and has separate premiums for office visits and drug coverage.

Medicare recipients are charged separate monthly premiums for Medicare part B (office visits) and part D (prescription drug coverage), which go away under Medicare-for-All.

Many Medicare patients also purchase supplemental private insurance policies (Part C), which are prohibited by H.R. 676.

Proponents argue that under Medicare-for-All, one would no longer need to fight the insurance company for denied care - leaving out that those denied care would then have to fight with the government as Medicare recipients do now.

There is no relationship between Medicare and Medicare-for-All other than the name which was selected for marketing propaganda purposes. Considering the ACA legacy of false promises, it is unfortunate that proponents have selected a misleading name.

Medicare-for-All Bill Details

The Medicare for All bill in Congress in 2018 (H.R. 676) calls for each state government to establish an agency that determines where each medical office may be located, what equipment may be in each medical office, what medical procedures will be permitted to be performed on which patients, and sets the pay for all health care workers.

The bill would establish government boards that set pay rates for all health care

[13] See Ezra Klein's column in Vox from 2016: https://www.vox.com/2016/1/17/10784528/bernie-sanders-single-payer-health-care Klein also points out that "If the entire system is squeezed down to Medicare pricing, a lot of hospitals are going to close".

workers (which, as written, may be up to 40% less than current pay depending on position and specialty[14]). H.R. 676 calls for payments to providers to be equivalent to Medicare and Medicaid rates (Sec. 202) – which today are about 40% less than market reimbursement rates. About 90% of hospitals lose money on Medicare/Medicaid and make up the short fall by charging private customers and insured, more. Since private customers and insurers would be eliminated, this might require average health care pay to drop by up to 40% (Blahous, 2018 and others). On the other hand, some of this might be offset bya reduction in billing expenses - but still necessitating salary reductions of up to 20%.

Government boards would determine the location of all medical offices in each state (Sec. 303 (d)) and would specify what medical equipment may be set up in each medical office (such as lab, x-ray and other diagnostic or treatment equipment).

The Act would establish a national quality board that establishes all standards of care. Effectively, government agencies would run all aspects of health care in the United States, establishing pay scales, office locations, medical equipment availability per office and specific care guidelines.

It will be great if this can be made to work but we need honest analysis, unlike what was done for the ACA, which resulted in numerous false promises. *I very much want this to work out – Medicare is slated to go bankrupt approximately the year I am eligible for Medicare*[15].

Advantages of Medicare-for-All Concept

A major advantage of a "single payer" scheme is consolidation of separate risk pools into one large risk pool to equitably distribute risks.

A second major advantage is that presumably there would be a single nationwide provider network rather than the ACA's tiny provider networks. Patients could seek care from any licensed provider anywhere.

A third advantage is that a universal single payer scheme eliminates the "free loader" problem (although this depends on how single payer is defined).

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[14] Using an online database provided by the Wall Street Journal, my own doctor was reimbursed by Medicare at up to 75% less than what I am charged for the same service. See https://graphics.wsj.com/medicare-billing/

[15] See "Medicare will run out of money in 2026, three years earlier than expected, government report says", retrieved from http://www.chicagotribune.com/news/nationworld/ct-medicare-money-20180605-story.html

A fourth advantage would be to simplify the billing function at medical providers. Some studies estimate costs of billing at around 14% of practice revenue; this would not go to zero but it would be reduced. Insurers today pay out 80% or more of collected premiums to providers. The remaining 20% or less covers the costs of administration, sales and marketing and claims processing. Medicare-for-All would eliminate sales and marketing, but costs of administration and claims processing would continue, presumably in a government agency.

Fifth, a national single payer scheme would enable older workers to exit ESI and start their own businesses. Due to the prohibitive cost of ACA policies, workers over 40 with families and most all couples over age 60 cannot afford to leave their ESI benefits and start out on their own. A single payer scheme would presumably break the shackles that hold workers to their jobs and unleash entrepreneurial innovation.

Sixth, Medicare's Part A goes bankrupt in the mid 2020s unless an entirely new system is implemented.

Disadvantages of Medicare-for-All

A potential disadvantage is that a monopoly single payer would control the market and may be opposed by health care providers. Single payer would result in the collapse of insurance companies with a loss of large numbers of jobs, and the loss of numerous jobs in insurance billing operations in private hospitals and medical offices. In fact, the Medicare-for-All bill recognizes this and includes a provision to provide job retraining benefits to the large number of workers in billing departments and insurance companies who would become unemployed (H.R. 676, Sec. 303 (e)).

