Instead of ACA Repeal and Replace, Fix It

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Executive Summary

Repealing the Affordable Care Act (ACA) via the budget reconciliation process without replacement policies in place risks dramatically increasing the number of uninsured people and causing chaos in the individual (nongroup) insurance markets. Replacement plans will likely be controversial and cover fewer people than the ACA. Any replacement plan will need to receive some support from Democrats in order to pass the Senate. After repeal, an ACA replacement will require new revenues because there will be a new spending and revenue baseline. This may prove to be extremely challenging.

Faced with this reality, policymakers should consider fixing the major problems they have with the ACA rather than repealing it; this would not disrupt the parts that are working effectively. To that end, we propose a range of policies that would address critics' concerns and also strengthen the law, expand coverage, improve affordability, increase market stability, and lower the high premiums that exist in some markets.

We propose the following:

1. Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare Parts B and D.
2. End the employer mandate. The limited gains in coverage and the revenue it generates have not been worth the controversy it has caused.
3. Replace the Cadillac tax with a cap on the tax exclusion for employer-based insurance, ideally setting the cap at levels that would generate additional revenues to help finance vital enhancements.

4. Improve affordability by reducing premiums, deductibles, and other cost-sharing requirements for modest-income individuals, and extend to higher-income individuals a cap on premiums at 8.5 percent of income.
5. With a premium cap at 8.5 percent of income applied to all, relax the 3:1 age rating to be more in line with actual differences in spending for younger and older individuals.
6. Examine the essential health benefits package, recognizing that eliminating certain benefits would eliminate risk pooling for those services, shifting all costs to individuals needing those services. That is problematic for any service, but particularly so for prescription drugs, mental health, and substance use disorder treatment.
7. Stabilize the Marketplaces by taking steps to increase enrollment. This would include investing in additional outreach and enrollment assistance and allowing states to extend Medicaid eligibility to 100 percent of the federal poverty level (FPL) rather than 138 percent of FPL. People with incomes between 100 and 138 percent of FPL would move from Medicaid to Marketplace coverage and thereby benefit from the affordability provisions mentioned above. Further, it should be made easier for working families to be eligible for income-related tax credits.
8. Address the impact of insurer and provider concentration on nongroup market premiums by capping provider payments in those plans at Medicare rates or some multiple thereof—an approach currently used by the Medicare Advantage program. This would limit the use of market power by large provider systems and make it easier for insurers to enter new markets.
9. Use a broad-based source of revenue (e.g., assessments on all health insurance and stop-loss coverage premiums or general revenues) to permanently protect nongroup insurers from the consequences of enrolling a disproportionate share of very high-cost enrollees, as is done in Medicare Part D and Medicare Advantage.

Most of these steps have had bipartisan support in other contexts and therefore can provide a framework for a bipartisan compromise.

Introduction

As the new Congress contemplates partial repeal of the Affordable Care Act through the budget reconciliation process, they run the risk of increasing the number of uninsured Americans by approximately 30 million, crippling the private nongroup insurance market, causing nongroup insurance premiums to rise precipitously, and imposing significant added uncompensated care costs on state and local governments, hospitals, and other health care providers (Blumberg, Buettgens, and Holahan 2016; Buettgens, Blumberg, and Holahan 2017).

Moreover, as Congress works to craft a replacement plan that is based upon outlines of reform proposals,[1] they are likely to find it impossible to meet their stated goals of maintaining or broadening insurance coverage, making insurance more affordable, reducing government spending, improving quality of care, expanding consumer choice, and giving states and health care providers more flexibility and fewer regulations.[2] Difficult tradeoffs will have to be made, unpopular decisions will be required,

and complex and confusing rules and regulations—as onerous as those necessitated by the ACA—will prove unavoidable. In addition, replacement following repeal will require new sources of revenue to finance new policies because the revenue and spending baseline would change immediately, and a replacement plan will need some Democratic support. This constitutes a substantial political challenge.

Given the possibility of insurance market chaos during the period between repeal and effective replacement and the unavoidable challenges of implementing a new set of reforms, policymakers should ask whether correcting the flaws in the ACA might sufficiently address critics' major concerns. Fixing the existing structure could avert an increase in the uninsured population, a surge in health care costs, or another period of uncertainty during which stakeholders wonder if whatever is enacted will itself be overturned when the political landscape inevitably shifts.

