Before the

Department of Health and Human Services

Washington, DC 20201

July 12, 2017

In the Matter of
Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act &
Improving Healthcare Choices To Empower Patients

Docket ID No. CMS-9928-NC

Comments of FreedomWorks Foundation

FreedomWorks Foundation is a 501(c)(3) nonprofit and educational foundation dedicated to building, educating, and mobilizing the largest network of activists advocating the principles of smaller government, lower taxes, free markets, personal liberty, and rule of law. In doing so, FreedomWorks Foundation acts as a "service center" for the millions of citizen-leaders who make a difference in the fight for lower taxes, less government, and more freedom.

FreedomWorks Foundation appreciates the opportunity to provide comments to the Department of Health and Human Services (HHS) in response to this request for information on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act (ACA) & Improving Healthcare Choices To Empower Patients.

One of the core projects of FreedomWorks Foundation is the Regulatory Action Center. The Regulatory Action Center is dedicated to educating Americans about the impact of government regulation on economic prosperity and individual liberty. FreedomWorks

Foundation is committed to lowering the barrier between millions of FreedomWorks citizen activists and the rule-making process of government bureaus to which they are entitled to contribute.

In line with this project, FreedomWorks Foundation would like to offer the following broad comments about healthcare policy, ACA, and the potential for regulatory reform under its legal structure.

Background

The problem with America's healthcare system is a problem ACA ultimately exacerbated: third-party payers, be they government programs or insurance companies, blunt competitive market forces. If a consumer faces a fixed cost (or no cost) for the service or product they receive, then they have no incentive to compare prices and thus providers have no incentive to compete on this criterion. Fixed costs also induce overconsumption as patients receive essentially infinite benefit relative to cost for every marginal procedure or product while providers enjoy information asymmetry over patients, insurance companies, and government. Both of these factors put upward pressure on prices for care.

While third parties serve a purpose in a sustainable healthcare market place, the only way to sustainably slow and ultimately reverse this cycle of healthcare price inflation is to reevaluate third parties' role as the primary payers. Insurance and government safety nets should serve to cover unpredictable and catastrophic injuries and conditions, but not regular check-ups or non-life threatening or non-debilitating ailments. In the latter cases, markets directly between patients

and providers should be facilitated, allowing for competitive pressure to drive prices down. In short, health insurance should work more like automobile and home insurance.

Modern healthcare policy lacks this critical bifurcation between health insurance and actual healthcare products and services. As a result, a complex web of increasingly expensive subsidies and programs is constantly playing catch-up with runaway healthcare price inflation while simultaneously accelerating it. Should healthcare policy continue to focus only on expanding insurance or government coverage versus facilitating actual affordable care between patients and providers, no amount of taxes or borrowing will sustain the healthcare system in the long-term.

The ACA is a bill designed to increase the usage of third-party payments in the healthcare sector, which has the effect of increasing healthcare costs, not lessening them, because consumers do not see the true costs of their care. ACA not only expanded Medicaid and mandated insurance coverage for those not qualifying for Medicaid, subsequent regulations have raised the minimum standard of what qualifies as health insurance and thereby further reduced the already-limited presence of direct markets between patients and providers in certain areas of care. For these very basic reasons, ACA will do nothing to ultimately solve America's healthcare problem. Emulating the problem it further institutionalized, ACA is nothing more than an extremely expensive bandage.

These principles undeniably echo the four goals HHS has outlined in this request for information:

1. Empowering patients and promoting consumer choice.

2. Stabilizing the individual, small group, and non-traditional health insurance markets.

3. Enhancing affordability.

4. Affirming the traditional regulatory authority of the states in regulating the business of health insurance.

FreedomWorks Foundation has identified areas of regulatory reform achievable through HHS that will bring the healthcare system closer to a functioning direct market between patients and providers to the extent that such is possible under the constraints of the ACA. Ultimately, however, Congress must gradually eliminate the legal structures propping up a system dominated by third-party payments, including a full repeal of ACA.

Essential Health Benefits

The Essential Health Benefits (EHBs) standard under ACA not only was the primary driver behind mass insurance cancellations at the outset of the law taking effect, these standards are now increasing premiums across the country. EHBs are the minimum broad categories of coverage required by each insurance plan. There are ten EHBs set in statute. These are:

1. Ambulatory services
2. Emergency services
3. Hospitalization
4. Laboratory services
5. Maternity and newborn care
6. Mental health and substance abuse services
7. Prescription drugs

8. Rehabilitative and habilitative services and devices
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

By the very nature of some of these EHBs, in addition to the ACA's mandated Actuarial Value standards, it is clear why they caused mass cancellations and why they are driving premiums higher today. There is simply no reason why many millions of Americans would ever seek out some of these forms of care, particularly those related to bearing and caring for children. As with most products and services, the number of features provided generally has a positive correlation with price. This correlation is stronger in a field such as insurance as premiums are largely a calculation of the risk a claim is made. With more services qualifying for claims, the risk is higher and therefore premiums are higher as a result.

