Insight

Replacing the ACA: Reading the Replacements

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While many critics have repeatedly claimed that Republicans have no replacement plan for the Affordable Care Act (ACA), the fact of the matter is there are many plans—A Better Way (House GOP), The Patient CARE Act (PCARE), Improving Health and Health Care (AEI), H.R. 2300, Empowering Patients First Act (Price), The American Health Care Reform Act of 2017 (RSC), The 2017 Project (2017), and H.R. 5284, The World's Greatest Healthcare Plan (Cassidy/Sessions[1]), as well as at least 67 other pieces of legislation that were introduced by Republicans in the past Congress.[2] The question is what provisions are likely to be included in the eventual replacement plan. We have reviewed many of the public plans that have been circulating (some for years) and have noted that many of them largely contain the same or similar provisions. A summary of those provisions follows.

ACA Provisions Likely to Be Kept

There are a handful of provisions included in the ACA that proponents and opponents alike have supported, and are likely to be continued in any plan that replaces the ACA.

Ban on Pre-Existing Condition Exclusions

A primary concern for many of the newly insured, legitimately so, is what protections there will be for people with pre-existing conditions. The House GOP plan, Price, Cassidy/Sessions, PCARE, AEI, RSC, and 2017 all maintain the ban imposed by the ACA disallowing insurers from denying coverage to and medically underwriting (charging premiums based on one's health status) individuals with pre-existing conditions, so long as one maintains continuous coverage (discussed below). The PCARE and Cassidy/Sessions plans do not require continuous coverage for guaranteed issue, though they do allow insurers to charge higher premiums to individuals without continuous coverage. Each of these plans would provide a one-time open enrollment period to allow people currently uninsured to get coverage and receive these protections. The RSC, Price, and AEI plans explicitly require guaranteed issue only for individuals with continuous coverage, though they would also provide funding for high-risk pools (discussed below), and Price's plan would provide additional grant funding to states that do require guaranteed issue. President Trump has expressed support for continuing the ban on pre-existing condition exclusions.

Coverage of Dependents Until Age 26

Another provision with broad support is the requirement that insurers allow dependents to remain on their parents' health insurance until reaching age 26. The previous administration believes this single provision accounted for nearly 3 million young adults gaining insurance coverage.[3] While it is unlikely that all of these individuals would otherwise be without insurance, it is likely that this provision will continue. The House GOP plan, PCARE, and Cassidy/Sessions explicitly include this provision. The 2017 Project allows dependent coverage until age 25. The other plans do not specifically address this provision, but President Trump has

expressed support for continuing this allowance.

Ban on Annual and Lifetime Limits

The prohibition on the imposition of annual or lifetime limits on the monetary value of benefits offered by an insurance plan is also likely to be maintained. The House GOP and Cassidy/Sessions plans both explicitly support these provisions. The 2017 Project would only allow a tax credit to be provided to those who purchase a plan that, among other things, "has very high or nonexistent annual and lifetime caps on coverage."

ACA Provisions Likely Modified or Replaced

Continuous Coverage Rather Than an Individual Mandate

The ACA's individual mandate was a dictatorial mandate that individuals should have insurance. This intrusion into privacy was justified as necessary to prevent a "death spiral," which might ensue without it given the law's guaranteed issue requirements as well as the prohibition on medical underwriting. The mandate was seen as imperative for ensuring that healthy individuals, not just the sick, bought insurance and balanced out the risk pool.

However, the mandate has proven to be less effective than projected and is forcing some to choose between buying coverage they don't necessarily want and some other product or service. All of the replacement plans would offer an incentive for purchasing coverage, rather than a mandate. In order to be guaranteed the ability to purchase and renew health insurance coverage and to be protected from medical underwriting, as previously discussed, an individual must be continuously insured. A continuous coverage provision thus incentivizes both healthy and unhealthy individuals to enroll early and maintain coverage, while not penalizing individuals for not doing so. Individuals who do not maintain coverage will simply lose the benefit provided to those who do.

