

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

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## *Executive Summary*

Thursday March 23, 2017 marked the seventh anniversary of the Affordable Care Act's (ACA) passage; it also marked the day House Republicans were to set into motion legislation, the American Health Care Act (AHCA), that would repeal and replace substantive portions of the ACA. After myriad attempts to assuage outcries from the far right and the center of the Republican Party, including negotiations with the President, House Speaker Paul Ryan pulled the bill on Friday March 24, 2017 because there were not enough votes to support it. Within days of the move to pull the AHCA from debate and a vote on the House floor, Republicans were once again vowing to repeal the ACA. While the AHCA did not pass the first time, Republicans continue to amend it to make it appealing to both conservatives and moderates. They may vote on it again as early as the first week in May. Whether the version the House could pass would also be able to pass in the more moderate Senate is a huge question mark at this point, making the AHCA (in its original and amended forms) and other ACA-replacement proposals put forward by Republicans worth examining as the health care community braces for an uncertain future.

With Donald Trump's election and the Republicans' continued control of Congress, repealing and eventually replacing the Affordable Care Act (ACA) appears to be a top priority. Since the ACA's passage in 2010, the Republican-controlled Congress has held over 60 votes to repeal it. One of these attempts was successful in January 2016, although President Obama vetoed it. While there is widespread consensus among Republicans that "Obamacare," as it has become known, must go, they have yet to coalesce around a single replacement plan. The AHCA was Republicans' first attempt to put forward a plan that the party could rally around; instead, it revealed significant differences within the party, which must be bridged in future repeal and replace attempts. The proposed plans tend to have overarching themes, which will be explored here. The following article analyzes some of the most popular Republican proposals to replace the ACA, including:

- "Patient Relief from Collapsing Health Markets," by Congresswoman Blackburn, as well as Congressmen Bucshon, Flores, and Walden.
- "Empowering Patients First Act," by Secretary of the Department of Health and Human Services (HHS) Tom Price. (A version of this plan, H.R. 3762, was the one that President Obama vetoed early 2016.)
- "A Better Way," by Speaker of the House Paul Ryan.
- "The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act," by Senators Richard Burr, Orrin Hatch, and Representative Fred Upton.

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- “The Patient Freedom Act,” by Senators Bill Cassidy, Susan Collins, Johnny Isakson, and Shelly Moore Capito.
- “American Health Care Act of 2017,” by Congresswoman Diane Black.

Republican Congressional leaders made repealing the ACA the first item on their agendas when Congress convened in January, quickly putting processes in place that will allow for the hasty repeal of some key aspects of the law. Lacking any Democratic support, Republicans voted to use a process known as reconciliation, which allows the Senate to repeal and replace parts of the law that involve federal budgetary issues with just a simple majority (versus 60 votes that would be needed to completely repeal and replace the ACA). In other words, using the reconciliation process would allow Republicans to make dramatic changes to the ACA without needing any Democratic votes. Initially, most Republican leaders agreed that some kind of delay in the actual implementation of the repeal would be necessary to avoid disrupting the health insurance markets. As word of the repeal and delay tactic spread, however, many Congressional leaders began to waiver, stating that they would prefer to pass an ACA replacement plan at the same time as they repealed the ACA for fear of chaos in the insurance industry; this is the approach that the AHCA took.

U.S. House of Representatives v. Price (originally U.S. House of Representatives v. Burwell) further complicates the future of the ACA. In the case, the House argued that the Department of Health and Human Services (HHS) illegally distributed cost-sharing reduction (CSR) funds to insurance companies without Congressional approval. Last May, the House won in district court and HHS appealed. HHS’s opening brief was originally due in January 2017; however, after the election, the U.S. Court of Appeals for the District of Columbia Circuit granted the House’s request for a delay until February 21, 2017. On February 21, the Court ruled that the case be held abeyance at least until May 22, 2017. The Trump administration will now decide whether to pursue the case, which experts agree is likely.

As recently as April 12, 2017 President Trump said he wanted to use the potential withholding of CSR funds as a negotiating tactic to get Democrats to work with him on repealing the ACA. Democrats have expressed an unwillingness to do so. Meanwhile, with a looming deadline for insurers’ rate filings for the individual market, there is tremendous anxiety around this issue; organizations such as the America’s Health Insurance Plans (AHIP), the American Medical Association (AMA), the U.S. Chamber of Commerce, and others have pleaded with the administration to commit to funding the CSRs. If the administration does nothing before May 22, and should the D.C. Circuit court rule in favor of the House in the suit and the House refuses to appropriate the funds, CSRs available to low-income Marketplace enrollees would disappear, leaving insurers to cover those costs. (By law, insurers cannot pass on the losses of cost-sharing reductions to consumers.) It is possible that the House could issue last minute appropriations, even if the Court rules in its favor, saving insurers from billions of dollars in losses. Experts disagree on the likelihood of a Congressional bailout should the Court side with the House, some arguing on the one hand that Congress will not be eager to throw the health insurance market into a tailspin by presenting the industry with a multibillion dollar bill, while on the other hand, others arguing that Congress is unlikely to back down from this fight because of its intention to repeal the ACA in any case.

The questions surrounding what Republicans will do in terms of a repeal timeline, potential replacement plan, and appropriations of cost-sharing reduction funds should House v. Price favor the House, have led to great uncertainty within the insurance and medical communities. Supporters and critics of the ACA alike have warned Congress that a repeal without a replacement plan in place will likely send the health insurance market into disarray. Republican leadership, however, remains undeterred. Should the Republicans fail to come up with a replacement plan and/or should they fail to fund the cost-sharing reductions, insurers will likely pull out of the Exchanges for 2018.

This article analyzes the Republican proposals for replacing the ACA mentioned above and assumes that the market will hold steady as Republicans work to pass replacement legislation. Additionally, this article assumes that the potential impact that the ruling in House v. Price will be minimal. Any changes or disruptions discussed are solely related to the proposed plans under consideration.

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Update: The American Healthcare Act of 2017 (AHCA) was voted on and passed the House of Representatives by two votes on May 4, 2017. The AHCA underwent numerous amendments and modifications, including the “Upton amendment,” which is not discussed in this article but was a last-minute addition made to sway moderates to support the bill. The Upton amendment will provide an extra \$8 billion from 2018 to 2023 for states that obtain waivers under the MacArthur amendment, which is another late addition to the bill that would enable states to allow medical underwriting for pre-existing conditions for consumers who do not maintain continuous coverage. The funds would be used to help pay for coverage for those who are medically underwritten in state high-risk pools, etc. Interestingly, the Upton amendment seems to undercut some of the intent of the MacArthur amendment, since the MacArthur amendment was meant to be a punitive measure for people who did not maintain continuous coverage; the Upton amendment would make the effects of the penalty imposed by the MacArthur amendment relatively moot. While this amendment allowed House Leadership to garner the votes needed to actually pass the bill and move it forward to the Senate, the vote was extremely close and is likely to face an uphill battle and undergo numerous revisions in the more moderate Senate. Thus, closely examining other viable ACA replacement plans, particularly those put forward by Senators, is a worthwhile enterprise as it may help to predict what will become of the AHCA in the future.

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## I. Introduction

Below is a summary of each of the seven prior ACA repeal or replacement bills followed by a discussion of the impact they would have on the individual market, the group (or employer-sponsored insurance) market, Medicaid, and Medicare.

### A. PATIENT RELIEF FROM COLLAPSING HEALTH MARKETS PROPOSED BILLS

On February 2, 2017 the Energy and Commerce Committee held a hearing on four discrete bills designed "...to give patients cost relief from Obamacare, tighten enrollment gaps, and protect taxpayers."<sup>1</sup> In revisiting their approach to repealing and replacing the ACA in the aftermath of the AHCA's failure, Republicans may choose to pursue the strategy these bills seemingly embraced, which is to "...adopt piecemeal replacement legislation even as repeal legislation proceeds through reconciliation."<sup>2</sup>

The four bills address several common issues prevalent throughout the various Republican ACA replacement plans. These bills seem intended to reassure insurers that there will be mechanisms in place to ensure that the individual market does not collapse as a result of an ACA repeal. Unlike most of the plans analyzed in this article, these proposals are not intended to replace the ACA in its entirety, but instead to replace parts of the statute that affect the individual market that Republicans believe will offer immediate relief from the "collapsing health markets," as the hearing's title indicates.

### B. RESTORING AMERICANS' HEALTHCARE FREEDOM RECONCILIATION ACT (H.R. 3762)

The only bill that the Republicans in both the House of Representatives and the Senate (with amendments to the House version) have successfully passed since the Affordable Care Act (ACA) became law is known as H.R. 3762 or the "Restoring Americans' Healthcare Freedom Reconciliation Act." H.R. 3762 passed in early 2016 through the reconciliation process and President Obama vetoed the bill.<sup>3</sup> Immediately after the 2016 election, it was generally understood that the Republicans would use this bill to repeal parts of the ACA as a part of the initial "repeal and delay" strategy the Republicans floated. The bill called for the repeal of key budgetary aspects of the law, including the individual and employer mandates, premium tax credits and cost-sharing reductions, and Medicaid expansion, but it did not offer a replacement plan.<sup>4</sup> The bill called for a two-year delay in the repeal's implementation.

After the 2016 election, it seemed as though Republicans would pass the same version of the bill they passed in 2016 via the same reconciliation process, with the same two-year delay in implementation built in so that Republicans could iron out the details of their final replacement plan.<sup>5</sup> As the repeal and delay tactic gained more and more publicity, however, insurance companies, health care providers, consumers, and other stakeholders began to voice concerns over whether this plan would work without causing significant marketplace disruption.<sup>6</sup> Stakeholders feared that if Congress passed H.R. 3762 and, after the two-year delay, did not coalesce around a replacement plan, there would be a great deal of uncertainty and chaos in the insurance markets and among those who gained coverage through the Affordable Care Act.<sup>7</sup> By Inauguration Day, President Trump was calling for a simultaneous repeal and replace, instead of a repeal and delay. Given the difficulty the Republicans encountered in their first attempt at repealing and replacing the ACA, however, it is possible that they will revisit the repeal and delay strategy in the future.

### C. THE EMPOWERING PATIENTS FIRST ACT

President Trump's Secretary of HHS, Tom Price, authored both the "Empowering Patients First Act" (EPFA) and

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H.R. 3762, and it is widely understood that H.R. 3762 is a version of EPFA.<sup>8</sup> EPFA is both a repeal and replacement bill, while H.R. 3762 adopted only the repeal aspects of EPFA without its replacements.