Germane to the principles of sustainable healthcare reform outlined above, EHBs also inherently increase the price of care itself by expanding the role of third parties into more sub-sectors of the healthcare market. To whatever extent a direct market existed between patients and providers in these broad coverage areas before ACA, there is no longer an incentive for patients to shop and negotiate prices and payments for services for which they are technically already paying via their premiums. This eases pressure on providers to compete on prices as well. In fact, the incentives suggest the providers will compete to offer the most expensive, and perhaps superfluous, services as the patient is no longer responsive to price.

While the inherent problems with EHBs in regards to choice and cost may be clear, a solution outside of legislative action is more complicated. However, the problems created by

EHBs in terms of both the cost of coverage and care warrants significant study by HHS. There are steps HHS can take to minimize the problems caused by enforcement of EHBs under ACA.

First, HHS should seek to limit to the greatest extent possible what constitutes an EHB. This effort should have two fronts. First, HHS should seek to expand what qualifies as coverage for each of the ten EHBs in set in statute. Second, HHS should make no effort to expand beyond these ten categories what qualifies as an EHB, as ACA empowers HHS to do.[1] To the extent this has already taken place, HHS should pursue rolling-back the definition of EHBs to the ten categories in statute. Finally, HHS should exercise authority granted in ACA to inform Congress of changes necessary to EHBs.[2] Congress makes clear in the statute that they do not intend for additional EHBs to limit access by way of additional cost and other factors. A compelling argument can be made that existing EHBs certainly increase cost but also harm access by reducing the number of insurance companies willing to provide such comprehensive coverage in certain markets at competitive prices.

Actuarial Value

Similar to EHBs, the Actuarial Value (AV) standards imposed by ACA increase the presence of insurance in the market, the cost of insurance, and ultimately the price of care itself. AV is defined as the average percentage of total covered healthcare costs an insurance plan will pay versus what patients enrolled in that plan will pay in combined deductibles, premiums, and any other out-of-pocket costs. ACA sets the minimum AV for qualifying plans at 60 percent.

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[1] US Code Title 42, Chapter 157, Subchapter III, Part A, Section 18022, Subsection (b), Paragraph (1)

[2] US Code Title 42, Chapter 157, Subchapter III, Part A, Section 18022, Subsection (b), Paragraph (4)(G)

Ultimately, minimum AV standards limit the dollars spent by consumers in the healthcare market relative to insurance companies, fueling all the aforementioned problems caused by third-party payments in terms of cost inflation. Further, such standards limit the flexibility of insurance companies to offer purely catastrophic coverage or other high deductible plans that better match the risk and budgets of certain consumers, as these plans weigh down the AV average.

However, HHS is granted flexibility in calculating AV compliance.[3] HHS should seek to grant as much flexibility to insurance companies as possible in calculating AV compliance. This will allow for insurance companies to offer more affordable plans with higher deductibles, while the higher deductibles will encourage more consumer pressure on healthcare providers to compete on prices. This would both expand the total number of individuals covered while marginally expanding direct price negotiation between patients and providers for non-emergency care.

Medical Loss Ratio

ACA requires insurance companies to spend a fixed percentage of premium dollars collected on actual medical benefits versus overhead and profits through what is know as a Medical Loss Ratio (MLR). This regulation is just as problematic as EHBs and AVs, however it is also the regulation on which HHS has the most flexibility to act.

Currently, ACA sets an MLR of 80 percent for individual plans and 85 percent for employer plans. While the intent of MLR was clearly to protect consumers, the unintended

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[3] See CMS Draft 2018 Actuarial Value Calculator Methodology, August 29, 2016. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2018-AVC-Methodology.pdf

consequences of such a rule are numerous. First, it limits the incentive for insurance companies to enter the market as it distorts the risk-reward calculation any business makes before opening or expanding. The reward is capped while the risk remains unknown, as is the very nature of insurance. This limits consumer choice in insurance markets.

More problematic is that MLR standards, like EHBs and AV standards, also increase the share of third-party payments in the health care market. By setting the total amount of money an insurance company can keep as a percentage of the money it collects and spends, the company has every incentive imaginable to collect and spend as much as possible. This drives up premiums as well as the actual cost of care, as the insurance companies join patients in lacking a strong incentive to be conscious of the prices providers charge.

HHS has noteworthy discretion in MLR enforcement and has previously granted waivers to some states, reducing the required MLR.[4] ACA grants HHS this authority in order to ensure stabilization of insurance markets, almost implicitly acknowledging the shortcomings of MLR standards outlined above. Since high MLR standards incentivize higher insurance spending and reduced competition between insurance companies, HHS should continue to grant MLR waivers and broaden the waiver program to reduce MLRs to the maximum extent possible.

Conclusion

FreedomWorks Foundation appreciates the opportunity to provide these broad suggestions to HHS regarding regulatory reform under ACA. ACA facilitated an expanded role

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[4]Suzanne M. Kirchhoff, "Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress," Congressional Research Service, August 26, 2014. https://fas.org/sgp/crs/misc/R42735.pdf

for third-party payers in the healthcare market place, only enlarging the core problem of healthcare price inflation. To the extent possible, HHS should seek to empower patients to apply market pressure on providers to begin the process of halting and reversing healthcare price inflation. Neither government nor insurance companies will ever be able to spend a patient's healthcare dollars as efficiently as the patient themselves. To the extent that HHS can implement the reforms suggested above, America's healthcare system will be that much more sustainable long-term.

Thank you.

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