Another issue is how to pay for a nationwide single payer health system. Sen. Sanders frequently points to Denmark for his model, but left out that Denmark's health system was funded by an 8% essentially flat rate, non-progressive "Health Contribution" tax (through 2012, after which the health tax was gradually moved to general taxes) on all workers, plus additional and similar local government tax funding[16]. The Danish system does not provide dental or vision care (Sanders' Medicare-for-All would cover these), nor does it provide full prescription drug benefits. H.R. 676 proposes a wide variety of new Federal taxes, which the Blahous study concluded would represent a doubling of Federal taxes.

H.R. 676 would provide free health care to everyone residing in the U.S., permanent resident or not, legal or not legal: "*All individuals residing in the United States (including any territory of the United States) are covered under the*

[16] See https://www.skat.dk/SKAT.aspx?oId=133800 and http://www.civitas.org.uk/pdf/Denmark.pdf

Medicare For All Program entitling them to a universal, best quality standard of care."

This is a potentially costly feature whose impact, including on immigration, has not been described in analyses of the program[17].

Most countries in the world set up systems to discourage immigration of sick and elderly. Canada, for example, uses a points-based system to determine who is eligible for residency. Potential immigrants to Canada lose points as they age: "**Age: A maximum of ten points is awarded to persons who are between twenty-one and forty-nine years of age**. **Persons outside this range lose two points for each year that they are under twenty-one or over forty-nine."** (Library of Congress)**.**

Ostensibly Canada has implemented Emanuel's ranking system - those with a statistical ranking for greater productivity output score higher. But it also impacts access to Canada's public health system. A 65 year old seeking residency in Canada loses the 10 bonus points assigned to those under age 50 and then loses 2 points for each year over age 49. By age 65, they have lost 40 points and are de facto prohibited from residency status in Canada and hence, access to Canada's single payer health care system (access to Canada's public health system is for Canadian citizens and legal permanent residents only[18]).

Unlike most other countries, the U.S. proposes to offer free health, dental and vision care to everyone including anyone residing in the United States, legal or not, in the United States.

This policy would attract some unhealthy individuals to migrate to the U.S., through legal or not legal pathways. This feature would add undisclosed additional costs to the proposed Medicare-for-All program. There are also potential side effects that are not understood, such as the impact of an influx of unhealthy immigrants on U.S. health care usage and how that might impact access by residents.

This issue needs to be recognized and understood. So far, it has been ignored, and

[17] These comments ARE NOT intended as an argument against immigration to the United States. The point of this section is to illustrate that other countries foresaw a problem with government-provided low or no cost health care as an incentive for unhealthy individuals to immigrate. I and my wife, for example, cannot immigrate to most countries, even if we wanted to visit elsewhere for a year or two, due to our being in our 50s. This is an issue that other countries have addressed in their own ways. The Medicare-for-All bill pretends this problem does not exist.

[18] See https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/health-care-card.html Also note that Canada's single payer system does not cover prescription drugs, dental care, vision care nor ambulance services.

illustrates the poor analysis done on large government programs leading to unfulfilled promises and cost overruns and the propensity to make things worse for those intended to be helped.

Medicare-for-All might be a solution but at this point, it is a sound bite of politician's making promises that are unlikely to be fulfilled. Serious and honest discussion of single payer solutions is needed, not false promises like those made for the ACA.

10. While a "public option" is of interest, it may not solve the root problem. In a market that has "N" insurers, the public option suggests we have "N+1" insurers with the +1 being the proposed government program. If a public option is as cost effective as proponents claim, other insurers would likely exit the market. The 55% of counties with just one insurer in 2018 would likely end up with a "public option" as the only option. In effect, the public option is a single payer option. The floor of a public option price is the same doctor and hospital fees that confront for-profit insurers - only by paying doctors and hospitals less can a public option achieve significant savings. But that would cause doctors and hospitals to charge other policyholders higher rates to restore profitability levels, or deny service to "public option" insured persons.

    Do medical providers deny service to ObamaCare policy holders? **YES**. As of late 2017 in to 2018, the late Sen. John McCain received cancer treatment at a Mayo Clinic in Arizona - a hospital that does not accept patients covered by any ObamaCare policies per their own list of accepted insurers (Mayo, 2017); no ACA/individual market insurer in Arizona appeared on their list.

    While the "public option" sounds appealing, it may be a de facto single payer without the thought and planning needed to implement a functional single payer system.

11. Allow individuals and small businesses to join together in associations to obtain volume purchase discounts. Prior to the ACA, individuals could obtain discounted insurance through trade associations and other group purchase programs.