Now that Secretary Price is at the helm of HHS, EPFA has emerged as a likely frontrunner for a potential ACA replacement.<sup>9</sup> Furthermore, because the EPFA is an actual bill and not a white paper proposal, it is one of the few plans Republicans have submitted that includes detailed, legislative language, and thereby, provides some insight as to how the other plans discussed may appear, once finalized.

Secretary Price has introduced several iterations of EPFA since 2009. Each of them calls “...for a full repeal of the ACA and all health care-related provisions included in the Health Care and Education Reconciliation Act.” The repeal would include Medicaid expansion, as well.<sup>10</sup> Instead of sweeping new legislation, Secretary Price proposes to enact his changes via amendments to the Internal Revenue Code, the Public Health Service Act, and the Employee Retirement Income Security Act of 1974 (ERISA).

Many of the provisions in EPFA directly contradict those in the ACA and would result in a radically different health insurance landscape. The EPFA would give a significant amount of regulatory power back to the states. It also would eliminate the ACA’s requirement that all individuals and large employers purchase health insurance (the “mandates”). Last, it would eliminate the ACA’s revenue-generating provisions, such as the annual tax on health insurers, the medical device tax, the annual tax on pharmaceutical drug manufacturers, the payroll tax and taxes on dividends, capital gains, and investment income for high income earners.

Some of the EPFA’s proposals, however, appear too extreme to obtain bi-partisan support. This bill is perhaps the most ideologically and fiscally conservative of all the popular proposals.<sup>11</sup> If adopted as the ACA replacement plan, everyone involved in health care – insurers, providers, and consumers – would see sweeping changes to the way in which health care is purchased, delivered, and experienced today.

## D. A BETTER WAY

House Speaker Representative Paul Ryan released his “A Better Way” plan in June 2016. Congressional leaders in the House viewed A Better Way as the preferred guide as they developed their ACA replacement plan.<sup>12</sup> Like the “Empowering Patients First Act,” A Better Way would completely repeal the ACA and implement new reforms through step-by-step legislation. The A Better Way plan is still in white paper form and, therefore, is sparse on details but it embraces many popular Republican themes.

## E. THE PATIENT CHOICE, AFFORDABILITY, RESPONSIBILITY, AND EMPOWERMENT ACT

Senators Richard Burr, Orrin Hatch, and Representative Fred Upton released the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act on February 4, 2015. While it has not received as much attention since Donald Trump’s election as has Secretary Price’s or Speaker Ryan’s plans, it remains an important proposal that could play a large role in the development of Republicans’ replacement for the ACA. Senators Burr and Hatch, in particular, are longtime health policy heavyweights with significant influence because of their tenure as Senators.<sup>13</sup> The House of Representatives has voted to repeal the ACA many times, but it has proved much more difficult to do so in the Senate, making the fact that this bill has two authors who are both Senators notable. Like Paul Ryan’s A Better Way, the Patient CARE Act is a white paper, and thus offers many ideological proposals that are light on detail.

Many key elements of the paper are almost identical to both A Better Way and Secretary Price’s Empowering Patients First Act. There are some profound differences, however, between Patient CARE and the other

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proposals examined in this paper. Most of these differences come in the form of more centrist policies, which could appeal to Republican leaders as they attempt to craft future ACA replacement legislation that does not disrupt insurance markets and that will likely require some support from Democrats to become law. Estimates from two nonpartisan think tanks that have evaluated Patient CARE, the Center for Health and Economy and the Commonwealth Fund (using RAND Corporation models), predict that Patient CARE would not increase the number of uninsured relative to the ACA as profoundly as either Empowering Patients First or A Better Way, making this proposal one worth considering as the ACA replacement debate continues.<sup>14</sup>

## F. THE PATIENT FREEDOM ACT OF 2017

Senator Bill Cassidy, joined by Senators Susan Collins, Johnny Isakson, and Shelly Moore Capito, released the “Patient Freedom Act of 2017” (PFA) in January 2017, the Monday following Donald Trump’s inauguration. Not a white paper, this bill has been formally proposed and has actual legislative language. While many popular provisions from other Republican plans are present in the bill, it is unique in that it would allow states that currently operate their own Exchanges under the ACA to maintain them. In other words, it would not mandate an entire repeal of the ACA.

Instead, the bill would allow states to take a more piecemeal approach, and to repeal certain elements of the ACA, but preserve others that are popular and seem to work well. The PFA would give states the ultimate authority in how health care operates, with each state allowed to choose from one of three approaches:

1. They could keep the ACA (with some modifications, funded at 95 percent of the current ACA; states that use the federal marketplace could continue doing so or operate their own exchanges).
2. They could use PFA’s preferred option based on subsidized Roth health savings accounts, called the “state alternative option.”
3. They could simply create their own system although in so doing, they would forgo federal funding.<sup>15</sup>

The bill seemingly is an attempt to bridge the gap between some fundamental Republican positions and existing law, but is so complicated due to its many options, that it would likely need major revisions to be implemented effectively and without disrupting the market. Although this measure is likely to encounter opposition from the far right who believe that the ACA must be repealed in its entirety, elements of it are likely to appeal to moderate Republicans and possibly even some Democrats.<sup>16</sup>

## G. AMERICAN HEALTH CARE ACT OF 2017

On March 6, 2017 House Republicans in the Ways and Means and Energy and Commerce committees introduced two bills, collectively known as the “American Health Care Act of 2017” (AHCA) designed to repeal and replace substantial elements of the ACA. AHCA is significant in that it represents the Republican leadership’s first attempt to do away with the ACA since the November 8 election. It is also significant because its introduction led to a great deal of infighting within the Republican Party and revealed significant ideological hurdles Republicans will have to overcome to realize their vision of undoing President Obama’s key legislative accomplishment. The legislation was revised several times between March 6 and March 24, reflecting efforts to appease both the hard right and centrist factions within the Republican Party, but the bill was pulled to avoid an embarrassing defeat on the House floor because the House Leadership was unable to obtain the votes needed to pass it. Since then, Republicans have continued to discuss potential ways to fix the bill, including several proposed amendments, the most recent of which was issued on April 26, 2017. While the AHCA is widely viewed as a bad

bill by both liberals and conservatives alike (it had only 17 percent public approval on March 23, 2017 per a widely-reported national poll), it is worth examining as it presented many popular (and unpopular) Republican ideas that have already resurfaced in the weeks since the bill's initial defeat.<sup>17</sup> It also highlights the Herculean effort that will be involved in repealing and replacing the ACA.

The AHCA legislation would not have repealed the ACA completely, but it would have done away with the most substantial health care reforms the ACA mandated. Although the AHCA was meant to pass Congress via the Senate's reconciliation process, not all of the proposed changes appear to have fiscal implications, which could be been problematic if the legislation actually moved from the House to the Senate. Certain provisions, such as the repeal of the ACA's individual and employer mandates, which impose federal tax penalties on those who do not have health insurance, are clearly budget-related, while others, such as allowing states to eliminate essential health benefit or community rating requirements, do not appear to be.

When analyzing the AHCA, it is important to discuss the legislation as it was originally released on March 6, 2017 as well as its subsequent amendments to gain a fuller understanding of the divides within the Republican Party and the challenges that will likely arise in any future attempts to replace the ACA. For example, the Congressional Budget Office's (CBO) projection of the original AHCA's impact on the federal deficit was that it would reduce the deficit by \$336.5 billion over the course of ten years, while the revised projection based on the second iteration of the legislation showed that savings would amount to about \$150 billion over a decade. The difference between the two versions of the AHCA was more than \$185 billion (this was in large part due to repealing the ACA's taxes more quickly than proposed in the initial draft of the AHCA). The CBO analysis of the latest version of the AHCA has not yet been released. Many of the changes made to the AHCA were driven by a small but vocal conservative faction, the Freedom Caucus, that rose to power in the wake of the ACA's passage and has consistently demanded nothing less than a full repeal of the statute. Without the support of the Freedom Caucus, which has about 40 members, it is doubtful repeal legislation would pass. Many of the changes made to appease the Freedom Caucus to try to secure the AHCA's passage were so extreme, however, that moderate Republican House members who had supported the original version of the bill balked at its form. When it was time for the initial scheduled vote, the bill encountered resistance from both ends of the GOP spectrum and was pulled. As of April 30, President Trump and members of his administration promised that a new health care plan (actually just an amended AHCA) would be coming to the House floor for a vote imminently.

## II. *Individual Market: An analysis of the impact of ACA replacement proposals on the individual market*

### A. PATIENT RELIEF FROM COLLAPSING HEALTH MARKETS BILLS:

#### 1. *PLAN VERIFICATION AND FAIRNESS ACT OF 2017 (H.R. 706)*

This legislation would tighten verification requirements used to determine a person's eligibility for a special enrollment period (SEP). SEPs, which occur outside of the ACA's annual enrollment period window and are meant for those who experience "qualifying life events," have come under fire due to the rather lax verification process used to decide whether or not a person actually has experienced such an event. Many speculate that the system is flawed and has harmed the individual market's risk pool by allowing people who may not be truly qualified to enter the market when they become ill by claiming that they have experienced a qualifying life event.<sup>18</sup> In its 2017 Notice of Benefit and Payment Parameters, issued in 2016 during the Obama administration, HHS recognized the need to enforce better verification processes and demanded more oversight. HHS has introduced a pilot program to ensure

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the accuracy of applicants' claims of qualifying life events through document verification. The processes established by this program are set to begin in June 2017.

This legislation would require the Secretary of HHS to enact a special enrollment verification process similar to that described in the 2017 Notice of Benefit and Payment Parameters.<sup>19</sup> The statute would not allow qualified health plans to begin coverage for individuals who apply to the individual market on the basis of a qualifying life event until HHS verified said event. It is unclear whether coverage could be started retroactively to the date of application once an applicant is cleared. Some fear that the increased demand for proof of qualifying life events via documentation might discourage qualified individuals from applying because the process is too cumbersome.<sup>20</sup> The health insurance industry, however, views the stricter verification methods this bill would implement favorably. A letter from the American Health Insurance Plans (AHIP) regarding this proposal states that "...pre-enrollment verification represents the most effective approach to ensure the appropriate use of SEPs in promoting both affordability for consumers and stability in the new Exchanges."<sup>21</sup> Rather than replace any components of the ACA, this proposed legislation appears to modify them to make them more rigid.