The Case against Partial or Complete Repeal and the Challenges of Replacement

Simply repealing the financial assistance (premium tax credits and cost-sharing reductions for Marketplace insurance), Medicaid expansion, and individual mandate while leaving the insurance market reforms (e.g., essential health benefit requirements, prohibitions on pre-existing condition exclusions, modified community rating) in place—as is being considered as part of the 2017 budget reconciliation process[3]—would cause enormous disruption to individuals and insurers, and it would be fraught with political peril. Nearly 30 million people would lose coverage (Blumberg, Buettgens, and Holahan 2016). Hospitals and other health care providers would lose large amounts of revenue (Buettgens, Blumberg, and Holahan 2017). Private insurers selling coverage in the nongroup market would lose large numbers of covered lives. People who do not have access to employer coverage or public insurance would see such sharp spikes in premiums that the vast majority would not be able to afford coverage. If insurance market reforms were eventually repealed as well (this would have to be done through separate legislation, not budget reconciliation), many of those with health problems could be denied coverage outright or offered only limited benefit plans at high premiums.

State budgets would be adversely affected as the number of uninsured climbs and the demand for uncompensated care climbs with it. In addition, states have reaped savings by no longer funding services now provided through the Medicaid expansion and the Marketplaces; those savings would vanish (Dorn et al. 2015).[4] Providers would be faced with more patients unable to pay their bills (Buettgens, Blumberg, and Holahan 2017). Plus, the recent slowdown in health care spending would be put at risk because at least some of that slowdown is attributable to changes brought by the ACA (McMorrow and Holahan 2016).

Contrary to what some have claimed, the ACA has not been a high-cost program (Clemans-Cope, Holahan, and Garfield 2016). The Congressional Budget Office estimates that the tax exemption of contributions to employer-sponsored health insurance leads to about $250 billion in forgone revenue per year for the federal government (CBO 2013, 243–49). But we estimate that the cost of financial

assistance through the Marketplaces and the ACA's Medicaid expansion will cost the federal government only $109.3 billion in 2019 under current law (Blumberg, Buettgens, and Holahan 2016). Elsewhere, we estimated that national health expenditures for 2014 to 2019 will be $2.6 trillion lower than originally estimated, partly because of various provisions of the ACA (McMorrow and Holahan 2016). Together, the Marketplaces' use of relatively large deductibles and other cost-sharing requirements for middle-income enrollees and narrow provider networks combined with a significant coverage expansion via Medicaid for low-income enrollees have kept costs down (Blumberg and Holahan 2015a).

The central components of the current replacement proposals include expansion of health savings accounts (HSAs), replacement of income-related tax credits and expanded Medicaid eligibility with age-related tax credits, and sales of insurance across state lines. But these provisions are likely insufficient to provide affordable access to necessary care for low-income people—those most likely to become uninsured in the absence of the ACA. HSAs largely benefit higher-income people because the tax benefit increases with marginal income tax rates; low- and middle-income people benefit much less because of their lower tax rates, and they generally do not have the extra resources to contribute to the accounts anyway. In addition, HSAs are most beneficial to those not using much medical care. As a result, expanding them would have little effect on coverage.

Age-related tax credits available to all regardless of income would provide much smaller subsidies to modest- and lower-income people than income-related tax credits would, unless much more federal spending is provided to fund them. The smaller amount of assistance per eligible person would mean that affordable health insurance plans would have substantially higher cost-sharing requirements and narrower covered benefits, leaving those with health care needs facing higher costs and reduced access to care.[5] Plus, the smaller the amounts of assistance, the lower the levels of insurance coverage and the higher the number of uninsured.

Allowing insurers to sell coverage across state lines in an insurance environment largely unregulated by the federal government would permit insurers domiciled in unregulated states to effectively undermine laws in states with more regulation (Blumberg 2016). This could lead insurers to offer only high cost-sharing, limited-benefit policies nationwide in order to avoid adverse selection, in turn decreasing consumer choice and placing increased financial burdens on those with health care service needs.

Traditional high-risk pools are often proposed as a mechanism for insuring those with high health care needs separately from others, but past experiences with these pools have proven them to be unsuccessful in addressing the needs of most high-cost or high-risk people (Blumberg 2011; Pollitz 2016). Such pools either cover too few high-risk people because of inadequate government spending commitments (likely implemented through very strict eligibility requirements or enrollment limits) or, if they are designed to adequately cover the large high-risk population, would be prohibitively expensive.