Cap on the Employer Exclusion Rather Than the Cadillac Tax

One revenue-raising provision with broad consensus among the authors of replacement plans is a limit on the employer exclusion of health care benefits from payroll taxes. A cap on the exclusion has a similar impact and rationale as that of the ACA's excise tax on employer-sponsored insurance, better known as the Cadillac Tax. Both aim to curb health care costs by curtailing the incentive to offer incredibly generous health care plans that often lead to overutilization; these types of plans tend to have very little cost-sharing for the patient, which would otherwise encourage the patient to be a more savvy, cost-conscious shopper.

The primary difference between the two policies is the tax treatment of benefits provided over the threshold. The primary criticism of the Cadillac Tax is that it imposed a 40 percent tax on the value of every premium dollar above the threshold, regardless of the employee's income; thus, when the tax gets passed on to the employee, an employee whose income would otherwise be taxed at 25 percent, for example, would have that portion of his benefits taxed at much a higher rate. On the other hand, the cap on the exclusion would treat each dollar above the threshold the same as wages earned, making the tax less regressive.

All of the plans discussed above include a cap on the employer exclusion, except two. The RSC plan wholly eliminates the tax exclusion for employer-paid health insurance (while maintaining the business expense deduction for such costs) and instead provides an "above the line" standard deduction of health care benefits from both income and payroll taxes, up to the amount of that deduction.[4] The Cassidy/Sessions plan would

allow all individuals (including those in the individual market) to deduct the cost of their premiums from their taxable income. In addition, Cassidy/Sessions would allow employers to either allow employees to apply the tax credit to the cost of their employer-sponsored insurance or continue to be subject to the current tax treatment and the Cadillac Tax. Several of the plans that call for a cap on the exclusion would exclude employee contributions to a health savings account (HSA) from the cap, and the House GOP plan also allows the cap to be adjusted based on geographic differences in cost of living.

Tax Credits Based on Age Rather Than Premium Subsidies Based on Income

The ACA aimed to resolve the challenge of health insurance affordability by providing premium subsidies to any individual purchasing a Qualified Health Plan in the individual market through government-established exchanges. The subsidies are based on an individual's income, such that lower-income individuals received greater subsidies. Many of the ACA replacement plans discussed above would instead provide tax credits available to any individual purchasing health insurance based on the individual's age.

The rationale for age-based tax credits, rather than income-based, is that data has shown that one's health care costs correlate more closely with one's age than their income. For instance, a 50-year-old is likely to have greater health care costs than a 25-year-old earning the same income, and thus providing the two with equal subsidies is going to be relatively less beneficial to the 50-year-old. The House GOP, Price, AEI, PCARE, and 2017 plans all provide age-based tax credits, typically ranging from $900 to $3,000, with some plans being more generous and other slacking specificity. PCARE limits eligibility for the tax credits to individuals making up to 300 percent of the federal poverty level (FPL). The Cassidy/Sessions plan would provide a flat tax credit of $2,500, subject to adjustments based on both age and geography; several other plans also provide geographic adjustments. The RSC plan, as previously mentioned, would provide a standard deduction for health insurance of $7,500 for individuals, regardless of income and actual health care costs.

Age Bands Rolled Back to pre-ACA Average of 5:1 Rather Than 3:1

Prior to the ACA, health insurance was primarily regulated by the states, pursuant to the McCarran-Ferguson Act, rather than the federal government. However, many of the states imposed similar regulations on the health insurance products offered in the state. One such regulation was the amount by which insurers may vary premiums according to one's age. The average premium variance prior to the ACA was a ratio of 5:1, which reflected the average cost difference between 21-year-olds and 64-year-olds.[5] The ACA restricted age-rating differences to a ratio of no more than 3:1, which has the impact of increasing the degree to which younger individuals, who typically earn less, subsidize the care of older individuals, who tend to earn more. Most of the plans discussed here would either return the authority for such regulations to the state or would widen the federal allowance to 5:1.