## 2. *STATE AGE RATING FLEXIBILITY ACT OF 2017 (H.R. 708)*

This proposed legislation would simply amend the ACA's age rating bands from a three-to-one ratio to a five-to-one ratio, although it would allow states to expand or reduce the ratio as they saw fit.<sup>22</sup> The expansion of the age rating ratio has long been a popular proposal among insurers, and is a feature in most Republican replacement plans. They argue that the current ratio has led to prohibitively and unnecessarily high premiums for young people considering purchasing insurance in the individual market. Increasing this ratio, they say, adjusting premium tax credits and cost-sharing reductions accordingly, would allow them to charge lower rates for the youngest enrollees. This would increase the size of the risk pool with younger, healthier people and ultimately reduce rates for everyone.<sup>23</sup>

Critics counter that young people, by virtue of their demographic and likelihood of still being insured under their parents' plans or through Medicaid, will still not sign up, while older people in the individual market will be confronted with much higher premiums.<sup>24</sup>

## 3. *HEALTH COVERAGE STATE FLEXIBILITY ACT OF 2017 (H.R. 710)*

This bill would modify the ACA's mandated 90-day grace period granted to enrollees who receive advanced premium tax credits to remedy any delinquent premium payments before insurers are allowed to discontinue coverage. Insurers are required to cover health care claims during the first month of this period. H.R. 710 would instead allow a state to determine the length of the grace period or, if the state does not establish one, would reduce the grace period window from 90 days to one month.<sup>25</sup> Insurers support this measure and have claimed that, under current law, enrollees have managed to game the system by not paying for coverage for the last three months of the year, only covering delinquencies should a health issue arise.<sup>26</sup> Insurers say the bill would be more in-line with existing state rules and would stabilize the risk pool.<sup>27</sup>

Meanwhile, critics of such a reform maintain that the ACA has not resulted in broad fraudulent behavior that has negatively affected insurers or the risk pool and that a measure such as this would disproportionately impact those who are economically "...disadvantaged."<sup>28</sup> Like..." the other proposed legislation discussed in this section, this bill would not radically change the ACA, but would instead operate within pre-existing parameters to modify it.

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## 4. *PRE-EXISTING CONDITIONS PROTECTION AND CONTINUOUS COVERAGE INCENTIVE ACT OF 2017 (H.R. 712)*

This proposal addresses one of the most popular and successful components of the ACA: the requirement that insurers offer coverage to all applicants, regardless of whether they have pre-existing health conditions. As Republicans have debated what to do about the ACA, both proponents and opponents of the ACA have insisted that any replacement maintain the prohibition on coverage denial due to a person's pre-existing conditions. This legislation differs from the others discussed in this section because it anticipates the full repeal of the ACA, while the others would simply modify existing law. Should the ACA be repealed, this bill would prevent health insurers from imposing pre-existing condition exclusions on any applicants.<sup>29</sup> Interestingly, while it defines pre-existing conditions broadly, it specifies undiagnosed genetic conditions as those not to be considered pre-existing and could therefore, presumably, be a basis for denial of coverage.

Guaranteed issuance / availability would be mandated under this legislation, but insurers would be allowed to restrict enrollment to open or special enrollment periods based on qualifying life events, which it defines as those in section 603 of ERISA. While guaranteed issue would be assured, the proposed bill does not mention whether insurers would be allowed to medically underwrite premiums, meaning that insurers would have to offer coverage to everyone, but could charge people with pre-existing conditions much higher rates than those without.<sup>30</sup> Under current statute, insurers are not only not allowed to deny people coverage based on pre-existing conditions but are also not allowed to consider a person's pre-existing conditions when determining his or her premium rates. Thus, as H.R. 712 stands, those with pre-existing conditions would have the offer of coverage, but may not be able to afford that coverage.

Notably, this bill reserves a portion to address the "continuous coverage incentive" element referenced in the title. Presumably, this will mirror similar provisions in other Republican replacement plans discussed later, which the insurance industry vigorously supports.<sup>31</sup>

## B. EMPOWERING PATIENTS FIRST ACT

One of the ACA's most championed components, and one that has become extremely popular, is that of guaranteed issuance.<sup>32</sup> Instead of guaranteed issuance regardless of pre-existing conditions, EPFA would bar insurers from taking pre-existing conditions into account when accepting applicants and/or in premium pricing if the consumer had "continuous coverage," which is defined as insurance for the 18 months prior to applying in the individual market. If an applicant had a break in coverage, however, insurance companies would be allowed to consider any pre-existing conditions the applicant might have and charge up to 150 percent more than the standard premium for the first two years of coverage in the individual market, or deny coverage altogether.<sup>33</sup>

EPFA would provide funds for high-risk pools for "...those rejected by individual market insurers or whose premium offers are above a certain level."<sup>34</sup> In other words, insurers could reject applicants because of pre-existing conditions or raise the applicants' premiums to prohibitively high levels. These applicants would be able to apply for high-risk pool coverage if their premium rates were too high for them to afford coverage or if they were denied coverage.<sup>35</sup> It is unclear how people would apply for high-risk pools and who, exactly, would qualify.

EPFA would provide \$1 billion annually for three years to be divided among the states for their high-risk pools.<sup>36</sup> States could apply for bonus grants (amounts not specified) under certain circumstances, e.g., if they

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provided guaranteed issuance to individuals with prior group coverage (continuous coverage), if they showed a reduction in premiums or other cost-sharing requirements, if they broadened the definition of those who can qualify for coverage in high-risk pools, or if they adopted the National Association of Insurance Commissioners (NAIC) model plan. Given the fact those qualified for high-risk pools account for a huge portion of medical spending each year (the sickest ten percent of the population accounts for 66 percent of health care spending), an annual \$1 billion allowance to be divided among all states seems inadequate and would do very little to fund these programs.<sup>37</sup> A study by the Commonwealth Fund estimates that it would cost \$178 billion annually to cover the sickest of the uninsured population.<sup>38</sup>

Under the EPFA, premium rates and associated universal tax credits would also be decided in a different manner than under the ACA. Instead of taking a person's place of residence, income, age, and tobacco usage into account, as currently mandated, premiums and tax credits would be based solely on one's age, making tax credits available to anyone purchasing coverage in the individual insurance market. These credits are meant to offset premium costs to ensure that everyone can afford coverage in the individual insurance market. The fixed tax credits would break down as follows:

- Ages 18-35: \$1200 per year
- Ages: 35-50: \$2100 per year
- Ages 50 and older: \$3000 per year
- Dependents up to age 18: credited \$900 per year.<sup>39</sup>

Should a person's premium amount be less than the fixed tax credit, he or she would be able to keep the difference. By comparison, according to a California's Marketplace 2016 market analysis, about 60 percent of Covered California enrollees receive, on average, \$1200 per year in income-based cost-sharing reductions alone.<sup>40</sup> Under the ACA, cost-sharing reductions are given to consumers at or below 250 percent of the federal poverty level (FPL) on a scaled basis to help offset out-of-pocket costs. EPFA's fixed tax credit model, however, does not consider income or place of residence. While federal spending on tax credits would be significantly reduced, it is likely that people's access to health insurance would be similarly reduced due to unaffordability.<sup>41</sup>

EPFA includes many provisions designed to reduce premiums and increase competition with a strong reliance on free market models. It does not, for example, include a mandate for insurers to provide plans with specified essential health benefits, instead determining that to qualify for a tax credit, one must purchase insurance "that constitutes medical care (i.e., major medical, qualified coverage in the state of purchase)..."<sup>42</sup> This would allow insurers to offer a wider variety of plans than under current law, such as high-deductible, low-benefit plans that could reduce premiums and attract people who are young and do not have pre-existing conditions. EPFA would go further in the attempt to attract younger, healthier people by allowing insurance companies to use a suggested five-to-one ratio in pricing the same plan for people of different ages. (Currently, the ACA does not allow insurers to price plans for the oldest Marketplace enrollees more than three times as much as they price the same plan for the youngest Marketplace enrollees.)<sup>43</sup> Under EPFA, states would have the authority to increase or decrease this ratio.

EPFA also would rely heavily on health savings accounts (HSAs) as a means of offsetting medical costs. EPFA would raise the annual contribution limit for HSAs, allow HSA contributions to be used for a wider variety of services, and expand the eligibility of tax-deductible contributions equal to that of the maximum IRA contribution level.

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

Lastly, EPFA would encourage interstate insurance sales, a practice currently allowed under the ACA. The main difference here would be that insurers would not be subject to the laws and regulations of any “secondary” states in which they operated. An insurance company could essentially choose which state’s laws it wanted to follow and base its headquarters there.<sup>44</sup> This proposal seems contrary to Secretary Price’s and other Republicans’ desire to give states more regulatory autonomy. While the concept of increased competition among providers and access to health insurance through the sale of insurance policies across state lines makes sense from a free market perspective, the actual practice has proven difficult for insurance companies, frustrating to state regulators, and confusing to and unpopular with consumers.<sup>45</sup>

In line with interstate insurance sales is EPFA’s proposal to establish Independent Health Pools (IHPs), which would give those participating in them stronger bargaining power. These pools, cooperative in nature, would be legal nonprofits into which individuals would enter to obtain insurance for themselves and their dependents. Participating in a “pool” would presumably enable members to get better rates than if they simply purchased insurance individually. Like encouraging interstate sales of insurance, the intention of IHPs is to increase competition among insurers and give individuals more options when selecting health plans.

## C. A BETTER WAY

A Better Way would replace the requirement that everyone purchase health insurance (the individual mandate) with the concept of “universal access.”<sup>46</sup> Unlike the ACA, which bans insurance companies from ever factoring pre-existing conditions into premium ratings, A Better Way would incentivize “continuous coverage” as a means of avoiding unfavorable premium ratings. If a consumer maintains continuous insurance coverage for 18 months prior to applying to the individual market, then insurers would not be able to factor any pre-existing conditions into premium rate determination.<sup>47</sup> A Better Way does not address what would happen should a consumer experience a lapse in coverage in the 18 months before he or she applied to the individual market, but given that Secretary Price’s EPFA embraces the same continuous coverage policy, it is safe to assume that the consequences for those who have not maintained continuous coverage under A Better Way would be the same – insurers could consider pre-existing conditions in determining premium rating. Although insurers technically would not be allowed to refuse anyone health care, in line with the concept of universal access, people with pre-existing conditions who have not had continuous coverage would likely pay extremely high premiums.