These policy approaches would substantially increase segmentation of insurance risk pools, making insurance extremely expensive and often inaccessible for those with any significant health care risk.[6]

While these policies could decrease premiums for the young and healthy, they would increase premiums for many people, and out-of-pocket costs would increase markedly for virtually all those purchasing insurance in the nongroup market.

Approaches to Address the ACA's Problems and Opponents' Concerns

We recommend a number of policies that could both respond to the ACA's most serious problems and address many of the most significant complaints made by the law's opponents. Our policy recommendations would address issues with the individual and employer mandates; the excise tax on high-cost health plans, or "Cadillac" tax; the affordability of coverage; age rating; essential health benefits requirements; and high nongroup insurance premiums in some geographic areas. A package of reforms to the ACA could include the following approaches.

Replace the Individual Mandate Penalties

The income tax penalties associated with the individual mandate are by far the most unpopular feature of the ACA (Karpman, Blavin, and Zuckerman 2016; Kirzinger, Sugarman, and Brodie 2016). The mandate and penalties are intended to

1. maximize insurance coverage, short of instituting a fully financed government system into which the entire population is automatically enrolled; and
2. retain the currently insured and attract the healthiest uninsured individuals into coverage, such that health care risks of a diverse population can be shared broadly.

The reason the individual mandate is important for reaching the first objective is clear: more people enroll in insurance if they are required to do so or subject to a fine than would without these stipulations. The second objective is most critical for those without access to affordable employer-based insurance because without an individual mandate, insurers fear adverse selection, particularly in nongroup insurance markets. Enrollment rates in employer-based insurance are high, so adverse selection concerns are much lower in those markets. An individual mandate provides more robust enrollment in nongroup plans, which lowers premiums and ensures that the pre-existing condition prohibition and other consumer protections against health status discrimination can function without bankrupting insurers.

To replace the tax penalties, some proposals would introduce a continuous coverage provision, recognizing the need to encourage younger and healthier people to enroll in insurance and maintain coverage.[7] This requirement is actually an individual mandate but with much harsher and longer-lasting penalties that would fall very heavily on those with health problems, unstable employment, and limited income (Blumberg and Holahan 2015b). Under a continuous coverage requirement, those missing a one-time open enrollment period and those experiencing a period of uninsurance in the future could face medical underwriting without limits,[8] effectively locking many of those with health needs out of

coverage until they either gain access to employer-sponsored insurance or until they reach age 65 and become eligible for Medicare.[9] Middle- and lower-income people are more likely to have gaps in insurance coverage because of changing employment, life, and financial circumstances, and they are least likely to be able to pay for medically underwritten coverage that would have higher premiums, fewer covered benefits, higher cost-sharing requirements, or a combination of these. As a result, they are the most vulnerable to becoming uninsured and going without access to needed care long-term, under a continuous coverage requirement.

A better alternative, which would not differentially penalize those with health issues and would take the income of the uninsured person into account, would be to replace the ACA's tax penalties with a modified version of the premium surcharges used today in Medicare Part B and Part D. These premium surcharges have had bipartisan support under Medicare. Individuals who do not sign up for Part B upon becoming eligible pay a penalty of 10 percent of the regular Part B premium for each 12-month delay in enrolling, with the penalty assessed for the rest of their lives while enrolled, once they do ultimately enroll.[10] In Part D, a penalty for late enrollment is also imposed via the premium, equal to 1 percent per month that the individual is without qualified prescription drug coverage; again, this penalty is imposed for the rest of the person's life while enrolled.

Medicare imposes monthly or annual penalties that amount to small percentages of premiums per month uninsured, but they accumulate without end and apply to premiums paid by beneficiaries indefinitely. For a younger population, we suggest stronger penalties that apply once a person enrolls but are not long-lasting. Ideally, the premium surcharge would be designed to approximate the size of the current individual mandate penalties. This approach would set the level of the premium surcharge (e.g., 1.5 to 2.0 percent per month), a maximum period of time to "look back" for the duration of uninsurance (e.g., one or two years uninsured), and a maximum period of time for the surcharge to be applied (e.g., charged for a maximum of one or two years).

The objective of the surcharge should be to make the penalties strong enough to be effective in maximizing enrollment, yet not so punitive as to risk making coverage so expensive that the vast majority of individuals could not afford to obtain coverage after a long spell of uninsurance. Clearly, this is a challenging balance to strike. To ensure the penalties are smaller for lower-income people than for higher-income people, the surcharge should be imposed on the portion of the premium paid by the household, not the portion paid for by the federal government. It will also be necessary to set the premium surcharge percentage lower for family policies than for single policies, since the thresholds for income relative to poverty increase much more slowly with family size than do premiums.