    The ACA outlawed this practice arguing the ACA would create a competitive market where multiple insurance companies would compete for each individual consumer, thereby driving prices down. As of 2018, 55% of counties have only one monopoly insurer (a single payer?). Per CMMS, prices went up by an average of 105% nationwide in the 4 years from 2014 to 2017 (ASPE HHS, 2017). The prophecy that the ACA would lead to a competitive insurance market and lower prices was incorrect.

    Meanwhile, insurance companies merged to give themselves pricing leverage. Two insurance companies now control 50% of the market nationwide (Gaynor, et al, 2017).

Retail pharmacies merged (Walgreen's bought half of Rite-Aid's stores). Pharmacies are merging with pharmacy benefit managers (PBM). CVS pharmacy merged with a PBM and is merging with the Aetna insurance company. Walgreen's bought an insurance company.

Medical providers, notably hospitals, merged to give themselves more pricing power - and increased their prices charged (Kacik, 2018). The percentage of physicians now working as employees of hospitals reached 38% in 2015, who bill services at 100% to 200% higher prices than private office visit prices.

Many metro areas now have only one or two hospital chains as a result of mergers. This means near monopoly pricing power in many communities.

Large business groups are permitted to negotiate group discounts, enlarging their market power.

In 2018, the Trump Administration issued a rule re-establishing volume purchase programs allowing small businesses and "associations" to purchase health insurance policies that meet "large group" requirements (Appleby, 2018). This rule takes effect in 2019 and preliminary price quotes suggest savings of several tens of percent versus individual policies but it is too early to draw conclusions. However, many states prohibit small businesses and associations from entering into group purchasing programs (Rosenberg, 2018).

Everyone in the market has access to group leverage to negotiate better prices - *except individuals*. Individuals are prohibited from working together to achieve better value. And even with the new rules taking effect in 2019, most individuals are likely to remain unable to negotiate volume purchasing discounts.

This created a lopsided and unfair market where individuals have no market power relative to insurers, pharmacies and medical practices, all of whom have merged to give themselves tremendous market power. By pushing the high risk patients into the individual market and prohibiting volume purchasing by individual consumers, the ACA destroyed access to "Affordable Care" for those in the individual market.

The ACA failed to deliver on its primary objectives and made the situation far worse for the individual market.

12. In addition to the above ideas, there are proposals for solutions with "free market" orientations. Some are simple - *require all market participants to make pricing simple and transparent.* Others are more involved, such as providing catastrophic insurance packages coupled with "direct primary care" where a flat annual fee is paid to a provider for so-called concierge level provider access (also known as

direct primary care). Presumably some concepts (above) and others not described here, could incorporate both ideas - such as combining single payer with transparent pricing or direct primary care and other methods.

13. Would price transparency have an impact? According to research, yes. One study (Chernew, et al, 2018) found that price transparency – and consumers considering price in their decisions – would lower out of pocket costs by 30% and insurer costs by 50%. A popular argument is that patients cannot price shop in an emergency. Yet ER costs are just 2% of overall health care spending, and if we include all urgent care and same day appointments (most of which are not emergencies), will get only to 10% to 12% of health care spending. Clearly, there is opportunity for economical decision making by consumers.

14.) Government officials have routinely lied about the ACA and this leads away from solving bona fide problems.

    According to the CBO (CBO, 2016 Table 1), the majority of the nongroup ACA market do not receive subsidies (through 2016) yet government officials at CMMS, HHS and in some states, repeatedly claim a majority of consumers are subsidized. This is not true and this "PR spin" must stop.

    In November 2017, Rep. Suzanne Bonamici (D-OR) sent an email to constituents falsely claiming "77% of Oregonians" receive subsidies with a link to the cited reference: Her own reference directly contradicts her claim clearly stating that 77% refers to 77% of those buying Marketplace policies and does not include those purchasing policies "off exchange". As data presented earlier in this paper shows, 40% of those in the individual market in Oregon received subsidies and 60% received no subsidies in 2015. Claiming that 80 to 90% of ACA insured receive subsidies is an extraordinarily frequent lie told by politicians and media – why is it necessary to continue telling this lie?

    A related problem is non-stop "cheerleading", particularly by planted news stories that discuss benefits exclusively without acknowledging problems amply described in this paper. One would think there are no problems at all with the ACA implementation from what the news reports - causing most to be oblivious to real costs and the unsustainability of the ACA individual policy markets.

