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Rep. Tom Price Plan(s): Future of ACA Week 5

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This week continues our survey of key Republican proposals to “repeal and replace” the ***Affordable Care Act (ACA)***. This week we take up the Empowering Patients First Act and the Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015. The former is intended to replace the ACA; the latter to repeal the ACA’s key features. ***Congressman Tom Price*** (R-GA) is the sponsor of both bills.

While the Trump/Pence transition plan consists merely of high-level bullet points, and House Speaker Paul Ryan has put forth a policy proposal, Representative Price’s proposals take the form of actual legislation and thus provide critically important details. Price’s views carry particular weight since he is President-Elect Trump’s nominee to head the Department of Health and Human Services and thus will play a major role in the repeal and replace effort.

This post focuses principally on Price’s replacement bill, the Empowering Patients First Act. In particular, we examine the bill’s underlying policy prescriptions in an effort to discern how the legislation would deal with six key features of the ACA outlined in our Week 2 analysis: (1) the individual mandate; (2) premium subsidies; (3) access to coverage (exchanges/marketplaces); (4) the employer mandate; (5) insurance reforms and underwriting rules; and (6) coverage for low-income individuals, children, and the aged (Medicaid).

The individual mandate and the pre-existing condition exclusion

To the ACA’s opponents, the individual mandate—the requirement that most U.S. citizens and green card holders must obtain and maintain health insurance coverage or pay a tax penalty—is among the most objectionable features of the law. In contrast, many of the law’s opponents favor the ACA’s ban on pre-existing condition exclusions. The challenge in fashioning the ACA’s replacement is to do away with the individual mandate while preserving the ban on pre-existing condition exclusions. How pre-existing condition exclusions are handled is of major consequence. A recent Issue Brief by the Department of Health and Human Services claims that upwards of 133 million Americans have some kind of pre-existing condition.

Under the Price plan, carriers would still be required to provide coverage to any applicant, would not be able to vary premiums to reflect enrollees’ health status or to limit coverage of preexisting medical conditions, and would be allowed to vary premiums by age only to a limited degree. But these

protections would be available *only* to individuals who maintain continuous "creditable coverage" under rules similar to those that have been in place since 1996 in the group health insurance markets under the Health Insurance Portability and Accountability Act (HIPAA). The Price plan would expand these protections to creditable coverage purchased in the individual market. For this purpose, "creditable coverage" includes most health coverage, such as a group health plan, HMO, individual health insurance policy, Medicaid, or Medicare.

A pre-existing exclusion period is the period of time that a group health plan can legally limit access to the health benefits offered by that plan because of a pre-existing condition. Under HIPAA, the maximum pre-existing condition exclusion period that can be applied to an individual is 12 months (18 months for late enrollees). A plan may not, however, impose a pre-existing condition exclusion period if the person has had creditable medical coverage for at least 12 months, provided the person did not have a break in coverage of more than 63 days. If the prior creditable coverage was for less than 12 months, the plan may impose an exclusion period, but the period must be reduced by the number of months of such coverage. For example, if the prior coverage was four months, the maximum exclusion period is eight months.

A recent post by the RAND Corporation entitled, "Can a Continuous Coverage Requirement Produce a Healthy Insurance Market?" generally views continuous coverage requirements favorably. The post claims that a continuous coverage requirement might even be better than the ACA's individual mandate at discouraging individuals from waiting until they become sick to purchase insurance. According to the post:

Compared to the limited penalties imposed by the individual mandate, the financial penalties and loss of consumer protections for pre-existing conditions may provide a much stronger incentive to purchase insurance.

The post offers a caution, however, noting that there is little direct evidence on how well a continuous coverage requirement "might work in practice." RAND recommends, for example, the adoption of hardship exemptions and automatic enrollment provisions. The creditable coverage approach assumes that it will be a simple matter for individuals without access to employer-based coverage, among others, to purchase and retain health insurance. But if health insurance coverage is too expensive, or if the only available coverage is substandard or has large gaps, then carriers may end up imposing pre-existing condition limitations and exclusions, or simply hike premiums.

The HIPAA-style creditable coverage requirement is not unique to the Price plan. It is also included in the Ryan plan. There is a difference, however. The Ryan plan includes a one-time option for everyone to buy health insurance without pre-existing condition exclusions and pricing based on health status. This feature is not part of the Price plan. Presumably this is because the Price plan, being legislation, must be scored for budget purposes. Congress would likely have to appropriate additional funds to cover the costs associated with this one-time enrollment opportunity.

Moderate- and low-income premium subsidies

As we explained last week, the ACA's premium tax credit must be used to purchase products that provide an "essential health benefit" package, which includes 10 specified benefit categories and which, among other things, have prescribed limits on cost sharing. In addition, the ACA premium subsidies are tied to the cost of coverage so that the recipient of the coverage spends no more than a pre-established percentage of household income—i.e., that the coverage is "affordable." For these individuals, the Price plan envisions grants to the states for the purpose of establishing high-risk

pools, reinsurance pools, or some “other risk-adjustment mechanism used for the purpose of subsidizing the purchase of personal health insurance.”

