BIPARTISAN POLICY CENTER

Future of Health Care: Bipartisan Policies and Recommendations

August 2017

The Bipartisan Policy Center's **Future of Health Care** initiative members have been meeting over the past six months with policy experts, actuaries, health system and insurance industry leaders, consumers, and providers to explore policies that could improve the coverage, quality, and cost of health care for millions of Americans.

We come together in the shared goal that the current health care system requires immediate reform. Our internal deliberations, not unlike those in Congress, have been intense and at times quite challenging. We have divergent views on health care policy and differing opinions on the appropriate role for federal and state governments, private industry, and individuals. However, we share a deep concern for those Americans whose coverage is threatened by a fragile individual insurance market and are at risk in the absence of prompt, thoughtful, and bipartisan congressional action. We also believe that the capacity to address the more fundamental structural challenges in the current system can only occur if Congress works across party lines to reduce health insurance premiums through measures to stabilize the insurance market for the near term.

Here we present a set of policies we see as having the most potential for meaningful short-term policy impact. While no member of our group would necessarily support each individual recommendation advanced in a vacuum, they combine our best thoughts on how to balance sound policy and political viability in a fashion that can be successfully advanced as early in the 115th Congress as is possible.

Through difficult negotiation reflecting the equity of discomfort that is inherent in reconciling substantive and political differences, we have developed the proposal that we release today. It is our hope that consensus from Congress on these interim policies can engender a level of mutual investment and trust amongst and between both Democrats and Republicans. We believe such investment is a precondition for constructive and productive bipartisan collaboration on the much broader set of long-term reforms that are necessary to improve and sustain the nation's multi-faceted health care system.

Our approach includes two stages:

1) To provide near-term relief and to help secure bipartisan compromise and trust, we propose a set of policies to immediately stabilize health insurance premiums; to promote choice, competition, and stability in the individual health insurance market; to explore policies to promote greater insurance enrollment with less reliance on the "individual mandate"; and to enhance flexibility for states to implement innovative solutions for their residents. Any costs associated with these policies would be fully offset so as not to add to the federal deficit.

2) It is also necessary to move quickly beyond near-term fixes to consider more fundamental changes in health care: to build a strong, bipartisan consensus on its key design features; to slow rising costs; to promote greater enrollment in health insurance; and to improve the quality of care delivered to patients.

We have identified some key areas where ongoing legislative changes should be made to make health care in America more affordable, accessible, reliable, and sustainable over the long-term, all the while retaining adequate incentives for innovation. As BPC Future of Health Care leaders, we are committed to reaching agreement on the reforms necessary to achieve these goals by year's end, with the aspiration that the 115th Congress could act upon such reforms as soon as possible.

Near-Term Policies and Recommendations

We recommend "stage one" policies designed to improve choice and affordability in the non-group individual insurance markets, while also fostering bipartisan investment for the future. **Further, we recommend that Congress should establish a "stage two" bipartisan process to address longer-term health care affordability and sustainability issues. In the Appendix, we have identified the policies and issues we believe—at minimum—should be addressed in stage two. To secure stability and broad-based political investment in the individual market, we are specifically recommending:**

1. Lower Premiums, Continue Out-of-Pocket Cost Protections, and Stabilize the Individual Market by Temporarily Codifying Continued Payment of Health Insurance Cost Sharing Reduction Subsidies - Action is needed to help address uncertainty surrounding the federal payments of cost sharing reduction (CSR) subsidies, as the non-payment of CSR subsidies is projected to result in a 20 percent increase in non-group market premiums and, as it does, increase tax credit payments and the federal deficit by over $190 billion over the 10-year budget window. Projections also indicate that failure to pay CSR subsidies would result in insurers exiting the market, leaving at least 5 percent of the U.S. population residing in local markets without an individual market insurance option.

To avoid and address these problems, we recommend that Congress act immediately to codify continued federal funding for the government payment of CSR subsidies for Plan Year 2018. We also recommend that Congress take action no later than March 31, 2018, to codify appropriations for CSR subsidy payments for Plan Year 2019. As necessary, Congress should direct the Secretary of Health and Human Services (HHS) to make appropriate adjustments to time frames and procedures related to Plan Year 2018 Open Enrollment to allow for the potential for updates to submitted premium rates, the calculation of the second-lowest cost Silver Plan, and related protocols.