    HHS/CMMS and state-level staff have - often - deliberately hidden, obfuscated or lied about bona fide problems in their eagerness to promote the Act. All have deliberately hidden actual prices from voters by, for example, falsely presenting the "age 40" premiums as typical.

    Media stories routinely lie about the ACA. One of the most frequently told lies is that a Bronze plan covers 60% of your expenses, a Silver plan covers 70% of your expenses and so on. This is easily proven as false: You have a Bronze policy with an $8k out of pocket maximum limit and $100,000 in expenses - clearly, your

coverage is greater than 60%!

Similarly, if your deductible is $8,000 (a typical value in the ACA market) and you have $5,000 of medical expenses, your costs are 100% and the insurers' are 0%.

So what does the "60% of costs" mean?

The 60% refers to the costs of the entire insurance pool - for the pool of Bronze customers, their overall payout will be about 60% of total costs incurred by everyone in the pool combined. Let's say there are 1,000 customers in the this pool. If all of their costs were added together, the amount covered by insurance would be 60% of their combined costs.

But this 60% value DOES NOT APLLY TO INDIVIDUALS.

As shown in the prior paragraphs, the amount covered by the insurer can vary from 0% to nearly 100%.

The entire concept of "metals" as used in the ACA insurance markets is so poor as to be false advertising and should be abolished.

Of course, the ACA was sold on the basis of lies – everyone has heard the "If you like your health plan you can keep your health plan. If you like your doctor, you can keep your doctor" which Politico declared "Lie of the Year" in 2013. The claim that the average family for four would save $2,500 per year or shopping for insurance would be as easy as buying a TV on Amazon.com were both lies.

Lies lead us away from informed, constructive dialogue leading to genuine solutions that help everyone.

15. The ACA has side effects that can be severe. In the ACA markets, health insurers generally offer narrow coverage networks. Our own policies were "in network" in just 3 counties. If we needed access to health care anywhere else, say while traveling, we would pay "out of network" prices (which are secret until one gets the bill). Most policies checked provided zero dollar benefit for hospitalization or surgery incurred while traveling elsewhere in the state or the U.S. meaning we had no coverage at all and were effectively uninsured with an ACA policy.

    For families with college age students attending college out of the area, this is particularly hard. Students on their family policy generally have no health insurance coverage for anything other than an ER room visit while away at college. Further, they are surcharged huge "out of network" prices for out of pocket care (if covered at all). Students who study abroad are required to purchase health insurance both for the country they are studying in, plus an ACA compliant policy in the U.S. *even while studying abroad* - hence families in the ACA market

place *are required to purchase two health insurance policies for students studying abroad!*

ACA proponents – specifically Jonathan Gruber - ludicrously argue that one should "Just buy a more expensive policy with more benefits". First, in almost all markets, *there are no such policies available*. Second, Gruber is saying that $2,000 to $3,000 per month for a typical ACA policy is not enough – under his unique concept of "Affordable", consumers should pay even more (if such a policy is even available.

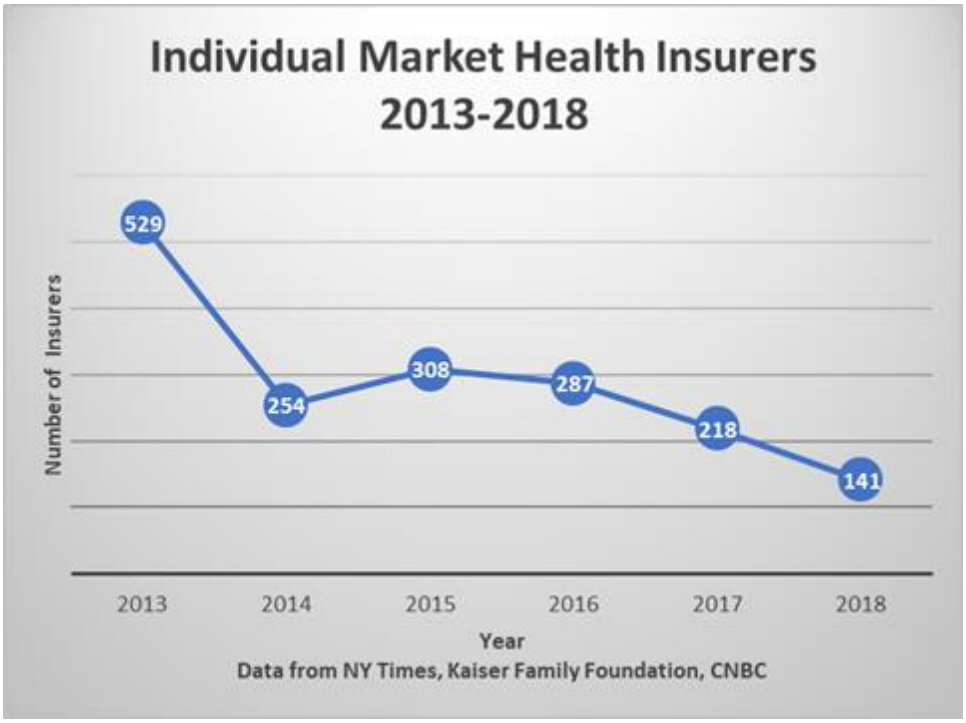
16. The ACA required everyone to have health insurance or pay a penalty fine. In late 2016 and 2017, there were periods were all insurers dropped out of many geographic locations (including all of Nevada except for 3 counties). State officials scrambled to find other insurers and accelerate approval of new plans (usually resulting in 1 monopoly insurer in these markets).