Although they are far preferable to a continuous coverage requirement, premium surcharges may be less successful than the current ACA penalties in increasing enrollment among healthy people. Many would likely be unaware of the surcharges until they decided to enroll, whereas uninsured individuals experience the ACA penalty each year when filing their tax returns. Participation in Medicare Parts B and D is very high, yet those high enrollment rates are most likely due to the high subsidization of these programs (75 percent for most enrollees) or to a single qualifying event—namely, turning 65 years old. Consequently, high participation rates under a "stick" like a premium surcharge are most likely to be

achieved if implemented in combination with improved "carrots"—increased premium tax credits and cost-sharing assistance (discussed further below).

This new approach would need to be coupled with increased education and outreach efforts and increased enrollment assistance. In addition, an administrative mechanism to collect and compile information on previous insurance coverage would have to be developed.

It is critical to remember that merely increasing penalties without improving affordability would have little effect. Most individuals who remain uninsured under the ACA are exempt from the individual mandate penalties because they don't have access to qualifying coverage that is deemed affordable under the law's standard. If additional penalties are to have a significant effect on coverage levels, coverage would have to be made more affordable for more people.

Ending the Employer Mandate

An ACA component that is particularly unpopular with employers is the so-called employer mandate. This component was included in the law out of concern that employers would otherwise drop health insurance coverage, sending their workers into the private nongroup insurance market and increasing the costs of federal financial assistance provided there. As we and other researchers have shown, the ACA's employer mandate has little impact on insurance coverage, and eliminating it would not lead to significantly lower rates of employers offering insurance to their workers or lower rates of workers enrolling in that coverage (Blumberg, Holahan, and Buettgens 2013a, 2013b; Price and Saltzman 2013).

Employer coverage has remained stable under the ACA because contributions to employer-based health insurance are not taxable and because employers provide coverage and tailor benefits to their workers' preferences in order to attract the best workers, maintain employee loyalty, and reduce turnover (Blumberg et al. 2012). These incentives would remain strong without the employer mandate in place, just as they existed before the ACA. Therefore, eliminating the ACA's employer mandate could improve its popularity without sacrificing the law's coverage gains.

Replacing the Cadillac Tax

A third unpopular component of the ACA is the high-cost plan, or "Cadillac," tax. This excise tax on employer-sponsored insurance plans whose costs exceed a certain threshold was intended as a cost containment strategy, meant to discourage employers from purchasing overly generous policies that might encourage enrollees to over-use medical care. It was also intended to raise revenue to help finance the financial assistance the ACA provides to low- and middle-income populations. Critics of the tax have raised several concerns, arguing that the tax does not sufficiently allow for variation in employer health insurance costs, imposes overly tight indexing rules, and has the potential to increase cost-sharing requirements that would have adverse effects on those with health problems and modest incomes (Aaron et al. 2017).

Capping or eliminating the exclusion has been a staple of proposed health policy changes for many years and has enjoyed bipartisan support among health economists. As we have shown, a cap on the

exclusion would have the same distributional effects as the Cadillac tax in most circumstances, and the same criticisms levied against the former could be levied against the latter (Blumberg, Holahan, and Mermin 2015). But carefully designed policy strategies can address much of this criticism, and under certain circumstances, a tax cap is more progressive than the Cadillac tax. Potential fixes include pegging growth in the tax thresholds to GDP instead of CPI; adjusting thresholds based on employer size, geographic differences, and health status variability across employers; and using some of the revenue to offset high out-of-pocket spending requirements for modest-income families.[11]

Thus, the Cadillac tax could be replaced with a cap on the tax exclusion of employer contributions to health insurance, if this is indeed more politically palatable. The thresholds to which the cap would apply could be set at levels that would help finance some of the proposed reforms below. However, the lower the cap on the tax exclusion, the weaker the incentives for employers to provide work-based insurance and for workers to take it up; as a result, employer-based insurance risk pools could be disrupted.

Improving Affordability

A major criticism of the ACA—from both supporters and opponents—is the continued presence of high nongroup cost-sharing requirements (e.g., high deductibles, high out-of-pocket maximums) and high nongroup premiums for some enrollees. Addressing this would require increasing federal financial assistance to make coverage for low- and moderate-income Americans less costly. As we have written elsewhere, such assistance should include increasing both premium tax credits and cost-sharing assistance for Marketplace coverage (Blumberg and Holahan 2015a). While the ACA has made substantial strides in increasing the affordability of coverage, many people still face very steep costs to obtain insurance (Blumberg, Holahan, and Buettgens 2015).