A Better Way would offer a one-time open enrollment period, during which anyone could apply for coverage in the individual market without being penalized for lack of continuous coverage or pre-existing conditions.<sup>48</sup> The proposal does not provide details about the length of the open enrollment period, nor does it address what sorts of life events would qualify for any special enrollment periods (loss of employer-sponsored health care, marriage, relocation, etc.). Should someone fail to obtain insurance during the open enrollment or special enrollment period, he or she would still have access to coverage, but would be subject to the same penalties as those who fail to maintain continuous coverage. Analysts have compared this provision to Medicare’s open enrollment policy, in which those who are eligible for Medicare must sign up during a fixed period or face penalties should they miss it.<sup>49</sup> The experience with the ACA’s annual open enrollment periods has shown, however, that there are large differences between the Medicare-eligible population and the typical Marketplace consumer. The Marketplace consumers tend to be less well-informed than typical Medicare recipients (senior citizens). The task of educating those who would purchase insurance via the individual market about a one-time open enrollment period, versus the ACA’s annual open enrollment period, would likely be very difficult.<sup>50</sup>

Similar to EPFA, A Better Way would appropriate federal funds for state-run high-risk pools to help those with

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

pre-existing conditions who face extremely high premiums and medical costs. It would also allow states to compete for \$2.5 billion in grants each year for 10 years, based on their ability to reduce premiums and the number of uninsured.<sup>51</sup> Compared to the \$3 billion allocated for high-risk pools EPFA would distribute to states over three years, A Better Way's proposed \$25 billion over 10 years for states' use would be a more viable option. Still, A Better Way does not detail how the money would be divided, nor who would be eligible for the pools. And, while it mentions premium caps, it gives no specifics on the amounts.<sup>52</sup> Estimates of how much it would cost to cover the qualified high-risk uninsured population are over \$170 billion annually, making A Better Way's suggested contributions, while more robust than EPFA's, still substantially short on funding.<sup>53</sup>

As in EPFA, A Better Way would mandate premium ratings based on age alone (unless the consumer had not maintained continuous coverage, in which case pre-existing conditions could be factored into premium rating considerations). A Better Way would cap the age ratio at five-to-one, versus the ACA's three-to-one ratio, meaning the oldest enrollee could not face a premium that exceeded five times that of the youngest enrollee.<sup>54</sup> States would, however, have the authority to adjust this ratio as they see fit.

Like with EPFA, A Better Way's fixed "universal advanceable, refundable tax credit" would be determined based on age alone, meaning that someone's income or residence would not influence his or her tax credit amount.<sup>55</sup> The credit would be available at the beginning of each month to anyone, regardless of income, who did not receive insurance through his or her employer, Medicare, or Medicaid. A consumer could use the credit to purchase insurance inside or outside of the Marketplace, unlike the ACA, which requires consumers to purchase insurance inside the relevant government-run Marketplace to receive a premium tax credit.<sup>56</sup> Additionally, A Better Way would allow consumers to use the credits on "a plan of their choice," while the ACA requires consumers to purchase plans with set benefit designs to obtain a premium tax credit. By doing away with mandatory benefit designs, consumers could purchase low premium, high deductible plans with leaner benefits (catastrophic plans). Should their premiums be lower than their tax credit, consumers could invest any remainder in some sort of HSA. Unlike Secretary Price's EPFA, Ryan's A Better Way does not specify tax credit amounts it would use, making it difficult to know the exact fiscal impact of A Better Way. The most specific reference the plan makes to tax credits is that they would be sufficient to purchase a typical pre-ACA plan. Many speculate that the final legislative language would reflect EPFA's credits.<sup>57</sup> The fixed nature of the credits is meant to discourage insurers from substantial premium increases, but proposes no alternative remedy if premiums do, in fact, increase, potentially making the tax credits less and less significant.

Reliance on HSAs, lifting federal regulations on interstate insurance sales, and encouraging individuals to pool together in IHPs are common threads between Secretary Price's EPFA and Ryan's A Better Way, as well as the other proposals discussed here. A Better Way would cap contributions according to maximum combined annual deductible and out-of-pocket expense limits. HSAs, which would be tied to high-deductible health plans in A Better Way, would allow consumers to use saved funds toward health-related costs, such as co-pays and prescription costs.<sup>58</sup>

A Better Way envisions interstate insurance sales as a means of increasing competition and driving down prices, which "would increase pressure on states to review and eliminate costly and unnecessary regulations that drive up premiums for consumers," a widely-held Republican view.<sup>59</sup> This approach is intended to return regulatory authority to the states, although it could have the reverse effect. It could enable just a few states to control the markets should insurance companies decide to headquarter in states with favorable regulations.<sup>60</sup>

Participating in IHPs would likewise be intended to increase competition and provide individuals with bargaining power generally reserved for larger employers.<sup>61</sup> Meant to strengthen individuals' abilities to find the most suitable health insurance at the best rates, IHPs could potentially have an adverse effect on the market.

IHPs could result in younger, healthier people pooling together and negotiating for low rates while older, less healthy people could receive much higher rates.<sup>62</sup> All of these policies are intended to promote a free market approach to health care, in theory, improving access and reducing costs. But many in the health care industry argue that the consequences of such policies would have the opposite impact and would only improve access and cost for young, healthy people, leaving those who need health care most without viable options.<sup>63</sup>

#### D. PATIENT CARE ACT

Many themes in the Patient CARE are common among practically all ACA replacement plans. Most of these are intended to reduce government involvement in the insurance markets, increase personal responsibility, reduce federal spending, increase “universal access” (versus the ACA’s universal coverage goal), and allow the health insurance industry to operate according to free market standards without as many restrictions and regulations as under current law. These changes are subject to the same criticisms as other Republican plans and, because Patient CARE is light on details in certain areas, an accurate assessment of the overall impact to the industry is difficult.

One of the most popular overarching themes Patient CARE shares with other replacement plans is the continuous coverage provision, which will replace the ACA’s individual mandate. As with EPFA and A Better Way, Patient CARE advocates a system in which insurers could not deny coverage to consumers with pre-existing conditions. In addition, those with pre-existing conditions would not face higher premiums than those without pre-existing conditions unless they failed to maintain continuous coverage for 18 months prior to applying for a new insurance plan. For consumers who do maintain continuous coverage, insurers would be responsible for guaranteed renewability of coverage, in addition to guaranteed issuance, regardless of any change in a consumer’s health status. Under Patient CARE, consumers would be entitled to a one-time open enrollment period, during which they could enroll without penalty for pre-existing conditions. The proposal does not specify the length or the mode of implementation of such a period, however. Like A Better Way and EPFA, the more limited open enrollment option is meant to combat marketplace churn, thereby stabilizing the markets, perceived to be caused by the ACA’s annual open enrollment period.<sup>64</sup>

Other policy overlaps between Patient CARE and various Republican plans include:

- Repealing the ACA’s requirement of standardized benefit designs
- An adjustable age rating ratio of five-to-one (as opposed to the ACA’s three-to-one ratio)
- Allowing dependent coverage through the age of 26
- Encouraging interstate insurance sales as a means to drive competition
- Promoting HSAs and increased flexibility in how they can be used
- Reintroducing state-operated high-risk pools (although Patient CARE does not specify any federal contribution amount to the pools)

All of these reforms are meant to lower costs and allow for increased consumer choice and flexibility.<sup>65</sup> As previously discussed in this analysis, there are valid concerns over whether these policies would achieve their intended goals and actually make health care more accessible and affordable.

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

The key differences in Patient CARE's individual market reforms when compared to other replacement plans are the ways in which it would determine premium subsidies and who would be eligible for them, as well as a method for enrolling everyone in health coverage, whether they affirmatively elect it or not. As opposed to EPFA and A Better Way, which would offer all eligible individual market consumers universal premium subsidies based on age alone, Patient CARE would determine these subsidies, or "targeted tax credits," based on age as well as income level. Individuals (and small business employees, where small business is defined as having 100 or fewer employees) who earn an annual income of up to 300 percent of the federal poverty level (FPL) would be entitled "to receive an age-adjusted, advanceable, refundable tax credit..."<sup>66</sup> Those who have incomes up to 200 percent of the FPL would receive the maximum subsidy. The tax credit amount would scale down accordingly for those with incomes between 200 and 300 percent of the FPL, although no formula is provided to predict how this credit reduction would work. For those earning less than 200 percent of the FPL, the breakdown would be as follows:

- Ages 18-34: Individuals - \$1,970, Families - \$4,290
- Ages 35-49: Individuals - \$3,190, Families - \$8,330
- Ages 50-64: Individuals - \$4,690, Families - \$11,110

The family credits would not adjust with family size. Credits would increase annually based on the consumer pricing index plus one percentage point.<sup>67</sup> The bill would create a health financing office within the U.S. Department of Treasury to oversee the administration of tax credits, whereas the IRS currently administers the subsidies provided through the ACA. The subsidy amounts proposed in Patient CARE are more generous than those in EPFA or A Better Way, but would still tend to benefit younger, healthier people overall. The Commonwealth Fund estimates that 85 percent of the youngest enrollees under Patient CARE would see reduced premiums due to Patient CARE's subsidies, while 100 percent of people above 50 would see increased premiums due to the proposal's tax credit structure.<sup>68</sup>

In an attempt to ensure that people have universal coverage, Patient CARE would allow states to adopt a policy of auto-enrollment. States could opt to pick a "default," budget neutral plan for those who do not enroll in a plan during a specified timeframe (a one-time open enrollment period), but who qualify for a premium tax credit. This proposal could mitigate the effects of people who do not understand the "one time only" open enrollment policy and who could be penalized in the future based on pre-existing conditions if they did not maintain continuous coverage. In this scenario, premiums would be equal to the tax credit amount so no one would face any financial burden as a result of auto-enrollment.<sup>69</sup> Due to such low premiums, however, the plans into which people would be auto-enrolled would likely have very limited benefits and high deductibles (catastrophic plans). While it remains unclear how many states would adopt auto-enrollment policies, what those policies would look like, how people would be informed of their status, and how many people would opt out of such policies once enrolled, such a policy would likely maintain or increase enrollment, particularly in states that did not expand Medicaid, and potentially fend off large disruptions in the individual market.<sup>70</sup>