    This points to another defect in the ACA –*The ACA penalizes consumers for not buying an insurance policy even when no policies are available.* The ACA's designers never conducted a quality review of their work to uncover obvious errors like this.

17. The ACA permits employees to receive up to a 30% discount (and 50% in some situations) for engaging in certain health and lifestyle behaviors. In the individual market, there are no discounts for healthy lifestyle behaviors. This is a further "cost" burdened on individual market consumers.

18. The ACA limits insurance companies to spending 20% of premiums on administration, marketing and profit. If profits are, say, 3% of revenue, the only way to increase profits (measured in dollars) is to increase revenue. The 20% cap gives insurers an incentive to increase revenue by negotiating higher prices, particularly in the majority of ACA markets where there are only 1 or 2 insurers. Insurer's interests are not aligned with their customer/patient's interests. An NPR report, in conjunction with ProPublica explains this ACA defect, in detail (Allen, 2018).

19. The competitive market for ACA policies has collapsed as shown by this chart of the number of insurers in the non group market, nationwide, from 2013 onward:



If the trend from 2015 onward continues we will have no insurers left in the market by 2020 to 2021 – more likely, we will have de facto monopoly markets in most of the country, which is a form of single payer but probably not the one proponents were seeking.

Note that the decline occurred from 2015 to 2017 during Obama's tenure. The decline has continued on a remarkable straight line basis since Trump was elected.

20) As of 2018, it is fashionable to blame the current majority political party for the collapse of ACA markets. The chart above shows the ACA insurance market dramatically shrinking since 2015. According to a 2016 news report, the ACA was then near collapse (Barnd, 2016) unless more Federal money was poured in to subsidize insurers:

"*With open enrollment for Obamacare beginning on Tuesday, insurance carriers warn that nearly 1.5 million Americans could lose their health insurance in the coming months. As more insurers abandon the program, the White House signals it wants to put roughly $175 billion into Obamacare to save it.*

"One way is to say … 'Let's just throw more money at this stuff," says Ed Haislmaier, a health policy researcher. "Money we haven't got, by the way."

Obamacare was supposed to be budget neutral, meaning insurers making healthy profits in the Affordable Care Act's first years would shift that windfall to insurers losing money. Two years ago, more insurers lost money and received only a portion of what was needed

to cover losses, creating what experts say is a nearly $3 billion shortfall.".

The problems are due to specific defects in the ACA that rendered it unsustainable from day 1. As written, the ACA could never achieve its sales-pitch goals and cannot be sustainable over time without constantly increasing subsidies.

Gaming The System

As prices rise substantially, more and more individuals will "game the system" and drop out of the ACA.

Several strategies to game the system include:

1) As rates quickly rose, individual consumers discovered they are exempt from the "Shared Responsibility Penalty" tax. If the least cost Bronze plan costs more than 8.05% [2015, or 8.16% in 2016] of one's income, then the consumer is exempt from paying a penalty for not having ACA compliant insurance (IRS Form 8965, page 3). Congress recognized that it cannot force people into bankruptcy - although such individuals might not have access to other insurance options.

   Let us put this in actual numbers – for 2017, let's say a 55 year old married couple is paying $10,512 per year with a $14,300 deductible Bronze plan (actual price quote for Portland market). If this couple earns less than $130,500/year, they are exempt from the ACA mandate.

2) Per (1) older couples and some families are exempt from the mandate penalty. Such couples may choose to buy less expensive, non-ACA compliant "short term insurance". Short term policies exclude "pre-existing conditions" and are similar to pre-ACA policies, including employer sponsored insurance, in coverage and cost.