Additional assistance should be income-related as under current law. Tax credits that vary with age but not income, which are part of several replacement plans, would either be too small to make adequate coverage affordable for middle- and low-income people or would require extraordinary increases in federal resources. Setting levels of financial assistance to make adequate coverage affordable to all, regardless of their income, requires not only affordable premiums but also affordable cost-sharing requirements (e.g., deductibles, coinsurance, copayments, out-of-pocket maximums) to ensure that people can use their insurance to effectively access medical care when they need it.

Elsewhere we have proposed a tax credit and cost-sharing assistance schedule for nongroup insurance that would reduce premiums and lower cost-sharing requirements at every level of income below 400 percent of FPL (Blumberg and Holahan 2015a). We also proposed a cap of 8.5 percent of income on benchmark insurance premiums, rather than the 9.69 percent cap set by the ACA for 2017.[12] The 8.5 percent cap would apply to all enrollees, including those with incomes above 400 percent of FPL (ACA assistance with Marketplace premiums stops at 400 percent of FPL today). Unlike the flat dollar-amount tax credits, the 8.5 percent cap for the higher-income group would not affect most of the higher-income individuals potentially eligible for it because premiums do not increase as incomes increase. However, it would provide additional protection particularly for those older adults, between 400 and 500 percent of the federal poverty level, who face the full effect of age rating under the ACA—

premiums up to three times the amount charged to a young adult—but whose income is not high and who are not eligible for financial assistance to help defray the cost. Our approach would also peg premium tax credits to the gold level (80 percent actuarial value) of insurance premiums instead of to the silver level (70 percent actuarial value) premiums used under current law, which would have the effect of reducing deductibles, coinsurance, and out-of-pocket maximums.[13]

Making Marketplace coverage more valuable and affordable would increase enrollment in nongroup markets, improve the nongroup insurance risk pools, reduce deductibles and overall financial burdens, and improve access to care for those with modest incomes.

Age Rating of Nongroup Insurance Premiums

ACA critics routinely cite age rating as a significant concern. Many insurers have complained that the ACA's 3:1 age rating bands for nongroup insurance do not reflect the true cost differences between their oldest and youngest adult customers (Blumberg, Buettgens, and Garrett 2009). The ACA's age bands were intended to make coverage more affordable for older adults, spreading a portion of their higher costs more broadly across the age distribution than was the case prior to 2014. The narrower the age bands, the more health care costs are shared across the age distribution.

We suggest that the additional health care risk of older adults be redistributed by income rather than by age. With the enhanced set of premium tax credits and cost-sharing reductions outlined above, especially the cap at 8.5 percent of income for benchmark premiums, age rating bands could be changed from 3:1 to 5:1 without making coverage unaffordable for older adults. With enhanced financial assistance in place, older nonelderly adults would have limits on their financial exposure, and loosening the age rating regulations would reduce the extent to which their health insurance costs are shared through the premiums of younger adults (Blumberg and Buettgens 2013).

Essential Health Benefits

Some critics blame high premiums on the ACA's essential health benefits requirements for nongroup insurance. Ten categories of benefits are required in all ACA-compliant nongroup insurance plans,[14] and states were provided with a number of options for defining how those requirements would be implemented (Corlette, Lucia, and Levin 2013). Some definition of required benefits is necessary to ensure that guaranteed issue of policies, prohibitions on pre-existing condition exclusions, and other strategies to eliminate insurer discrimination against the sick are meaningful. In most states, the essential health benefits benchmark plan was based on the small group insurance plan in that state with the most enrollment or the largest HMO plan, both reflecting a broadly accepted range of covered benefits. Additional benefits were added if necessary to meet federal standards.

Policymakers can re-examine the essential health benefits requirements under the law, but this is risky territory. Most of the health care claims costs associated with essential health benefits are attributable to services such as hospital inpatient and outpatient care, emergency room care, physician

and clinic services, laboratory and imaging services, and prescription drugs; these are the core of any insurance plan most Americans would consider adequate.