2. Improve State Flexibility and Expedite the Process for States to Pursue Innovative Health Insurance Strategies for their Residents under Section 1332 Waivers - In order to allow for states to more expeditiously pursue local solutions to address non-group market issues, we recommend that Congress modify the review process of state-based insurance waiver applications submitted pursuant to section 1332 of the Affordable Care Act (ACA).

Specifically, we recommend that Congress shorten the maximum time frame for the Department of HHS review of waiver applications from 180 days to 90 days. We also recommend that Congress require that the Secretary of HHS approve all section 1332 waiver applications that meet the four-part statutory criteria for such waivers, rather than allowing the Secretary to retain the authority to deny waiver applications even when they have been certified to meet the four-part criteria. We further recommend that HHS be required to conduct ongoing oversight and periodic review of state implementation of the waiver, rescinding waivers that are no longer meeting the requirements of the waiver in the out-years.

3. Provide Funding to States to Stabilize Health Insurance Markets and Reduce Premiums Through Reinsurance, Invisible High Risk Pools, and Other Policies - State insurance markets face a variety of challenges in the non-group segment, including the impact that high-cost enrollees have on premiums in small risk pools, as well as concerns over choice, competition, and insurer viability in rural and sparsely populated service areas.

To help address these challenges, we recommend that Congress establish a Health Insurance Stability Fund that awards funding to states that apply for assistance to help finance innovative programs designed to reduce premium costs, improve the risk profile of individual market enrollees, increase enrollment through outreach and marketing activities, and/or increase choice of health plans in a given service area. Policies and programs that could be financed through the Stability Fund include: reinsurance programs similar to the Transitional Reinsurance Program that operated from 2014 through 2016, invisible high risk pools that provide additional government financing for patients with certain conditions who are enrolled in Marketplace plans, and such other policies that are certified by the independent Centers for Medicare and Medicaid Services (CMS) Actuary to have the effect of reducing premiums for Marketplace coverage, without reducing the number of households covered.

Congressional appropriations for the Health Insurance Stability Fund should be allocated in such a way as to ensure that net federal budgetary costs of the Stability Fund (after accounting for corresponding premium tax credit savings) equal $7.5 billion for Plan Year 2019, and an additional $7.5 billion for Plan Year 2020. States would be required to submit applications in order to receive Stability Fund financing, in a form and method to be determined by the Secretary of HHS. During the two-year period, Congress should evaluate the feasibility and advisability of ongoing funding for the Health Insurance Stability Fund. In a scenario in which alternatives to the individual mandate are being developed, as envisioned in the recommendation below, we believe that it would be wise to allocate an appropriate portion of the Stability Fund dollars toward grants for outreach and enrollment efforts to help maintain continued balanced enrollment from healthy middle-income consumers.

4. Develop Alternatives to the Individual Mandate That Do Not Have Detrimental Impacts on Market Stability and Affordability - Concerns have been expressed about the operation of the ACA's individual responsibility policy, or "individual mandate," which requires that consumers either obtain qualified health insurance coverage or pay a tax penalty. At the same time, it has been abundantly highlighted that health insurance markets that provide for community-rated premiums and guaranteed issue and renewability do require some mechanism to incentivize and foster enrollment from a healthy cross-section of the population. Without such a mechanism, adverse risk selection results in rising premiums and an unsustainable market. Therefore, any reduction or elimination of the ACA's individual mandate penalties would need to be paired with a proven alternative mechanism that can ensure continued enrollment of a balanced risk pool. To date, we are not certain whether such a mechanism exists.

However, in the interest of finding such a mechanism, we recommend that Congress direct the Secretary of HHS and the Internal Revenue Service (IRS) to jointly develop alternatives to the individual mandate. Specifically, HHS and the IRS would be directed to develop options that utilize automatic enrollment in conjunction with a combination of late enrollment premium penalties and/or waiting periods for individuals failing to maintain continuous coverage, as a potential alternative to the individual mandate. Such a policy should be supplemented with meaningful investment in outreach and enrollment activities to increase coverage and stabilize the market.

If the independent CMS Actuary provides the certification detailed below, states may implement the policy, and HHS and the IRS may reduce the individual mandate's penalties to $0 per year, for residents of the state. For such an alternative policy option to become available to states, the CMS Actuary would need to certify that the removal of the individual mandate penalties (in conjunction with the implementation of the alternative policy) would not result in a detrimental impact on individual market premiums, the number of individuals with insurance coverage, or the federal deficit.