These proposals are likely to be met with resistance on the far right, who may view auto-enrollment as government overreach, and income-based premium subsidy determinations as too similar to the ACA. On the other hand, these policies are likely to be more attractive to Democrats, for whom universal coverage is paramount and who support the ACA's method for subsidy ratings, which grant premium tax credits based on a variety of factors, including income level, age, and family size, to individuals with incomes up to 400 percent of the FPL. While those on the left may push for higher adjustable premium tax credits than proposed in this plan, the fact that Patient CARE would take income into account at all, versus EPFA or A Better Way, may appeal to ACA proponents.<sup>71</sup>

## E. PATIENT FREEDOM ACT OF 2017

PFA would allow states to choose from one of three options:

1. They could keep the ACA (with some modifications, funded at 95 percent of the current ACA, and states that use the federal marketplace could continue doing so or operate their own Exchanges).
2. They could use PFA's preferred option based on subsidized Roth health savings accounts (HSAs), called the "state alternative option."
3. They could simply create their own system although in so doing, they would forgo federal funding.<sup>72</sup>

PFA would eliminate the individual "mandate" to purchase coverage and instead would penalize those who did not maintain continuous coverage. This approach is prevalent across all popular replacement plans and seems likely to be a fixture in the Republicans' final plan. Modeled after the Medicare Part D late enrollment penalty, should a person miss the initial open enrollment period (45 days minimum) and fail to maintain continuous coverage, PFA would enforce a monetary penalty to be paid for two years once a person did enroll. Additionally, PFA would allow insurance companies to medically underwrite a person's premium for failure to maintain continuous coverage for as long as the person was uninsured, or up to 18 months.<sup>73</sup>

As mentioned earlier, this bill allows states to choose from one of three approaches in how health care operates. For states that elect the state alternative option (option two), PFA would provide a workaround to the continuous coverage provision, which would likely appeal to younger, healthier potential enrollees. In an attempt to ensure universal access and universal coverage, PFA would allow states to adopt a "default health plan," into which the state would automatically enroll uninsured individuals. This plan would resemble a catastrophic plan, or a high deductible health plan, with limited prescription drug benefits and would establish a Roth HSA for recipients who do not already have one. Should a state elect to participate in the default health plan option, it would have to allow "eligible residents to enroll in such coverage on a continuous basis" without being subject to medical underwriting or a late enrollment penalty and would have to give individuals the opportunity to opt out of coverage should they so choose.<sup>74</sup>

Unlike most replacement plans, however, PFA would have annual open enrollment periods, as opposed to a one-time open enrollment period, which would likely allow more people to obtain health insurance, for reasons discussed previously, and during which people could switch health plans without penalty. Should a consumer switch health insurance during an open enrollment period, something called "modified health status insurance mechanism" would become effective, assuming a state chooses to adopt this measure. The "mechanism" would require the plan from which a consumer switched to pay for 75 percent of the consumer's health costs for the first three months of the plan year. Meanwhile, the plan to which a consumer switched would pay for 75 percent of the previous plan's premiums. The provision, it seems, is meant to motivate insurers to keep their consumers happy by penalizing an insurer whose consumers switch plans.<sup>75</sup> This approach may need a closer look, however, "...since expenditures during the first three months of a plan year are often subject to the plan deductible, [so] this arrangement would in fact benefit rather than penalize the insurer that lost enrollees."<sup>76</sup>

The bill is extremely complex, stemming from the fact that it would allow states to choose from three very different health insurance models. While the bill intends to give power back to the states, it is hard to imagine how meaningful federal oversight would be possible. Also, should states pick the third option, which would reject the ACA entirely (except for a limited set of requirements in PFA), the state would presumably be free to

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

design whatever sort of health care system it wanted. PFA maintains section 1332 of title I of the ACA, otherwise known as “the state innovation waivers” provision, and would allow states to apply for federal dollars to fund original health insurance market structures. Thus, the third option would provide states myriad choices, and HHS would have to regulate them. In theory, in the unlikely event that all states chose option three, there could be 50 different health insurance systems in this country.<sup>77</sup> Lastly, states would be able to switch options yearly, which could result in chaos for the market and for regulators.

Another factor that makes PFA even more complicated, arguably more so than the ACA, is the state alternative option (option two), the authors’ preferred option, which would use federal funds to contribute to Roth HSAs as a substitute for the existing subsidy and cost-sharing system.<sup>78</sup> Much of the legislation consists of explaining how this system would operate, should the legislation be adopted. If a state did not actively elect to participate in one of the three options PFA proposes, the state would automatically default into the state alternative option.<sup>79</sup> If a state elected to participate in, or defaulted into, the state alternative option, Roth HSAs would be available to individuals “who do not otherwise qualify for Federal or State subsidies for health benefits coverage,” which means that people below a certain income level who receive insurance through their employers would be eligible, in addition to those who do not.<sup>80</sup>

Relative to current law, some sort of subsidy would be available to many more people under PFA. States would receive 95 percent of current federal dollars used to finance the ACA’s premium tax credits and cost-sharing reduction funds. They would also receive two percent of the aggregate amount deposited into Roth HSAs for that state if the state elected to operate a population health initiative. The bill would give states the option to make up the difference between what PFA would subsidize and what the ACA would have subsidized, were it still in effect. If PFA is adopted, this proposition seems likely to meet with Republican resistance, but potential Democratic support. Because the funds would be distributed to many more people, however, the assistance each person would receive would be less than those eligible for ACA subsidies receive now, which will likely negatively affect low-income people the most.<sup>81</sup>

The federal government (or state, if it so chose) would make a monthly deposit into participants’ Roth HSAs to help pay for health insurance premiums and cost-sharing. While deposits made into HSAs would be considered taxable income, any income earned from the HSA would be tax-free, as would withdrawals from the account for medical expenses that insurance does not cover, such as premiums and cost-sharing. How much a person would receive each month would be based on age and place of residence, similar to Patient CARE, but different from most other Republican replacement frontrunners. There would be an “income-related phase-out” of federal subsidies for an individual making \$90,000 per year, or \$150,000 per year for a couple.<sup>82</sup>

PFA would keep the ACA’s taxes on health insurers, device manufacturers, and Medicare in place as revenue generators to fund the Roth HSAs and other subsidies. Additionally, while not mandated, PFA would allow states to adopt risk mitigation, reinsurance, and risk-corridor programs to ensure market stability, similar to the ACA.<sup>83</sup> PFA also would encourage states to adopt online marketplaces where consumers could easily shop for insurance and compare plans, as is the practice now. Furthermore, in an attempt to control costs and increase consumer awareness, the bill would require health care providers to disclose their prices and post them “to make it easy for consumers to compare the prices for similar items and services furnished by different providers.”<sup>84</sup>

## F. AMERICAN HEALTH CARE ACT OF 2017

Similar to most other proposals in this article, the AHCA would replace the individual mandate with a continuous coverage provision.<sup>85</sup> If people went more than 63 days without insurance, they would have to pay 30 percent higher premiums for 12 months upon obtaining health insurance. Liberals and conservatives alike argue

that the 30 percent premium increase “penalty” will not create enough of an incentive for people to maintain coverage and will cause significant disruption to the market beginning immediately.<sup>86</sup> The Congressional Budget Office’s (CBO) evaluation of the AHCA supports this assessment; because the penalty is not very severe, younger, healthier individuals would be discouraged from purchasing health insurance, negatively impacting the overall risk pool.<sup>87</sup>

The AHCA would create a “Patient and State Stability Fund,” which would provide federal funds for states to use for a variety of purposes, aimed at giving states more discretion in how their health care systems operate as well as ensuring the stability of the market. For the years 2018, 2019, and, as the result of an amendment, 2020, the federal government would provide \$15 billion to be divided among the states, and \$10 billion for each subsequent year through 2026. How much each state receives will be based primarily on its relative medical loss ratios.<sup>88</sup> States would be able to use the funds for the following purposes:

- High-risk pools
- Reinsurance to stabilize individual markets
- Reducing insurance costs for people with a lot of health expenses
- Promoting individual and small business pooling
- Promoting preventive health services: dental, vision, mental health, and substance abuse
- To pay providers directly
- Helping to reduce patients’ out-of-pocket costs (presumably as a replacement for the elimination of cost-sharing reductions)
- Creating an “invisible risk sharing program,” which would provide \$15 billion between 2018 and 2026 to assist participating insurers in covering the costliest medical conditions (this measure was added in an April 6 amendment to the AHCA)<sup>89</sup>

The CBO predicts that states would use the majority of the Patient and State Stability Fund dollars “...to reimburse insurers for some of the costs of enrollees with claims above a threshold;” in other words, states would use these resources to fund high-risk pools for very sick consumers.<sup>90</sup> While the available funds would be much greater than in either EPFA or A Better Way, they are also designed to finance a greater variety of functions delegated to the states and would likely still be inadequate to ensure coverage to just the high-risk population alone.

Predictably, given other Republican proposals, AHCA would alter the permissible age banding ratio from the current three-to-one ratio to five-to-one, “...or such other ratio for adults...as the State involved may provide.”<sup>91</sup> States would be able to maintain the three-to-one ratio status quo, should they so choose, but could alternatively broaden the ratio even more. As discussed above, this would likely lead to lower and more attractive premiums for young adults but significantly higher premiums for the oldest portion of the individual market risk pool, who are more likely to have higher medical expenses.<sup>92</sup>

Universal and advanceable tax credits based on age alone would be available for those making up to \$75,000 (individual) or \$150,000 (families) annually. The youngest enrollees would receive \$2,000 per year and the

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oldest would receive \$4,000 per year. The subsidies could be used for purchasing private insurance plans outside of the Marketplaces, which would likely lead to the end of Marketplaces. In the original version of AHCA, consumers would have been able to invest any excess premium assistance in their health savings accounts (HSAs), but this was eliminated in subsequent amendments over concern that people might abuse this provision.

Due to public outcry that \$4,000 per year for the marketplace's oldest (and often sickest) consumers would not be enough to provide substantial premium assistance, the amendment released on March 20 included a provision to allow the Senate to increase the amount that people over the age of 50 received via a reduction in the medical expense deduction threshold. This would have enabled people to deduct more medical expenses from their taxes. According to many reports, the change in the medical expense deduction threshold would have freed up an additional \$85 billion to go towards the neediest consumers over the age of 50. It is worth noting, however, that for low-income people who do not pay taxes or who are in particularly low tax brackets, this provision would not provide any relief.<sup>93</sup>

As in many other Republican plans, AHCA would do away with cost-sharing reduction payments for consumers who earn less than 250 percent of the federal poverty level, instead favoring investment in HSAs as a means to reduce out-of-pocket costs. This legislation would double the current HSA contribution ceiling, when linked with high deductible plans and would reduce penalties on using HSA funds to pay for non-medical expenses.