Cutting a benefit from the rest of the package puts the cost of that type of care wholly on those families who have a health care need for it. In many circumstances, such cuts would make obtaining that type of care unaffordable for those needing it. Eliminating a benefit eliminates the sharing of risk for that type of care. For example, men do not use maternity care and women do not use prostate care, but everyone's contributions to all types of care, regardless of individual needs, allow the costs of everyone's care to be spread over a large population (all those in the insurance pool). Cutting mental health and substance abuse disorder services from the benefit package would eliminate risk pooling for these services, and access to and use of these services would drop precipitously. Given the recent focus on mental health services as a mechanism to address gun violence and rising concerns over opioid addiction and other substance use disorders, restricting coverage for these services would contradict those expressed concerns and could require the development of a costly new government program to address these issues.

Finally, eliminating benefits for certain types of care could lead to increased costs within the set of insured benefits as well. For example, removing maternity care from the benefits package could lead to more medical complications among newborns and mothers later on. Eliminating prescription drug coverage would make it difficult for many people to treat their conditions with medications—an approach that is often substantially more cost-effective than hospitalization and other more expensive interventions.

Stabilizing Nongroup Insurance Markets

The ACA's nongroup insurance reforms, including the Marketplaces, were designed to increase the sharing of health care risk. Increasing nongroup insurance enrollment, both inside and outside the Marketplaces, could go a long way toward stabilizing the subset of markets that have experienced high premiums and reduced insurer participation. We suggest three policies (in addition to the increased financial assistance and modified individual mandate penalty structure presented earlier) that could increase nongroup enrollment significantly, with much of that enrollment among healthy new enrollees (Blumberg and Holahan 2017). In addition, we provide two policy strategies that would address the sources of high premiums and low insurer participation in some nongroup insurance markets.

MEASURES TO INCREASE ENROLLMENT

Three strategies that would increase enrollment in the nongroup Marketplaces are (1) increased funding for education, outreach, and enrollment assistance; (2) fixing the so-called family glitch; and (3) allowing Medicaid expansion up to 100 percent of FPL, instead of requiring it up to 138 percent of FPL. Additional federal funds are needed for education, outreach, and enrollment assistance to increase awareness of coverage options, available financial assistance, and premium surcharges for late enrollment, and to make it easier for individuals to sign up for coverage. This is essential and not expensive.

The “family glitch” denies Marketplace financial assistance to families facing high-cost employer insurance when one family member has access to affordable worker-only (but not necessarily family) coverage. This inequity, which results from a regulatory interpretation of the law, should be eliminated. Doing so would substantially improve the affordability of coverage for significant numbers of low- and moderate-income families and would create a strong incentive for these generally healthy families to enroll in nongroup Marketplace insurance plans, boosting overall enrollment in the nongroup insurance market (Blumberg and Holahan 2015a; Buettgens, Dubay, and Kenney 2016).

Allowing states to receive the ACA’s enhanced federal matching rate if they expand Medicaid eligibility up to 100 percent of FPL, instead of 138 percent as required by current law, would likely encourage some of the states that have not yet chosen to do so to expand Medicaid. This is critical to making adequate coverage affordable for this very low-income population. In addition, if states that have already expanded Medicaid move their eligibility rules down from 138 to 100 percent of FPL, nongroup enrollment would increase in those states. The proposed increase in premium and cost-sharing assistance (discussed above) would apply to those moving from Medicaid into private coverage. Most of this increased nongroup market enrollment should come from relatively healthy people, and they would be likely to improve the nongroup market risk pool once enrolled.[15]

REDUCING PREMIUMS

Two additional policy strategies would address other sources of high premiums in some nongroup insurance markets: (1) limits on provider payment rates paid by nongroup insurers and (2) government funding for high-risk people, allowing them to be fully integrated into the array of private insurance plans offered through the nongroup market (Blumberg and Holahan 2017). First, many nongroup insurance markets (both inside and outside Marketplaces) have significant insurer and/or provider concentration. This problem existed before the ACA and would persist even if the ACA was repealed. Consolidation of providers and insurers drives insurance premiums upward because insurers have little incentive to operate efficiently in the case of insurer concentration or, in the case of provider consolidation, because insurers have little to no leverage to negotiate payment rates with providers (Roberts, Chernew, and McWilliams 2017).

The most realistic proposal for addressing both types of concentration is to rely upon the precedent set by Medicare Advantage, a program for which there has been bipartisan support (Blumberg and Holahan 2017). This approach would place a cap on provider payment rates for nongroup insurers and their enrollees. The payment caps could be set at Medicare levels or some percentage above Medicare levels, or they could use some other metric. The cap would apply to in- and out-of-network services. Insurers could negotiate with providers for payment rates lower than the cap, but they would not pay more than the cap. Some providers may choose not to participate, even at rates significantly above Medicare payment levels, but most likely would participate because participation at Medicare rates is high and because the nongroup market represents a small share of the population. This approach would allow more insurers to enter markets where few insurers currently participate. Some insurers currently cannot participate in markets they want to enter because they cannot negotiate competitive payment

rates with providers there; with a payment rate cap, they would be able to enter new markets and pay lower payment rates to local providers than they could have negotiated on their own.