Under an automatic enrollment process, the IRS could identify (through the use of data currently collected under the individual mandate, and such other data as necessary) consumers who have income low enough to qualify for a Marketplace plan that requires no premium in excess of the premium tax credits that the consumer is entitled to on the basis of income (i.e., a "zero premium plan"). Through the state option for the alternative policy, Federal and State Marketplaces would then be authorized to enroll these consumers in "zero premium" Marketplace plans, and provide the consumers with the opportunity to opt out of such coverage.

Any individuals who are automatically enrolled in Marketplace coverage via the state option for automatic enrollment should be exempted from requirements for repayment of advance premium tax credits for the tax year in which they were automatically enrolled in coverage. We acknowledge that this policy includes a multitude of administrative and operational uncertainties that would need to be resolved, including, but not limited to, the timing gap between prior year-reported tax information on income and present Plan Year enrollment in a Marketplace plan, the changes in circumstances that frequently occur within that timing gap, and the effect of such changes on eligibility. We believe that those and other administrative uncertainties would need to be addressed for an automatic enrollment system to be functional.

5. Improve Consumer Ability to Cover Health Insurance Deductibles Through Health Savings Accounts - Under current law, annual contributions to Health Savings Accounts (HSAs) are limited to $3,400 for self-only coverage and $6,750 for non-single filers (e.g., for family coverage). By contrast, the maximum out-of-pocket limit for HSA-qualified High Deductible Health Plans is $6,550 for self-only coverage and $13,100 for non-single filers. **In the interest of improving the ability of consumers to contribute to HSAs, for 2018 and 2019, we recommend a temporary increase in HSA annual contribution limits for self-only and family coverage to match the out-of-pocket limits for HSA-qualified High Deductible Health Plans for self-only and family coverage.**

6. Offset the Federal Budgetary Costs of the Near-Term Policies - New federal spending or foregone federal revenues from the above-mentioned policies must be offset by balanced savings or revenue increases. **Therefore, in the Appendix, we highlight potential policies that Congress could enact (in any combination) to offset the budgetary cost of the near-term policies discussed in this proposal.**

We note that the policies included in the Appendix would generate budgetary savings significantly in excess of the expected budgetary costs of the near-term policies. We recommend that any combination of policies selected to offset expenditures be achieved with a balance between providers and consumers of health services, and equal but not substantially exceed the budgetary costs of the near-term policies recommended in this proposal. We also note that the potential policies offered are not necessarily supported by each member of our group, but reflect a menu of offset options from which Congress can consider.

Appendix: Near-Term Policy Recommendations

Near-Term Policies to Reduce Health Insurance Premiums and Stabilize the Individual Insurance Markets for 2018-2020			
	Description	**Duration**	**Federal Budgetary Cost**
Codifying Continued Federal Payment of Health Insurance Cost Sharing Reduction (CSR) Subsidies	Act immediately to codify continued federal funding for the government payment of CSR subsidies for Plan Year 2018, and take action no later than March 31, 2018 to codify appropriations for CSR subsidy payments for Plan Year 2019.	2018-2019	None
Improving State Flexibility and Expediting the Process for States to Pursue Section 1332 Waivers	Amend the statutory provisions of Affordable Care Act Section 1332 to: (1) shorten the maximum time frame, from 180 days to 90 days, for the Department of Health and Human Services (HHS) review and decision making on waiver applications; and (2) require that the Secretary of HHS approve section 1332 waiver applications that meet the four-part statutory criteria for such waivers, rather than allowing the Secretary to retain the authority to deny waiver applications even when they have been certified to meet the four-part criteria. HHS should be required to conduct ongoing oversight and periodic review of state implementation of the waiver, rescinding waivers that are no longer meeting the requirements of the waiver in the out-years.	Permanent	None
Providing Funding to States to Stabilize Health Insurance Markets and Reduce Premiums Through Reinsurance, Invisible High Risk Pools, and Other Policies	For Plan Year 2019 and Plan Year 2020, establish a Health Insurance Stability Fund that awards funding to states that apply for assistance to help finance innovative programs designed to reduce premium costs, improve the risk profile of individual market enrollees, increase enrollment through outreach and marketing activities, and/or increase choice of health plans in a given service area. Policies and programs that could be financed through the Stability Fund include: reinsurance programs similar to the Transitional Reinsurance Program that operated from 2014 through 2016, invisible high risk pools that provide additional government financing for patients with certain conditions who are enrolled in Marketplace plans, and such other policies that are certified by the independent Centers for Medicare and Medicaid Services (CMS) Actuary to have the effect of reducing premiums for Marketplace coverage, without reducing number of households covered. Congressional appropriations for the Health Insurance Stability Fund should be allocated in such a way as to ensure that net federal budgetary costs of the Stability Fund (after accounting for corresponding premium tax credit savings) equal $7.5 billion for Plan Year 2019, and an additional $7.5 billion for Plan Year 2020.	2019-2020	$15 Billion