Meanwhile, in an effort to curb premium prices the AHCA proposed to do away with the ACA's actuarial value (AV) requirements and metal tiers after 2019. Insurers could sell plans with AVs under 60 percent, but ACA's maximum out-of-pocket limits were maintained so plans would not be able to be less generous than catastrophic plans currently available.

Two of the AHCA's most impactful and controversial changes to the ACA were, significantly, not in the original document, but have been added in amendments in efforts to sway conservative Freedom Caucus members to vote for the AHCA. Beginning in 2020, the first amendment would allow states to obtain waivers to "... encourage fair health insurance premiums" essentially enabling states to redefine the ACA's essential health benefits (EHBs).<sup>94</sup> Freedom Caucus members, as well as many other conservatives, have long argued that the ACA's EHBs have increased insurance premiums and have not allowed insurers to create "... sufficient flexibility in benefit design."<sup>95</sup> It is likely that allowing more flexibility in the types of coverage insurers could offer would lead to lower premiums. However, while more people could afford to purchase coverage, many would only be able to purchase plans with high deductibles, cost-sharing amounts, and services that would not be covered.<sup>96</sup>

The second amendment is likely to be even more contentious than allowing states to undo EHBs as it would significantly alter the ACA's virtually universally-embraced prohibition against medical underwriting (also known as the community rating requirement). Notably, the original AHCA differed from many other Republican proposals in that medical underwriting for pre-existing conditions would not be allowed for those who failed to maintain continuous coverage. This was likely in response to wide-scale public resistance to repealing this extremely popular ACA provision. The conservative members of the House Freedom Caucus strongly objected to this, however, which is one of the reasons the AHCA did not pass in late March. Since then, the Freedom Caucus has successfully composed an amendment, introduced by Congressman Tom MacArthur of New Jersey on April 25, 2017. The amendment would allow states to obtain waivers to allow medical underwriting for people with pre-existing conditions should they fail to maintain continuous coverage in lieu of the 30 percent premium penalty proposed elsewhere in the AHCA. As with the 30 percent continuous coverage penalty, the medical underwriting penalty would apply to a consumer for a 12-month maximum.

The MacArthur amendment would essentially eliminate the ACA's community rating requirement. To be granted this waiver, states would have to have a program under the AHCA's Patient and State Stability Fund that would provide support to the population that would be impacted by medical underwriting, although the form of the program is loosely defined.<sup>97</sup> This would technically still provide access to insurance to those with pre-existing conditions but would likely make it unaffordable for many people.<sup>98</sup> The amendment has been met with widescale criticism from consumer advocates, the health care industry, the business community, and many moderate Republicans seem concerned about it, which will likely lead to lively debate if and when the AHCA moves from the House to the Senate.

Both the EHB and medical underwriting waivers would be granted if states could show that doing so would bring down premiums, increase coverage, or promote the state's public interest.<sup>99</sup> Analysts agree that the standards for obtaining these waivers would be very low and that waivers would be granted liberally to states that applied for them.<sup>100</sup> Importantly, it is unclear whether the existence of EHBs or community rating technically impacts federal spending. This could be a major hurdle and source of debate should the AHCA make it to the Senate because the aforementioned reconciliation process only allows statutory changes to parts of the law that directly impact federal spending.

### *III. Employer-Sponsored Market: An analysis of the impact of ACA replacement proposals on the employer-sponsored market*

#### A. EMPOWERING PATIENTS FIRST ACT

In addition to the changes proposed for the individual insurance market, EPFA would restructure the employer-sponsored insurance market, through which the majority of Americans receive health insurance. Currently, employers receive tax exclusions based on providing insurance to their employees, which costs the government an estimated \$260 billion per year in revenue.<sup>101</sup> The ACA introduced what came to be known as the "Cadillac tax," scheduled to take effect in 2020, which would have imposed a 40 percent excise tax on employer-sponsored insurance plans whose premiums exceeded \$10,200 per year for individuals and \$27,500 per year for families. Employer-sponsored health insurance has typically been tax exempt, and the "Cadillac tax" was extremely unpopular with Republicans. Instead of placing a tax on employer-sponsored coverage, EPFA would limit the tax exclusions employers receive for providing insurance for their employees. Any money used on plans that cost over \$20,000 per year for a family and \$8000 per year for an individual would be considered taxable dollars, adjusted annually for cost of living.<sup>102</sup>

In an effort to provide employers and employees more choice about what kind of insurance they buy and how they buy it, EPFA would allow an employer to grant employees a subsidy, so to speak. Instead of providing employees with company health insurance, an employer could grant its employees a pre-tax benefit through a defined contribution. The employee could then opt to use that benefit to purchase a plan through the employer or through the individual market. EPFA also would prohibit states from banning employer auto-enrollment, whereby an employer could automatically enroll an employee in the employer's insurance, so long as the employee had a chance to opt-out. In an effort to give small businesses greater purchasing and bargaining power, the bill would encourage small businesses to participate in association health plans (AHPs), which serve as a "pool" or "cooperative" for small businesses.

#### B. A BETTER WAY

All replacement plans do away with the ACA's so-called employer mandate and A Better Way is no different.

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

The ACA requires all employers with 50 or more full-time (defined as working 30 or more hours per week) employees to provide health insurance or else pay penalties.<sup>103</sup> Because employer-sponsored insurance is the way most Americans receive coverage, however, A Better Way proposes several policies designed to ensure that employer-sponsored insurance remains viable and popular.

A Better Way would not mandate that employers offer their employees health coverage, but would encourage it through the use of health reimbursement accounts (HRAs), AHPs, and self-insurance with the option to purchase stop-loss insurance. HRAs are considered “defined contribution” accounts and are generally tied to high deductible health plans. Employers would determine a fixed amount of money to go towards employees’ health expenses annually and, using that money, employees could purchase a plan in the individual market and receive reimbursement for medical expenses. HRAs presumably allow employers and employees greater flexibility because employers could opt not to offer group health insurance and could determine what kinds of medical expenses they would be willing to cover (from comprehensive coverage to emergency room-only coverage). Employees could shop around for insurance that best suits their needs and could maintain that insurance even if they lost their job.<sup>104</sup> Through AHPs, small businesses could band together and act as a greater bargaining unit to negotiate down premium prices for their employees. A Better Way makes it clear that such associations would not be able to discriminate against sick or high-risk patients and would not be allowed to charge them higher rates. The use of self-insurance would allow employers to directly fund their employees’ medical costs, while stop-loss insurance would protect these employers by covering expenses associated with any catastrophic, unanticipated employee claims.

Similar to EPFA, A Better Way would undo the unpopular “Cadillac tax” in the ACA and replace it with employer-sponsored insurance tax exclusion caps. Arguing that current tax exemptions for employer-sponsored insurance cause employers and employees alike to choose overly-robust and costly insurance, A Better Way would seek to curb such behavior and rein in spending. Instead of taxing employer-sponsor coverage that has premiums above a certain level, as the ACA would have done beginning in 2020, A Better Way would “cap the exclusion at a level that would ensure job-based coverage continues unchanged for the vast majority of health insurance plans,” and would exclude employees’ pre-tax contributions to HSAs from counting as cost of coverage subject to the cap.<sup>105</sup> The plan is short on details on what the exclusion level would be, but since it is similar to EPFA’s proposed cap, it would likely mirror the amounts specified in that bill. A Better Way’s stated intent in using these caps would be to force insurers to create more efficient plan designs, in turn resulting in more take-home pay for employees. Significantly, A Better Way would adjust its caps to reflect health insurance cost differences based on cost of living, a measure also provided in Secretary Price’s bill for employer-sponsored insurance caps, but that neither bill considers for premium ratings or tax credits for use in the individual market.

## C. PATIENT CARE ACT

The proposed changes to employer-sponsored coverage are virtually identical to those in EPFA and A Better Way, mandating a cap on the employer-sponsored coverage exclusion. The only difference is that the amounts to which the cap would apply are higher in Patient CARE. Instead of EPFA’s proposed (and A Better Way’s presumptive) \$10,200 per year for individuals and \$27,500 per year for families (adjusted for inflation and region), Patient CARE would place the cap at \$12,000 per year for individuals and \$30,000 per year for families, to be indexed at the consumer price index plus one percentage point annually.<sup>106</sup>

## D. PATIENT FREEDOM ACT OF 2017

PFA does not discuss the employer-sponsored market at length and does not propose any sweeping changes. Should a state choose to keep the ACA, the employer-sponsored market would continue to operate as it does

currently, although large employers would no longer be required to offer their employees health insurance. Should a state choose to eliminate the ACA, there would not be any major changes, except the same provision regarding large employers mentioned in the previous sentence. As described earlier, should a state choose the state alternative option (option two), Roth HSAs would be available to individuals who have employer-sponsored insurance and to which employers could contribute.

#### E. AMERICAN HEALTH CARE ACT OF 2017

AHCA would repeal the so-called “employer mandate,” as would all other proposals analyzed here. This could lead to potential disruption in the group market. It also would represent a large decrease in tax revenue generated under current statute.<sup>107</sup> Surprisingly, AHCA would leave the “Cadillac tax” in place, but would just push the effective year back from 2020 to 2026. This marks a significant shift from other replacement plans, which decried the “Cadillac tax” as something that would hurt employers and employees alike and represented government overreach. The approach many Republicans favored, introducing a cap on employer-sponsored insurance tax exemptions for the most robust plans, drew a significant amount of consternation from many stakeholders and the party’s more conservative factions, who said such a cap would amount to the creation of a tax, which they refused to support.

### IV. *Medicaid: An analysis of the impact of ACA replacement proposals on Medicaid*

#### A. EMPOWERING PATIENTS FIRST ACT

EPFA does not address Medicaid reform or how it would handle the existing Medicaid expansion population the ACA created.<sup>108</sup> Under the ACA, states were permitted to extend Medicaid eligibility to anyone with an annual income at or below 133 percent of the Federal Poverty Level (FPL) (states were allowed to choose to offer Medicaid to people with up to 138 percent of the FPL, which California did). Presumably, under a repeal, Medicaid would revert back to the pre-expansion, pre-ACA status quo. Those who became eligible for Medicaid under the ACA would no longer be, but instead would be eligible for the individual market described above, including high-deductible, low premium, limited benefit design plans (catastrophic plans).

