Hello SDAHU members. The rant starts now.

The patient is not well. Our health insurance system is chronically ill. Insurance agents often state that health insurance cost protection—insurance premium—is an accurate barometer of the cost of health care delivery. Medical insurance premiums have more than doubled in the past 6 years across the nation. Nationally, the average price for an individual ACA plan was $374 in 2015, and $409 for 2016. That is $5000 a year just to get an entry ticket.

This is partly due to the ACA expansion, as all qualified health insurance plans now cover the very same essential health benefits, which are not inexpensive to deliver. There is very little wiggle room to innovate in benefits, with the only moving parts being the size of a deductible, and the coinsurance amount. Outside of Platinum plan designs, out of pocket risk is almost the same, and quite high.

The insurance companies have not changed their byzantine and opaque pricing structures. It is still very hard to find out what things cost. Want a nasty little truth? Consumers assume that the negotiated rate in a health plan will significantly discount the cost of care from street rack rates. True, in most cases. But-as it turns out, paying cash to a provider, instead of using insurance, often has a larger discount than insurance can deliver. There is a downside, of course, as those cash payments are not going toward the out of pocket maximum.

Part of the premium increase wave is a function of the way our health insurance marketplace works. Every part of the system—ever consolidating hospitals, doctors, lab and diagnostic centers, device manufacturers, attorneys and pharmaceutical companies, and insurers, have done pretty well, financially, in the new ACA world of guarantee issued, and mandated health insurance coverage. Lately, the drug industry has been in the spotlight for excessive pricing of formerly affordable, older, and necessary drugs. Although generic drug prices have been stable, brand name drug prices have doubled in the past 5 years. I cannot see a way to attribute that amount of increase to pure market demand. There is some greed in there, too.

Next is our overall national health. I recently saw an article that over 50% of Californians are pre-diabetic, or diabetic already. Obesity continues as a trend, and the sometimes related hypertension and high cholesterol, and heart disease, also trend upward. Smoking is down, but drinking is up. I don't have a moral take on this, but it is clear that healthcare needs cost more when we are sick, and not controlling chronic conditions.

The health insurance agent has not been left out of the pie, either. Savvy agents looked at the ACA as an opportunity to grow business, and help people and employers comply with the law. Some 30 million people have acquired some kind of insurance. However, our sales industry has also given far more than most of these players, in terms of the devaluation of our services from the insurance companies we distribute products for. Some insurers have decided we are not worth a single nickel, if we help individual people get insurance outside of the annual enrollment window.

Actual per capita income growth has been far less than insurance premium increases. That makes insurance ever more expensive for consumers to buy. Couple that with the increasing deductibles and out of pocket risk in ACA plan designs, and you end up with a product that costs a lot to purchase, costs a lot to use, and costs too much in the event you actually trigger the true part of insurance—the out of pocket maximum risk protection. Even worse, out of network care is not yet part of this out of pocket risk. So, you can actually have to spend more than the typical $6000+ risk in your health plan. We have a

system that has expanded access and overall coverage, but is not accessible due to cost. How are we, as a nation, dealing with this right now? Premiums are now unaffordable for even the lowest cost catastrophic deductible plans, and even more so for richer benefit plans, in which you can lower the out of pocket risk.

The individual market has decided that the best way to proceed is to artificially make it look like it doesn't cost that much to buy health insurance, as long as you buy in the public exchanges. For 2015, that means about 9 million nationally, and about 1.3 million Californians, bought through the public exchange. Of those over 85% of enrollees are getting premium assistance of some kind, with a national average being a bit over $3200 per year. Further, over 50% of these subsidized consumers are also receiving cost sharing reductions that make the copays and deductibles, and risk, more affordable. So, at the end of the day, we shift tax and premium dollars around to make it appear like health insurance is affordable to buy and use, and that the market is healthy. Hmmm. Sounds like denial to me.

The employer based market has a "subsidy" for employees built in, as the employer pays much of the premium as a tax advantaged compensation method. Unfortunately, many employees are unaware of the actual premium cost of their health plan...it just looks affordable through payroll deduction. Rising premiums, and increasing deductibles and risk affect the employer based market as much as any other. The pricing pressure is unsustainable in all markets.