Near-Term Policies to Reduce Health Insurance Premiums and Stabilize the Individual Insurance Markets for 2018-2020 (continued)			
	Description	**Duration**	**Federal Budgetary Cost**
Developing Alternatives to the Individual Mandate That Do Not Have Detrimental Impacts on Market Stability and Affordability	Direct the Secretary of HHS and the Internal Revenue Service (IRS) to jointly develop alternatives to the individual mandate. Specifically, HHS and the IRS would be directed to develop options that utilize automatic enrollment in conjunction with a combination of late enrollment premium penalties and/or waiting periods for individuals failing to maintain continuous coverage, as a potential alternative to the individual mandate. If the independent CMS Actuary provides the certification detailed below, states may implement the policy, and HHS and the IRS may reduce the individual mandate's penalties to $0 per year, for residents of the state. For such an alternative policy option to become available to states, the CMS Actuary would need to certify that the removal of the individual mandate penalties (in conjunction with the implementation of the alternative policy) would not result in a detrimental impact on individual market premiums, the number of individuals with insurance coverage, or the federal deficit.	Permanent Beginning 2020 or Later	N/A
Improving Consumer Ability to Cover Health Insurance Deductibles Through Health Savings Accounts (HSAs)	For 2018-2019, temporarily increase the HSA annual contribution limits for self-only and family coverage to match the out-of-pocket limits for HSA-qualified high-deductible health plans for self-only and family coverage.	2018-2019	$2.6 billion
Total Costs	N/A	N/A	$17.6 billion

Policy Options to Produce Federal Savings/Offset Near-Term Spending

Policy Options Generating Federal Savings to Offset Federal Spending From Above Policies and Ensure Deficit Neutrality		
	Description	**Federal Budgetary Savings**
Modifying the Income-Based Limits on Repayment of Excess Advance Premium Tax Credits	Congress could increase the income-based limits on repayment of excess advance premium tax credits by such amounts as necessary to generate the savings required to equal the federal budgetary costs of the other policies in this proposal (net of any other offset savings enacted through other pay-for policies, such as those discussed below).	$3 Billion — $6 Billion Over 10 Years (Depending on Combination Below)
Improve Generic Drug Availability Through Changes to REMS Authority	Congress could provide the Food & Drug Administration (FDA) with the statutory authority to ensure that generic drug manufacturers can obtain samples of a brand drug covered by Risk Evaluation and Mitigation Strategies (REMS), or give the Federal Trade Commission (FTC) the authority to challenge manufacturers who refuse to provide samples of REMS-covered drugs to generic developers.	$753 Million Over 10 Years
Exclude Certain Services From the In-Office Ancillary Services Exception to Physician Self-Referral Laws	Congress could amend the "Stark" law prohibition on physician self-referral to eliminate the exception for radiation therapy, therapy services, advanced imaging, and anatomic pathology services. The exception could be retained in cases where a practice is clinically integrated and is required to demonstrate cost containment, as defined by CMS.	$3.3 Billion Over 10 Years
Prohibit "Pay-for-Delay" Agreements Between Brand Name and Generic Drug Manufacturers	Congress could authorize the FTC to stop drug manufacturers from entering into agreements under which brand name drug manufacturers and generic drug manufacturers agree to delay the availability of generic alternatives to brand name drugs.	$2.9 Billion Over 10 Years
Establish Medicare "Site-Neutral" Payments for All Off-Campus Hospital Outpatient Departments	Under the Bipartisan Budget Act of 2015, Congress established a "site-neutral" payment policy in Medicare Fee-for-Service (FFS) for services furnished at hospital outpatient departments (HOPDs) that were more than 250 yards from the main hospital building (i.e., the inpatient center). These HOPDs are referred to as "off-campus" HOPDs, and can be located up to 35 miles away from the main hospital building. The site-neutral payment policy requires that Medicare payments for off-campus HOPD services be reduced to equal the lower Medicare payment levels provided for physician office services and/or ambulatory surgical center services. However, the Bipartisan Budget Act of 2015 applied a grandfathering clause that allowed all off-campus HOPDs that were billing Medicare for hospital outpatient services prior to November 2, 2015, to be grandfathered and allowed the facilities to continue to receive the higher hospital outpatient payment rate into perpetuity. Under this policy, Congress could eliminate the grandfathering clause exception.	$3.8 Billion Over 10 Years