   The White House rudely and incorrectly referred to all non-ACA policies as "junk policies", yet most were equivalent to the typical employer provided insurance offered for decades.

   The term "junk policy" originally referred to scam policies sold pre-ACA that limited total reimbursement to small values such as $1,000-$2,000 per year. These were also referred to as "mini-Med" plans Post-ACA, "Junk policy" name calling was adopted as a propaganda messaging tool.

3) For those with investment income, particularly those who have saved and are near retirement age, put all investments into non-income producing (capital gain only) investments. Set aside living expenses in savings accounts. With one's income below the cut off for subsidies, live off the savings and let the government pay for health expenses. Withdrawals from savings are not income.

4) Transfer assets, including income-producing investments, into independent trusts (Mangan, 2016). Assign your adult children (or a third party) as trustee(s) for the trust. Have the trust pay you an income less than the subsidy cut off level and let the government pay for your health expenses. This can be combined with the savings account concept in (3). At age 65, have yourself restored as a trustee of the trust and regain control of the assets. For some people, this is a very workable solution. Consider the hypothetical 64 year old couple in Laramie, WY earning $65,000 per year (above the subsidy cut off) where a Silver policy costs $49,000 per year. By cutting their income by just $1,000 to $64,000 per year. HealthCare.gov says this couple will receive about $41,000 in subsidy benefits. Since premiums are paid in after tax dollars, this is similar to receiving a $50,000 pre-tax benefit. Clearly, this couple - and others with even higher incomes - should take drastic steps to cut their taxable income as they will come out ahead by doing so.

5) For older workers nearing retirement, income transferred into retirement accounts is subtracted from the MAGI. For workers over 50, up to $24,000 per year per worker may be contributed to an employer sponsored 401(k) program, thereby lowering income by the same amount. For a typical couple, this can result in annual government health subsidies of $5,000 or more. A $5000 return on $24,000 in a 401(k) plan is a fantastic return on investment. (As of 2018, the value is far greater than $5,000.)

6) Those who qualify may enroll in a religion-based health sharing network which is exempt from ACA mandates.

7) As the rates rise, more consumers may be eligible for Federal subsidies, thereby moving risk from insurers and consumers to the Federal taxpayer.

8) Insurer Centene is, in 2017, offering a lower priced Silver plan with deductible set to $7,050/person. This may have the effect of discouraging "unhealthy" sign ups into their risk pool, thereby gaming the system for their benefit. This plan will be priced significantly lower than other Silver plans. Since the Silver plan is the benchmark for subsidies, this lowers subsidy dollar values by up to 20% in the markets where offered. A reduction in subsidy levels may discourage subsidized consumers from signing up for ACA coverage.

9) Many states are approving a $15 per hour minimum wage. A 40 hour work week at $15/hour will, for many workers, exceed the Medicaid eligibility income level – therefore, states have an incentive to raise the minimum wage to a level that pushes Medicaid recipients off of state funded Medicaid and on to Federal-taxpayer subsidized exchanges. This offloads state expenses to Federal taxpayers and to consumers who pay more for certain goods and services due to higher wages.

10) According to HHS, if a consumer has received a notice of utility service cut off due to unpaid bills, the consumer is exempt from the individual mandate. Some authorities suggest consumers stop making payments to their utility (electric, gas or water) for 2-3 months, wait to receive the service cut off letter and then pay the utility bills. With the service cut off letter in hand, the consumer is then exempt from the ACA mandate.
11) Move out of the United States. Many countries, including in Central America, such as Belize, offer low cost insurance and low cost direct payment options. Belize and some other countries in the area welcome U.S. citizens. Most countries, however, are not open to immigration from Americans over age 40 to 50 (with some exceptions, such as making a large financial investment in the destination country).

With continued dramatic price increases year after year, those in the unsubsidized market are forced to drop out.

> "While enrollment data show stable enrollment for subsidized exchange coverage, the number of people enrolled in the individual market without subsidies declined by an alarming 20 percent nationally in 2017, while at the same time premiums rose by 21 percent. Many state markets experienced far more dramatic declines, with unsubsidized enrollment dropping by more than 40 percent in six states, including a 73 percent decline in Arizona." (HHS, 2018).

By design, the ACA markets are not sustainable.

Conclusion

The non-group market is unfairly absorbing all of the new risks in the health insurance marketplace. This is the root cause of the non-sustainable year-after-year price increases.

By definition and ACA design, the post-ACA newly insured have higher risks (costs) than the pre-ACA non-group market.