Second, renewed attention must be paid to the importance of additional sharing of health care risks for those purchasing coverage as individuals. Not all ACA-compliant nongroup insurance markets are enrolling a disproportionately high-cost population of enrollees, compared with the employer-sponsored insurance market, but some are (Blumberg, Holahan, and Wengle 2016). The three-year limit on the reinsurance program included in the ACA was insufficient for some markets, particularly those with low enrollment. Thus, implementing a mechanism for adjusting risk between the nongroup insurance market and the broader population (either the employer-sponsored insurance market or the larger taxpayer population) would correct for long-term differences in health care risk that may persist in some areas. The approach should be designed to redistribute funds to the nongroup market from the much larger employer-based insurance markets or from general revenues, when that nongroup market is experiencing significant adverse selection. In essence, this would be akin to raising high-risk pool revenues from a large population base that would be distributed to nongroup insurers enrolling a disproportionate share of high-cost individuals. Another way to think about the approach is as a risk adjustment mechanism between nongroup insurers and employer insurers or between nongroup insurers and the population at large.

Medicare Advantage and Medicare Part D offer precedents for permanent programs like this. For example, some percentage of each claim against a nongroup insurer exceeding $1,000,000 could be reimbursed from general revenues or from a broad-based dedicated revenue source beyond nongroup insurance enrollees and their insurers (e.g., all those with employer-based or nongroup insurance). Extremely high claims can be devastating for an insurer, and risk adjustment within the nongroup market alone cannot sufficiently limit exposure if the incidence of such large claims is higher than in the wider population. Such a broadly financed program would reduce risk for insurers, making it more attractive for them to participate in and out of the Marketplaces, lowering premiums, and increasing the markets' stability year to year.

Conclusion

Congress is seriously considering repeal of the coverage and tax provisions of the ACA, with the expectation that replace legislation will follow. This will not be a straightforward process. If the ACA is partially repealed, there will be a new spending and revenue baseline. The replace proposal will need bipartisan agreement on the design, and it will need new sources of revenue. The Congressional Budget Office (and others) will weigh in on coverage and cost impacts. Developing a plan that could garner the support needed in the House of Representatives and the Senate will be challenging.

With this in mind, we have delineated a package of health care reforms that could short-circuit this process. The proposals outlined here, many of which have had broad bipartisan support in other contexts, would address many of the problems raised by ACA critics and acknowledged by ACA supporters. Pursuing these policies would permit the new administration and Congress to put its own

stamp on health care reform while avoiding the consequences of repeal, which include increasing the number of uninsured by approximately 30 million people (Blumberg, Buettgens, and Holahan 2016), creating adverse financial impacts for hospitals and other providers, leading to turmoil in the insurance industry, and negatively impacting state and local budgets. If a new framework like this is agreed upon and enacted through legislation with bipartisan support, robust implementation efforts must follow in order for it to succeed.