The Empowering Patients First Act rejects the ACA’s approach to premium support and instead offers a refundable tax credit that can be applied to the purchase of health insurance coverage. The credit, which is inflation-adjusted, provides for a refundable, age-adjusted tax credit to be applied to the purchase of qualified health insurance, with subsidies tied to the average cost of coverage in the individual market. “Qualified health insurance” under the Price plan is defined in a manner similar to the way that the ACA defines minimum essential coverage. It includes any insurance that provides *medical care*, but does not include coverage that consists exclusively of HIPAA-excepted benefits (e.g., wrap-around, vision-only or disease-specific plans). The refundable tax credit under the Price plan is not available to those receiving federal or other benefits under Medicare, Medicaid, the Children’s Health Insurance (CHIP) Program, TRICARE (which provides civilian health benefits for U.S Armed Forces military personnel, military retirees, and their dependents), Veterans Administration (VA), the Federal Employee Health Benefits Program, or individuals in employer-subsidized group plans. The Price plan also allows individuals to opt out of Medicare, Medicaid, TRICARE, and VA benefits and receive tax credit to purchase commercial, individual market coverage.

A worrisome feature of the Empowering Patients First Act’s refundable tax credit is the amount of the credit, i.e., $1,200 for those between 18 and 35 years of age; $2,100 for those between 35 and 50 years of age; $3,000 for those who are 50 years and older; and $900 per child up to age 18. These amounts are a fraction of the cost of most major medical coverage products.

Access to coverage (exchanges/marketplaces)

The Price plan eliminates the ACA’s approach to the purchase of insurance products through exchanges or marketplaces in favor of a free-market approach, which extends to both product design and to point-of-sale. Because qualified health insurance under the Price plan need only cover “medical care” (as under the ACA’s definition of “minimum essential coverage”) the policies available for purchase will likely include a broad range of health insurance policies ranging from robust (e.g., high value, major medical plans) to bare-bones (e.g., preventive-services-only). In contrast to the ACA-governed policies, however, these policies would be allowed to have annual limits, lifetime limits or fail to cover preventive care. The Price plan also proposes to allow insurers licensed to sell policies in one state to offer them to residents of any other state. As a consequence, product design will not be constrained by state law.

The employer mandate

Both Price bills repeal the employer mandate. According to the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), this has significant budgetary effects. Among other things, CBO/JCT expects that because employers that do not offer health insurance that meets specified standards would no longer be assessed penalties, federal revenues would be *reduced* by $166.9 billion over 10 years. (This figure strikes us high.) The Empowering Patients First Act replaces this revenue (and the revenue lost by the repeal of the Cadillac tax) by capping employers’ exclusion of health care coverage at $20,000 for family coverage and $8,000 for an individual. These amounts are adjusted to reflect increases in the cost of living but there is no adjustment based on geography. The proposal to limit employers’ exclusion of health care coverage also is included in the Ryan plan. But the Ryan plan proposes “to cap the exclusion at a level that would ensure job-based coverage continues unchanged for the vast majority of health insurance plans” without any mention of

amounts.

This approach to raising money is not favored by most business interests. The current, unlimited exclusion costs the government an estimated $260 billion a year in foregone revenue, however. If the employer mandate and the Cadillac tax are off the table, then the revenues must come from somewhere. And the employer exclusion for health care is a plump target.

Insurance reforms (guaranteed issue and renewability and other underwriting rules that apply to commercial carriers in the individual and group markets)

The Empowering Patients First Act establishes adopts a series of structures designed to ensure that coverage is widely available. These include:

- Independent Health Pools(IHPs), which are non-profit entities established with the purpose of forming an insurance risk pool for their members; and
- Association Health Plans (AHPs), which would allow small business owners to purchase insurance within their state or across state lines through membership in a trade or professional association.

In addition, the legislation favors the expansion of Health Savings Accounts (HSAs); provides incentives to adopt HSAs through a one-time tax credit; and further amends the rules governing HSAs to increased contribution limits, permit account rollover to families, and other incentives. Wellness programs and incentives are also encouraged.

IHPs appear to be similar to AHPs, except that they include individuals as well as small groups. A summary of the bill explains that “IHPs are not health insurance issuers, and do not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals, or employees of employers, in any health insurance coverage (except for consideration received in direct conjunction with services offered through the IHP).”

In Week 4, we explained our concerns about AHPs (i.e., the MEWA-related issues). We have similar worries over IHPs. These groups will need to be tracked and regulated, and the rules enforced.

Reforms to government programs for low-income individuals, children, and the aged (Medicaid)

Finally, the Empowering Patients First Act would repeal the ACA’s expanded Medicaid coverage in states and the District of Columbia. This puts a good deal of pressure on the individual and group markets to take up the slack—if that is even possible. For those who remain Medicaid-eligible—i.e., children (under CHIP), pregnant mothers, the elderly, the blind, and the disabled—the legislation would allow individuals to opt out of Medicaid and instead receive a tax credit to purchase individual coverage.

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