#### B. A BETTER WAY

The most impactful changes in A Better Way come in its suggested overhaul of Medicaid. Medicaid expansion was a crucial component of the Affordable Care Act. Designed to cover those who would likely not be able to afford insurance on the ACA-created Exchanges, the expansion was meant to extend Medicaid coverage to include all individuals up to 133 or up to 138 depending on the state, percent of FPL. Prior to the ACA’s passage, Medicaid was available to “low-income children, pregnant women, elderly and disabled individuals, and some parents...” who earned up to 100 percent of the FPL (with additional provisions for certain populations), excluding all other low-income adults.<sup>109</sup> To fund the pre-ACA-Medicaid-eligible population, the federal government guarantees at least dollar-for-dollar matching funds for every dollar a state spends on the program. In California, the federal government pays for 50 percent of Medi-Cal (California’s Medicaid program) expenses and the state pays the remaining 50 percent.

To fund the ACA expansion population, the federal government pays 100 percent of Medicaid costs and will shift to covering 90 percent of Medicaid costs in 2020, assuming the current policy remains, with states responsible for making up the other 10 percent.<sup>110</sup> The amount the federal government pays states for Med-

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icaid is determined by the actual costs of the program.<sup>111</sup> In its decision in National Federation of Independent Business v. Sebelius, the U.S. Supreme Court ruled that it would be the states' decision whether to implement the expansion. Thirty-one states have opted to expand Medicaid, several of which have "modified" expansion programs. Nineteen states, all controlled by Republicans, have declined to expand the program.

As of September 2016, over 73 million Americans received health care through Medicaid. Since the Affordable Care Act took effect in January 2014, enrollment in Medicaid nationwide has increased 28 percent. In California alone, enrollment in Medi-Cal has increased by 52 percent, reflecting people newly covered under the ACA's Medicaid expansion, as well as those who were eligible for the program before the ACA was implemented but had not sought coverage.<sup>113</sup> Over 13.6 million Californians are currently enrolled in Medi-Cal, about 3.7 million of whom are part of the ACA's expansion population.<sup>114</sup>

While A Better Way would not do away with the ACA's Medicaid expansion entirely, it would completely restructure the ways in which states receive funding for Medicaid programs (for pre-and post-expansion populations) and, in so doing, would cause 4 million (a conservative estimate) or more current Medicaid enrollees to lose health coverage over the next decade.<sup>115</sup>

In A Better Way, Ryan asserts that "[s]ince states finance no more than half of the total cost of their Medicaid programs, states have mixed incentives with regard to overseeing the financial growth of the program."<sup>116</sup> Instead of providing health care in the most streamlined, cost-effective approach, he and many conservatives argue, states implement the program inefficiently because they are not responsible for the majority of the costs and because the federal government finances it on an open-ended basis.<sup>117</sup>

In its "Report to Congress on Medicaid and CHIP" in June 2016, however, the Medicaid and CHIP Payment and Access Commission (MACPAC) shows that 70 percent of Medicaid cost growth is due to the broadening of Medicaid eligibility, not necessarily to program inefficiencies.<sup>118</sup> For fiscal year 2014, the year the ACA Medicaid expansion took effect, program spending increased eight percent nationwide due to the expansion.<sup>119</sup> Per capita spending remained low relative to spending attributed to eligibility expansion, "although recent evidence suggests that spending growth may be somewhat higher among newly eligible adults, who as a group are less healthy (at least partly owing to their previous lack of access to affordable health care)."<sup>120</sup> This suggests that Medicaid spending has grown not because of a lack of motivation on behalf of states to create innovations to make Medicaid more efficient, but instead because, due to targeted population outreach and education as well as the ACA's Medicaid expansion, the program's participation has broadened.

Ryan and many of his conservative colleagues believe that to reduce Medicaid spending and increase innovation in program delivery, states must assume more regulatory and monetary authority over Medicaid, which in turn means a reduction in federal regulations and funding.<sup>121</sup> Though A Better Way does not offer specifics regarding how much funding states would receive, based on prior budget proposals Ryan has submitted, it is safe to assume that federal Medicaid funding could be reduced by about one-third of its current total budget.<sup>122</sup>

A Better Way advocates two payment options long championed by conservatives as a means of curbing perceived unrestrained inflation in Medicaid spending: per capita allotment grants and block grants, which would impose strict limits on federal contributions to states' Medicaid programs.<sup>123</sup> The plan would limit funding (regardless of whether it was in per capita allotment or block grant form) to Medicaid expansion populations only in states that adopted the Medicaid expansion by January 1, 2016. States that chose to extend Medicaid eligibility in the future would have to fund any expansion on their own, without federal funds. Per capita allotment payment is the plan's default methodology, while states would have to actively select to have a block grant payment structure.

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

Because block grants are the less flexible option, they are likely less attractive to states compared to per capita allotments. Block grants would provide states with annual fixed amounts with which states could operate Medicaid. These grants would determine federal funding to states' Medicaid programs based on "aggregate, historical spending levels multiplied by a predetermined growth rate," for each state, instead of actual growth rates.<sup>124</sup> Block grants would make it difficult for states to expand coverage in the future, particularly in the event of an unprecedented demand for Medicaid (due to a recession or a catastrophic event, for example), because the federal funding would be fixed and inflexible, regardless of actual need.<sup>125</sup> To curtail spending at the federal level, the estimated growth rates used to dictate federal funding would have to be lower than under current law.<sup>126</sup>

According to A Better Way, should a state default to per capita allotment, federal funding for Medicaid would be based on 2016 state spending per enrollee in each beneficiary category, adjusted for inflation.<sup>127</sup> While the caps set on various beneficiary categories would be allowed to grow, they would be set at rates below the ACA's predictive growth rates models, although A Better Way does not put forward an exact formula. Beginning in 2019, the ACA's enhanced federal funding for the expansion population would begin to be phased out, although no timeline is provided, and would eventually return to pre-ACA federal funding levels.<sup>128</sup> As with block grants, to attain the intended objective of reducing federal spending, the growth rates per capita allotments used to determine spending would need to be capped lower than currently expected.<sup>129</sup> Additionally, despite the stated intent to give more authority and flexibility back to states through this funding design, these caps would be permanently fixed for each beneficiary category and, therefore, do away with "states' current flexibility to make changes in their spending per enrollee by either modifying benefits or changing provider payment rates."<sup>130</sup>

States will likely prefer to receive federal funding through per capita grants versus block grants, however, because per capita grants allow states to account for increased enrollment, while block grants are fixed and inflexible, even if there is an unprecedented enrollment shift. Regardless of which option states choose, it is likely that there will be a significant disparity between the states based on historic spending levels that would become locked in with either proposal and would negatively impact low-income states more significantly.<sup>131</sup> Similarly, states would no longer have the ability to expand coverage and restructure benefit designs because they would lose the ability to shift federal funding within their Medicaid programs. While states may be motivated to innovate their Medicaid systems and make them more efficient due to decreased funding, as conservatives believe, they may also find themselves with the burden of financing funding gaps or narrowing coverage for Medicaid recipients, as critics of this approach believe.<sup>132</sup>

In addition to payment restructuring for Medicaid, Ryan's plan would also support a variety of conservative measures designed to reduce spending and increase personal responsibility. Arguing that the ACA's Medicaid expansion "discourages work," A Better Way gives states the option to include work requirements for Medicaid recipients, a favorite Republican concept and one embraced by Seema Verma, Centers for Medicare and Medicaid Services administrator. Critics of such potential requirements argue that "[m]ost Medicaid beneficiaries who can work do so," and that it would be burdensome to states, who would have to create new job development programs. Supporters believe it could provide Medicaid recipients an opportunity and incentive for obtaining better employment.<sup>133</sup>

Additionally, A Better Way would give states the option to use waiting lists and enrollment caps for "non-mandatory populations," as well as make allowances for states that wish to reduce Medicaid eligibility below 138 percent FPL.<sup>134</sup>

### C. PATIENT CARE ACT

To grant states “the financial certainty and programmatic flexibility to implement reforms that will strengthen and improve care for the low-income patients in their states,” Patient CARE proposes a capped allotment system similar to that in A Better Way.<sup>135</sup> Capped allotments based on health status, age, and “life circumstances” for states would be based on pre-ACA Medicaid expansion spending (pre-2014). It would also define the Medicaid-eligible population by pre-expansion terms: only pregnant women, low-income children, and low-income families at or below 100 percent of the FPL would be considered Medicaid-eligible, as opposed to under the ACA where anyone whose income level was at or under 138 percent of the FPL qualified for the program.

As with the premium tax credits envisioned in this proposal, the capped allotments would grow according to the consumer price index plus one percentage point. There would be an additional “defined budget” for long-term care for low-income elderly or disabled people who choose not to use the premium tax credit proposed in Patient CARE. To make up for those who received Medicaid through the ACA’s expansion and would lose their coverage under this model, however, Patient CARE would offer premium tax credits to the expansion population (anyone at or below 138 percent of the FPL and who did not have health insurance through an employer or another program), making at least some kind of health insurance attainable for many of those who would be affected by the expansion’s repeal.