Policy Options Generating Federal Savings to Offset Federal Spending From Above Policies and Ensure Deficit Neutrality (continued)		
	Description	**Federal Budgetary Savings**
Reduce Funding for the Prevention and Public Health Fund	Congress could reduce appropriated funding for the Prevention and Public Health Fund by a total of $2 billion over the next 10 years. The policy would amount to a 16 percent reduction in Prevention and Public Health Fund appropriated amounts, relative to current law.	$2 Billion Over 10 Years
Eliminating Medicare Advantage "Double Quality Bonuses"	Congress could eliminate the cap on Medicare Advantage (MA) benchmark amounts and the doubling of quality increases in specific counties. Explanatory Note (per the Medicare Payment Advisory Commission): Current law contains two special adjustments to the county MA benchmarks that make the benchmarks inequitable across counties. These adjustments are based on older, inequitable, administratively set payments. Both of these adjustments affect MA benchmarks primarily for high-quality plans and often offset one another. Eliminating both the cap on benchmarks and the doubling of quality increases would make the benchmark-setting process simpler and more equitable, while leaving overall payments at roughly the same level. There would be a reduction of roughly 0.1 percent of MA program spending.	$3.5 Billion Over 10 Years
Increasing the Medicare Advantage Coding Intensity Adjustment and Accounting for Encounter Data	Beginning in 2019, Congress could change the yearly increase to the MA minimum coding intensity adjustment from 0.25 percentage points to 0.67 percentage points until the minimum adjustment plateaus at 8.76 percent in 2023 and thereafter. Under a revised approach to this policy, future year scheduled coding intensity adjustment increases discussed above could be cancelled, prior to 2023, if CMS determines that encounter data and related claims information reported by the MA plans can verify that MA-vs.-Medicare FFS coding differences can be explained by actual patient acuity rather than coding patterns.	$18 Billion Over 10 Years
Reduce Medicare Payments for Beneficiaries' Bad Debt	Under this policy, Congress could reduce the percentage of allowable bad debt incurred by Medicare beneficiaries, for which Medicare reimburses participating facilities, from 65 percent to 55 percent by 2020.	$7.7 Billion Over 10 Years
Total	N/A	$45 to $48 Billion

Long-Term Policy Issue Areas

Long-Term Policy Areas and Options That Policymakers Should Pursue	
	Description
Funding to Address the Ongoing Opioid Epidemic	Develop policies to assist states to better support substance use disorder treatment and recovery support services.
Employer Mandate	Develop a budget-neutral policy to modify or repeal the Affordable Care Act's "Employer Mandate."
Greater Flexibility for States to Secure More Efficient and Affordable Administration, Delivery, and Financing of Health Care	Develop policies to allow for additional state flexibility in financing and providing coverage to low-income populations.
Addressing Prescription Drug Costs	Develop policies that can rein in the cost of prescription drugs.
Insurance Benefit Design and Consumer-Directed Benefit Reforms to Ensure More Affordable and Appropriate Use of Care	Develop policies that could promote the implementation of value-based insurance design, as well as the use of Health Savings Accounts (HSAs) within the context of consumer-directed health plan designs.
Delivery System Reform and Innovation in Provider and Health Plan Payments	Develop policies that can accelerate the movement toward value-based provider payments, quality improvement, provider risk-sharing for the cost of patients' care, and other innovations that could advance responsible cost containment across all federal health insurance programs.

Notes

Notes

Expert Panel on the Future of Health Care

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*Participated in the initiative but sought to pair the near-term recommendations with other near-term reductions in adverse selection and underlying nongroup premiums.

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