35 pre-ACA state-run “high risk insurance pools” have moved all of their members solely into the individual non-group market, as did the other 15 states without high risk insurance pools.

About 20% of the newly insured are signing up, using health services, and then dropping out, adding to costs for everyone else.

As of 2017, 100% of these new risks are borne exclusively by the non-group market and are not shared with any other group.

The design of the ACA turned the individual market into a “high risk” pool, which is directly opposed to making insurance affordable, as implied in the Act’s title. Bluntly, for

the unsubsidized non-group market, the "Affordable" Care Act is a failure as it has doubled or tripled costs while reducing desired benefits.

Most of the individual insurance risk pools (which are by insurer, by state) are too small to equitably spread the risk.

A solution is to immediately expand the individual market risk pools by combining risk pools "in state" (as permitted by the ACA), by permitting insurers to merge risk pools across state lines, by merging individual and small group markets (as in Massachusetts and Vermont), by restoring a reformulated "risk insurance" program, and/or moving government workers to the exchanges to immediately increase the size of the risk pools, or adopting state-wide single payer models.

Exorbitantly high prices are forcing healthy and near healthy of all ages out of the market. With opportunities to "game the system", more and more of the healthy will leave the ACA marketplace as insurance remains unaffordable with rapidly rising prices.

This leads to the "death spiral" reported by Providence Health and one of the "Blues": the ACA is not sustainable in its present form as evidenced by major market dropouts by UnitedHealth, Aetna and Humana, as well as the abandonment of many counties by insurers.

In October 2016, President Barack Obama said the Act has "real problems"; former President Bill Clinton said the Act is "crazy" and doubled prices with half the benefits. Hillary Clinton said she wanted to fix it, but proposed 5 solutions that miss the root cause problems. Bernie Sanders ran on a platform of abolishing the Act and replacing it with government run health care. In 2017, one-third of the Democratic Senators in Congress co-sponsored Sander's plan to repeal and replace the ACA with "Medicare for All"

If the ACA is working great, why are a large group of Democrats proposing to repeal and replace the ACA?

The key point is that original proponents of the ACA all agree, by virtue of their campaign claims, that the ACA is broken, and are now seeking to "repeal and replace" the ACA.

Most ACA policies provide no insurance coverage for catastrophic costs (hospitalization, surgery) while traveling in the U.S. outside one's narrow geographic network, leaving most ACA covered individuals uninsured. The majority of the individual market is thus worse off than prior to the ACA (most pre-ACA policies provided access to broad networks).

Policy makers must undertake urgent actions to save the ACA from dying as rates become prohibitive and consumers have no choice but to leave the market.

What are policy makers doing to fix this crisis? Five years into the ACA program there is no leadership; politicians who promoted the ACA have gone "radio silent" with no meaningful solutions. The 2017 Republican proposal failed to address the root cause failures of the ACA.

With no end in sight to year after year of double digit price hikes, consumers are scared, frightened and angry with political leaders who are not working to fix obvious defects - which are (*were*) fixable!

It is now ten years since the ACA was proposed. In ten years' time, the U.S. could have fought and won World War II – *two and half times*. What are politicians' excuses for doing nothing?

The ACA's nongroup market is, in an engineering sense, an "out of control system", where the price hikes, each year are consistently greater than the year before, with no end in sight[1].

If nothing is done, the ACA collapses.

Updates Section
Various updates have been made, continuously throughout this paper. An updates change log appears as the last page in this document.

Late 2017

The ACA's definition of "affordable" is implemented by the IRS in Form 8965. If the least cost Bronze plan exceeds 8.13% of household income, consumers are exempt from the mandate. As described earlier, most couples over age 50 and most families from their late 30s onward are exempt from the individual mandate because ACA policy costs have greatly exceeded the ACA's own definition of affordable. The individual mandate is essentially moot. Additionally, Gruber's own published research was unable to find any evidence that the mandate had any impact on insurance coverage.

July 2018

This paper documents defects in the ACA that render the ACA not sustainable. As noted earlier, when one party unilaterally passes defective legislation and expects the unilaterally opposed party to fix the legislation, we have a deadlock.

Politically, the ACA cannot be fixed even if there are potential solutions. Even the Democratic proponents of the ACA are confused. In 2016, all Democratic Presidential candidates proposed national single payer schemes to repeal and replace the ACA and in 2017, one third of Senate Democrats and a large number of House Democrats signed on to the Medicare-for-All bill to repeal and replace the ACA. But then in late 2018, most of this group is promoting the "success" of the ACA. The prices for policies are now at such

high levels that the majority of non-group consumers are remaining uninsured, and the majority of non-subsidized consumers are exempt from the mandate per IRS Form 8965.