Unlike current practice under the ACA, where those eligible for Medicaid are not eligible to receive premium tax credits and cost-sharing reductions, Patient CARE would allow Medicaid-eligible individuals to choose between Medicaid and a tax credit to buy private insurance through the individual market. These proposals would likely result in a significant shift in today’s Medicaid population to the individual market.<sup>136</sup> Because anyone under 200 percent of the FPL would receive the same tax credit, however, individuals whose incomes are slightly above 100 percent of the FPL would likely have a difficult time affording health care costs under Patient CARE, even if they could afford some kind of coverage.<sup>137</sup>

### D. PATIENT FREEDOM ACT OF 2017

PFA would maintain the ACA’s Medicaid expansion in states that chose to do so. For states that choose option two, Medicaid expansion recipients would transition from Medicaid to Roth HSAs. States that did not expand Medicaid would receive federal funding at 95 percent Medicaid match funds.<sup>138</sup>

### E. AMERICAN HEALTH CARE ACT OF 2017

Predictably, many of the most dramatic changes in the AHCA were in its proposed reforms to Medicaid similar to the suggestions made in Speaker Ryan’s A Better Way. These changes would impact both the pre-and post-expansion populations and, according to the Congressional Budget Office’s (CBO) projections, would result in a loss of coverage for over 10 million people over the next decade. Notably, the revisions made to AHCA via one of the many amendments reflect the influence of the most conservative factions of the Republican Party.<sup>139</sup>

Beginning in 2020, AHCA would end the enhanced federal matching rate for the Medicaid expansion population created by the ACA. Instead of the federal government financing 90 percent of funding for this population, as mandated under current law, federal funding would switch to the rate for its pre-expansion population (in California, this would be 50 percent).<sup>140</sup> While the initial AHCA would have allowed states that have not already done so the option of expanding Medicaid until December 31, 2019, an amendment altered the legislation so that states would have only had until the end of 2017 to adopt Medicaid expansion. This, combined with the reduced federal matching rate for the expansion population set to take effect in 2020,

would likely mean that no additional states would expand Medicaid for people in the 100 to 138 percent FPL range or to non-disabled, childless adults. Per the CBO's estimates, states' decisions not to expand Medicaid alone would lead to about five million fewer enrollees annually within a decade, relative to the population should the ACA remain in effect.<sup>141</sup>

Most significantly, the nature of Medicaid's federal funding would change under AHCA from an open-ended system to either a per capita allotment or block grant, seriously impacting the flexibility of the program and the way in which it is delivered. The initial version of the AHCA would have mandated a switch to per capita allotment funding beginning in 2020; at the insistence of conservative Republicans, however, an amendment was added that would allow states to choose between per capita allotments and block grants from the federal government. As discussed above, either of these options would fundamentally alter the way in which Medicaid operates and could have significant negative implications for the program's ability to serve its intended populations in the event of a recession, catastrophe, or dramatic health care inflation. Structuring Medicaid in this way would, however, provide states with increased flexibility in running their Medicaid programs, although given the current level of federal financial participation, it is unlikely states would be able to use this flexibility to increase current benefit levels.

Lastly, AHCA would provide states with incentives to implement policies long championed by conservatives as a means of reducing Medicaid spending. The initial version of the legislation would incentivize states to make Medicaid eligibility determinations more regularly, to ensure that people are not fraudulently enrolled.<sup>142</sup> In one of the amendments, states would also be able to receive extra funding should they opt to implement work requirements for "able-bodied" Medicaid recipients.<sup>143</sup>

## V. *Medicare: An analysis of the impact of ACA replacement proposals on Medicare*

### A. EMPOWERING PATIENTS FIRST ACT

EPFA's proposals for the Medicare-eligible population reflect popular Republican ideas around transitioning the program away from its traditional fee-for-service model toward one modeled after private insurance, as well as Secretary Price's long history advocating for greater physician protections. While EPFA does not go into as much detail as Speaker Ryan's A Better Way regarding offering "premium support" (also known as vouchers), to purchase private insurance, EPFA would allow Medicare-eligible individuals to opt out of the program and receive a tax credit to purchase private insurance instead.<sup>144</sup> Secretary Price's plan would also allow Medicare enrollees to contribute to HSAs from their own funds, a concept likely to be embraced by Republicans who advocate the use of HSAs as a means to supplement out-of-pocket health expenditures.

Secretary Price's history as a physician and his voting record as a member of Congress have demonstrated his keen interest in protecting physicians, and his proposals for Medicare reform continue in that vein.<sup>145</sup> EPFA would allow Medicare recipients to "voluntarily enter into contracts with participating and non-participating Medicare-eligible professionals without penalty," and would enable the beneficiaries to submit Medicare payment claims directly.<sup>146</sup> Additionally, in situations where such contracts existed, any Medicare reimbursement rates ("Medicare limiting charges") would not apply, which would allow participating physicians to be reimbursed at the same rates private insurance plans would pay, not at reduced Medicare rates. Historically, Secretary Price has opposed cost-cutting measures directed at physicians that were meant to keep Medicare spending in check. While these proposals may not fundamentally alter the structure of Medicare, they could lead to increased federal spending on Medicare, a concept that may be incompatible

with most Republicans, although the concept of fewer government regulations may appeal to conservatives.<sup>147</sup>

Since President Trump's election, Price has vowed that he would not modify Medicare as Secretary of Health and Human Services. This would maintain the President's repeated campaign promise to not change Medicare. Making clear that his duties as HHS Secretary would differ from those he held as a Congressman, in January 2017, Secretary Price said he would "convey to the Medicare population of this nation, they don't have reason to be concerned."<sup>148</sup> While he offered no specifics, his statement indicates a departure from EPFA's proposals and indicates that if EPFA were to become the favored ACA replacement plan, the references to Medicare would be removed.

## B. A BETTER WAY

Speaker Ryan has long backed sweeping Medicare changes, converting the health care behemoth from a single payer system to a privatized one. While such proposals are extremely controversial, Republicans have embraced them, making it likely that they will become law under the Republican-controlled Trump administration, despite the fact that Trump made multiple campaign promises not to alter Medicare. Notably, A Better Way and most other ACA-replacement plans would do away with the Medicare-sustainability clauses in the ACA, with the exception of the Patient Freedom Act of 2017, resulting in \$800 billion in savings losses. Ryan's proposal would attempt to reduce Medicare spending and increase its solvency in other ways, however, with a particular eye toward integrating Medicare's current fee-for-service structure with private, managed care plans.<sup>149</sup>

Under A Better Way, Medicare Advantage (MA) would be significantly strengthened, providing seniors with greater access to managed care plans. MA has been extremely successful, with almost 32 percent of seniors choosing MA plans over traditional fee-for-service plans. Ryan and other conservatives argue that Medicare functions more successfully with MA plans because they "promote choice and competition."<sup>150</sup> A Better Way would repeal the ACA's caps on MA expenditures, which benchmarked MA reimbursement rates at the same levels as traditional Medicare rates, allowing MA plans to be paid at higher rates than traditional fee-for-service Medicare plans.<sup>151</sup> Ryan's plan would also reintroduce annual open enrollment periods, during which seniors could switch to a new MA plan. This appears counterintuitive to Ryan's overall objective of stabilizing insurance markets, particularly since he wants to do away with annual open enrollment periods in the individual market to reduce churn. Lastly, MA plans would no longer have to offer uniform benefit designs to all participants, required under current law. This would presumably enable insurers to offer more limited benefit plans to seniors.<sup>152</sup>

A Better Way proposes other Medicare reforms designed to "preserve the promise of Medicare," which Republicans believe is under threat because of the ACA.<sup>153</sup> The plan would do away with the ACA-established Independent Payment Advisory Board and Center for Medicare and Medicaid Innovation, which were tasked with testing and evaluating various payment and service delivery models for Medicare and Medicaid. Conservatives believe these groups were given too much power to mandate program changes, potentially disadvantaging program recipients.<sup>154</sup> To meet the goal of increased competition and reduced spending, A Better Way would repeal the ACA ban on physician-owned hospitals. In an attempt to streamline the program and increase transparency around the actual cost of health care, Medicare Parts A and B would be combined and have a single deductible. Furthermore, Medigap plans would be restricted to encourage "more careful purchasing," by participants and their providers.<sup>155</sup> A Better Way would require a new "Medicare Compare" website so consumers could compare various fee-for-service and MA plans, which would be ranked based on set quality measures. Lastly, to reflect the increasing life expectancy and demands on Medicare, A Better Way proposes to raise the qualifying age for Medicare to mirror that of Social Security beginning in 2020.

# AFFORDABLE CARE ACT REPLACEMENT PLANS, EXAMINED

A Better Way's most substantial Medicare reform proposal would not take effect until 2024, when seniors would be offered "premium support," a subsidy or voucher, to purchase private plans, although they could still choose a traditional fee-for-service plan.<sup>156</sup> The intended effect of such a reform is to increase health plan competition, thereby driving down government spending, making Medicare consumers more cost-conscious when choosing a plan.<sup>157</sup> Medicare would pay the subsidy directly to the private plan or fee-for-service plan to help offset the cost of Medicare recipients' premiums. Similar to the way the ACA determines how much premium assistance a person receives in the individual market based on age, socioeconomic level, place of residency, and tobacco use, A Better Way's subsidies would be based on Medicare recipients' socioeconomic status, with low-income seniors receiving the most assistance while high-income seniors receive the least, and with recipients receiving more assistance if they became sick.<sup>158</sup> A Better Way does not, however, provide any details on how premium support would be calculated, making it impossible to determine how much impact such assistance would actually make for purchasers, particularly those with low incomes.<sup>159</sup>

Ryan envisions a Medicare Exchange, similar to the federal Exchange the ACA created, where private and Medicare plans would compete. Liberal critics assert that this approach takes a simple, straightforward, single payer program and turns it into a costlier and more confusing one.<sup>160</sup> Moving Medicare from a government-operated program, critics of Ryan's plan argue, does not make fiscal sense, since private plans traditionally cost more and have higher rates of inflation than do fee-for-service plans. Furthermore, A Better Way claims that people who already receive Medicare as of 2024 would be grandfathered into the new system, with "the choice to enroll in the new premium support program." However, the A Better Way white paper does not clarify whether this would create two different systems under which insurance companies would have to operate: one for pre-existing Medicare beneficiaries and one for those who enter the system in or after 2024.<sup>161</sup>

A Better Way's proposed Medicare reforms would also change the way in which insurers receive payment. Instead of payments being based on cost of providing care, insurers would be "paid based on the average plan bid or the second lowest plan bid in their area – a change that could create greater financial uncertainty for insurers."<sup>162</sup> Because Ryan's plan is vague on many details about how Medicare premium support would work, who would regulate the system, how insurers would be paid, etc., it is difficult to know what sorts of disruptions, if any, to expect in the future.

## C. PATIENT CARE ACT

Although the "Frequently Asked Questions" supplement to Patient CARE mentions Medicare, stating "[w]e believe we also need to reform Medicare, and have endorsed a range of bipartisan ideas outside the context of this proposal that would put the program on sounder footing and shore it up for the millions of seniors who depend on the program," the actual Patient CARE white paper makes no mention of the program.<sup>163</sup> Medicare reform remains a popular issue with Republicans, but also an extremely contentious one, as mentioned previously. Because Patient CARE acknowledges Medicare reform but neglects to strongly advocate for it, unlike EPFA or A Better Way, it seems safe to assume that the authors would support leaving the program untouched during the replacement debates.<sup>164</sup>

## D. PATIENT FREEDOM ACT OF 2017

PFA does not mention any changes to Medicare. Presumably, it would leave the program as is.

## E. AMERICAN HEALTH CARE ACT OF 2017

The AHCA does not address Medicare directly, but it would eliminate the ACA's Medicare-related taxes meant to ensure the program's solvency.

AFFORDABLE CARE ACT REPLACEMENT  
PLANS, EXAMINED

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