Notes

1. "A Better Way to Fix Health Care: Snapshot," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-Snapshot.pdf; and "Empowering Patients First Act: Section-by-Section Overview," Office of Congressman Tom Price, May 13, 2016, http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf.
2. Joseph Antos and James Capretta, "The Problems with 'Repeal and Delay,'" *Health Affairs Blog*, January 3, 2017, http://healthaffairs.org/blog/2017/01/03/the-problems-with-repeal-and-delay/; and Ezra Klein, "There Is No 'Terrific' Replacement for Obamacare," *Vox*, January 9, 2017, http://www.vox.com/policy-and-politics/2017/1/9/14206052/obamacare-replacement-mcconnell-trump.
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4. See Brian Fanney, Michael R. Wickline, and Spencer Willems, "Arkansas House Speaker Details Cuts If Medicaid Plan Fails," *ArkansasOnline*, April 12, 2016, http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/; and David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," *Kaiser Health News*, April 21, 2016, http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion/. Medicaid expansion in Arkansas was extended on April 21, 2016.
5. In addition, current proposals would offer larger tax credits to older adults, but none would provide tax credits large enough to compensate for the higher premiums older adults would face if 3:1 age rating limits were replaced with 5:1 or 6:1 limits—another change from the ACA envisioned under these approaches. Consequently, affordability of coverage and, ultimately, access to medical care would be increasingly compromised with age. Age rating bands limit the extent to which insurers can vary premiums with age. For example, 3:1 age bands under the ACA prohibit nongroup and fully insured small group insurers from charging premiums for 64-year-olds that are more than three times the premium charged for the youngest adult for the same plan.
6. Linda Blumberg and John Holahan, "Don't Let the Talking Points Fool You: It's All about the Risk Pool," *Health Affairs Blog*, March 15, 2016, http://healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool/.
7. "A Better Way: Health Care," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf; and "Patient Choice, Affordability, Responsibility, and Empowerment Act," US House Committee on Energy and Commerce, February 5, 2015, https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf.
8. Much depends upon how the rule would ultimately be drafted; no specifics have yet been provided in any of the public proposals. Still, it is hard to see how a time limit on this type of requirement could be implemented. If the person seeks coverage after a period of uninsurance and is denied or charged a premium that they cannot afford, they would remain uninsured. When would a "time clock" on such a requirement begin, and when would

it end? Would it start at the beginning of a spell of uninsurance? When someone shopped for insurance and found it unavailable or unaffordable? How would that be documented? Would it end after a defined period of uninsurance? Could that time be differentiated in terms of whether the individual sought coverage and was refused, could not afford to enroll at higher rates, or simply remained uninsured without shopping? Limits could be imposed on how much more someone could be charged relative to "standard" rates, but there has been no mention of such limits in the proposals released. Even if limits were put in place, the coverage would likely remain unaffordable for most of those who would be charged the higher premium, so the limit may not provide any practical protection compared with a no-limit scenario.

9. Medical underwriting is prohibited in the nongroup and fully insured small group insurance markets under the ACA. Underwriting is the process that insurers undertake to assess the health care risk of potential enrollees, and that information was used to determine whether coverage was to be offered at all in the nongroup market (federal law prohibited coverage denials in the small group market beginning in 1996), the premium to be charged if coverage was offered to an applicant, and the benefit and cost-sharing packages offered to applicants (in states that permitted such differentiation based on health risk).

10. "Part B Late Enrollment Penalty," Centers for Medicare and Medicaid Services, https://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html; and "Part D Late Enrollment Penalty," Centers for Medicare and Medicaid Services, https://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment-penalty.html. Special enrollment periods are available for those not taking Part B due to enrollment in a group health insurance plan. No penalty is assessed for those enrolling late under these provisions.

11. Aaron and colleagues (2017) provide a detailed discussion of policy approaches to address the criticisms of the Cadillac tax or a cap on the employer-based insurance tax exclusion.

12. The benchmark, or second-lowest-cost silver premium offered in the enrollee's rating region, is used to determine the amount of premium tax credit for which an applicant is eligible under the ACA. The percent-of-income caps used to determine premium tax credit amounts increase somewhat for every year that health care costs grow faster than general inflation. In addition to proposing lower percent-of-income caps to improve affordability, we suggest eliminating the indexing of the caps.

13. Under current law, individuals choosing the second-lowest-cost silver Marketplace plan available in their area cannot be charged a premium that exceeds the percent-of-income cap applicable for the applicant's income level. If the individual picks a more expensive option, they must pay the full difference in cost; if they choose a less expensive option, they will get the savings. If the premium tax credits were instead tied to the second-lowest-cost *gold* plan available in the area, individuals could much more easily afford higher actuarial value coverage, with lower deductibles, coinsurance, copayments, and out-of-pocket maximums.

14. "What Marketplace Health Insurance Plans Cover," Centers for Medicare and Medicaid Services, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

15. Under current law, Medicaid-eligible people can enroll in the program even if their employer offers insurance deemed affordable to them; however, Marketplace tax credit–eligible individuals are prohibited from getting financial assistance if their employer offers them affordable coverage. In states that move eligibility to 100 percent of FPL, the law should allow those with incomes between 100 and 138 percent of FPL access to Marketplace premium tax credits and cost-sharing assistance, even if they have an employer offer of insurance. The enhanced premium tax credit and cost-sharing assistance schedules we propose would reduce the negative financial impact of a transition from Medicaid to Marketplace coverage for people in states that had already expanded to 138 percent of FPL and made a decision to change their Medicaid eligibility threshold to 100 percent of FPL.

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