Is there a real path towards affordability, then? The extremely long and hilariously divisive presidential nomination process has shown candidates offering solutions ranging from 100% single payer "Medicare for all" to abolition of the ACA, and a blend of state block grants, interstate insurance sales, imported drugs, and a return to plan designs that exclude services. Frankly, nothing in these options is really new. My Medicare clients who stay out of Part D donut holes love their coverage. Unfortunately, Medicare is not self-sustaining, and is rife with rules that defy affordability. For example, compounded drugs are not covered in Medicare. Estrogen replacement is a lot more expensive if you buy the required brand option, because you can't get a compounded version that will do the very same thing, but is a lot less costly.

Importing medications from Canada and Mexico sounds good on the surface, as there are significant discounts on many drugs, when compared to US pricing. However, counterfeit medications are a big issue in these countries, while our FDA scrutinized, and insular, drug system has a lot less of that problem.

In the nationalized coverage models, it is hard to accurately compare to the US system. England, France Germany, Japan are all geographically smaller and socially less diverse, and less populated than we are. Insuring 50 million people is a lot different than taking on over 300 million people. The issue I want to note is that we all face the same demographic problems; people are living longer, and surviving medical conditions that used to kill them, and there are many more people taking benefits than younger people working to fund them. The bell tolls everywhere.

Selling across interstate lines is not a solution to affordability, either. I think the death of the ACA is not going to happen. We are way too far down the road to throw it all away. Plus, based on current predictions from pundits, and my gut, the Republican party will likely not win the presidency, and may lose control of the senate. So much for repeal, for the umpteenth time.

I have opined on the unconscionable lack of consumer sensitivity from the insurance companies-- from whom we are required by mandate to purchase--, so I will not revisit that sore spot, except to say this: The success of any insurance system is partly determined by the consumer satisfaction and experience. Given the sometimes woeful and slow carrier performance in enrollment and installation, particularly

during the overloaded fourth quarter, will employers be willing (or forced) to spend MORE to go with a carrier with a better reputation for administration? Will agents, whose reputation is affected by bad carrier performance, start demanding better performance from insurers?

In the end, I am getting tired of hearing myself whine about the problems. It is time for solution building, and out of the box thinking. I need your help, dear readers. I think professional health insurance agents have a real feel for the pulse of this insurance world, and have ideas that might help solve the problems we face. We need those to come out. To help in this request, I will throw out some early suggestions. NOTE: I do not necessarily subscribe to all of these….

What if we expanded federal influence, and regulated insurance companies as if they were utilities? They have a monopoly, and there are increasingly fewer of them. They provide a required and necessary product. The MLR is an example of how this model is used right now, as is bundling charges for things like knee replacements. **Should we also include hospital chains, too?**

What if we transferred certain benefits to a federal model? For example, move 100% paid preventive care out of health insurance plans, and handle the cost of that through taxes, rather than premium transfer. **What about having a single buyer for prescription drugs**? A national Part D. Would the reduced price of drugs also be the death knell for pharma innovation? **What about reforming the patent rules for brand drugs, and supporting generic equivalents coming to market sooner?** What about trimming waste in exotic drugs? We throw away over $3 billion worth of unused biologics each year, mostly because the packaging of the drugs is in a size that exceeds what a patient typically needs.

What about payments to providers of all types? Should that be determined by the market? Since the insurance companies aren't really stepping up yet to make cost comparison data easily available, **what about forcing transparency to happen**? Will consumers take advantage of that data?

What about penalizing unhealthy behavior from consumers? The ACA does allow a rate up for smoking, but nothing else. Should people be rewarded (OR PENALIZED) for compliance with chronic conditions? **Do we cover too many things for too many people?** For example, should we consider stopping replacing knees and hips at certain ages? Or, like England, not treat most prostate cancer in older men? Uncomfortable to talk about NOT covering things, isn't it….?

What about the agent delivery payment system? Do you want payment for services regulated through legislation? Or, do you prefer that to be negotiated with insurance companies and the free market? Should we remove ourselves from the premium equation completely, and move to a fee based model? Will consumers be willing to pay for our services? How about small agency survival? Technology—electronic enrollment, online assistance, and less paper can help lower some costs. However, agency consolidation is creating super agencies with large scale technology platforms, including private exchanges. Can the small agency compete, and do so affordably? Should smaller agencies be looking to consolidate to gain clout? How would that look?

I hope this rambling rant inspires some conversation, and causes some comments and ideas, which I will share in a future column. If we are the consumer advocate we profess to be, we need to act like it.

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