When politicians say "We support the ACA", we ask, "Which part of the ACA do you support?"

- $57,000 per year premiums for a married couple earning $65,000 per year in pre-tax income?
- $65,000 per year premiums for a family of five?
- Premiums plus deductibles that exceed one's after tax income?
- A subsidy cut off level unrelated to actual insurance prices?
- The merging of all high risk patients into the very small individual market risk pool, paid for exclusively by the members of the individual market pool?
- 167% price hikes in 4 years?
- No insurance coverage when traveling outside one's home county?
- Large subsidies for insurance companies?
- No price transparency for consumers trying to make economic decisions?
- Denying individuals the opportunity to band together and negotiate better pricing where 100% of the health care industry has merged to become larger to negotiate against powerless individuals?

Those "standing by" the ACA are saying they support these defects and features and are focused on ideology rather than solving real problems.

It is now ten years since the ACA was proposed during the 2008 campaign. In ten years the U.S. could have fought and won World War II – two and half times! But ten years later, Congress has failed to address most any of the serious defects in the ACA nor fix the harm they have done to actual citizens.

Paper Updates

As of 2018, this paper is updated as a way for me to keep notes. I learned in 2017 that my elected representatives do not give a damn about solving these problems. Sen. Merkley's staff made it extremely clear that only if I held an academic position with a PhD, or was an executive with a health care or insurance organization, would they even bother to listen. They could not have been more clear in their disdain for constituents, recognizing bona fide problems, and seeking solutions. With attitudes like this, it is no wonder that the ACA failed to deliver on its sales pitch goals and has made many parts of the health market worse off.

Footnotes

[1] In Oregon, each year's rate hikes have been greater than the preceding year, which is an exponential price curve. This is not sustainable and is an "out of control" system in the engineering sense.

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Revision History

Revision A - first draft release
Revision B - added comments from Avalere Health, comments about Centene, and comments about Wellmark, in Iowa.
Revision C - added comments from Sioux City Journal about Wellmark plans and corrected Revision B edit about Wellmark.
Revision D - Moved the "Solutions" section to later in the document. Minor editing changes based on feedback.
Revision E - added comments on risk of new Medicaid insured.
Revision F - added citation to CNBC article on how to get subsidies.
Revision G - added chart of the CMMS genuine age rate multiplier curve.
Revision H - added combining individual and small group markets, added information on the actual costs of the pre-ACA "high risk" pools.
Revision I - added note about the risk reinsurance program that ends in 2016; this did collect a fee from all insured to level risks. With its ending in 2016, all risks are now born solely by the individual market risk pool.
Revision J - added CBO (2016) reference to confirm that the majority of ACA nongroup market does not receive any subsidies, contrary to mis-statements by HHS/CMMS.
Revision K - added to suggested solutions to stop claiming the majority receive subsidies
Revision L - August 2016-minor edits, added information on Alaska
Revision M - September 2016-added "Sixth" note that permitting pre-ACA policies to continue post-ACA, after policy cancellations, leads to smaller risk pools.
Revision N - October 2016, general edits to improve readability
Revision O - January-February 2017, added references for Alaska high risk cost, link to CNN Money article specifically noting the high risk pools were shut down.
Revision P - February 17. Minor editing. Added note about New Mexico's high risk insurance pool, which confirms that pushing the state run high risk pool patients into the ACA individual market will cause large rate hikes.
Revision Q - March 2017. Minor editing for clarity. Added the 10th method to obtain an exemption to the ACA mandates. Added direct quote from The Oregonian regarding lack of affordability for those who are middle aged and older.
Revision R - October 2017. Added paragraphs regarding ACA Section 1401 and the surprising de facto expiration of the low income subsidy program as mandated by the ACA itself.

Revision S - October 2017. Added Laramie, WY 2018 price quote to illustrate how prices are disconnected from the real world. Formatted and clarified the “solutions” section pgs 12-14 to make it more readable.
Revision T – May 2018. Cleaned up some wording. Added section explaining how an ACA's design defect gives an incentive for insurers to negotiate higher health care service fees, not lower fees.
Revision U – July 2018. Added that the majority of polices provide no coverage outside one’s immediate home area, leaving the majority of non-group markets uninsured, even though they pay exorbitant premiums. Edited the entire text to bring it up to date; this was originally written in 2016 and some of the older references were confusing in 2018. Confusing sections, caused by ACA market and political changes in 2016, 2017 and 2018, were edited to make them readable.