Health Savings Accounts

For years, many individuals have used health savings accounts (HSAs) to cover the cost of qualified medical expenses. Such accounts make those expenses more affordable because contributions to HSAs are excluded from an individual's taxable income, which in essence reduces the cost of those expenses by an amount equal to the individual's income tax rate, or as much as nearly 40 percent. The ACA has hindered the value and availability of these accounts by restricting the types of products and services that qualify as eligible medical expenses and, through benefit design regulations for standard plans published by HHS, decreasing the availability of HSA-eligible insurance plans, which are regulated by the IRS. All of the replacement plans

discussed in this document would expand availability and use of HSAs, and President Trump has continuously expressed strong support for HSAs. Some of the plans would provide initial HSA contributions from the federal government, some would allow any excess tax credit amount to be deposited into HSAs, and most would exclude contributions to HSAs from counting towards any cap on the employer exclusion.

New Provisions

High-Risk Pools

When it comes to insuring high-risk individuals, it is necessary to provide alternative coverage mechanisms. Individuals classified as high-risk are those whose health status practically guarantees their health care costs will be so high that it is impossible for their premiums to cover their claims and still be affordable and/or within the rules established. Studies have shown that 1 percent of insured individuals account for nearly a quarter of all health care costs.[6] Therefore, all of the plans discussed, except the Cassidy/Sessions plan, would provide some amount of federal funding to states for the establishment of high-risk pools. Notably, 37 states operated their own high risk pools prior to the passage of the ACA, so the concept is not a new one.

The Cassidy/Sessions plan would establish a federal risk adjustment system, based on the existing Medicare Advantage model, until a permanent model designed specifically for the individual market is established. In addition, the Cassidy/Sessions plan would provide limited grants to states for providing health care services to uninsured individuals; these grant amounts would equal 25 percent of the unclaimed tax credits otherwise available to residents of each state.

Sale of Insurance Across State Lines

Several plans would allow the sale of insurance across state lines, and President Trump has adamantly supported this proposal. The idea is that allowing the purchase of insurance across states will increase competition and in turn lower prices. However, because health insurance is largely built around provider networks, which are typically contained wholly within a state, the degree of benefit this change would provide to patients and consumers remains to be seen.

Medicaid

While not every replacement plan specifically addresses the Medicaid eligibility expansion that occurred under the ACA, it is widely assumed that this provision will be repealed or modified through reconciliation. Under the House GOP plan, states would have the option of receiving Medicaid funding either through a block grant or per capita caps. The AEI and Cassidy/Sessions plans would provide states capped allotments for each of the four eligibility categories: aged, disabled, adults, and children. The AEI plan would transition Medicaid eligibility for all populations to between 100 and 138 percent of FPL. PCARE would also provide capped allotments to states based on their population's health status, age, and eligibility, as well as additional funding for long-term care services and support for the elderly and disabled. Price, Cassidy/Sessions, AEI, and PCARE would each allow individuals eligible for Medicaid to instead choose to take the tax credit and purchase insurance in the individual market. The RSC plan would allow states to provide HSA-style accounts for Medicaid beneficiaries.

Other Provisions to Consider

While many plans are silent on certain other provisions, it is likely that much of the authority to regulate

insurance products will be returned to the states. As such, states would likely restore some of those regulations that were in place prior to the ACA which have proven to help keep costs down. One such provision relates to eligibility to enroll during Special Enrollment Periods; many states would likely apply standards similar to those allowed in the group market under HIPAA.

Another policy typically regulated by states prior to passage of the ACA, was the length of grace periods provided to enrollees for missed premium payments before coverage would be canceled. The standard length of the grace period required by states before the ACA was 30 days. The ACA imposed a federal standard of 90 days, allowing individuals to not pay their premiums for a full three months before an insurer could cancel their coverage for failure to pay. It is easy to understand how such a provision would quickly lead to financial losses for insurers and increased premiums for consumers. Some plans speak to the need for some type of risk adjustment program, but most are lacking in the details. It is widely agreed, though, that some form of risk adjustment and/or risk mitigation mechanisms will be necessary to maintain stable insurance markets, particularly the individual market.

[1] This legislation was introduced May 19, 2016. It is not the same as the recent legislation introduced by Senators Bill Cassidy and Susan Collins, S. 191.

[2] See pages 7 and 8: http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

[3] https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf

[4] http://rsc.walker.house.gov/files/Initiatives/AHCRA%20-%20SDHI%20Further%20Explanation%20115th.pdf

[5] https://www.soa.org/Research/Research-Projects/Health/research-health-care-birth-death.aspx

[6] http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/