Review of Potential Policy Changes to the Affordable Care Act

January 30, 2017

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Introduction

This review is a compilation of how major proposals to reform, build on, or replace the Patient Protection and Affordable Care Act (ACA) would address various policy elements and dimensions of the ACA. The descriptions do not include any evaluation or assessment of the relative strengths or weaknesses of either the current ACA provisions or changes proposed.

The first section of provides an outline, that describes the primary elements of the ACA and the major repair/replace proposals. The second section is a list, with references and links to the fifteen major proposals considered for this review as of this version.

The third section introduces how the ACA addresses (or does not address) the element and then provides a brief description (with page reference) to how major repair/replace proposals address the element.

This review is the product of Covered California and is a “work in progress” prepared to assist Covered California and others to understand various potential ways to address coverage, cost and quality issues.

Federal Policy – ACA Repair/Replace Outline

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MAJOR ACA REPEAL/REPLACE PROPOSALS

The following proposals have been developed by policy thought leaders and various members of the United States Congress as possible alternatives to the Affordable Care Act. The inventory below will be updated as proposals are released. Please click the links below for to read complete proposals.

A Better Way – House GOP / Speaker Paul Ryan – June, 2016

Improving Health and Health Care - An Agenda for Reform – AEI (co-authors: Lanhee Chen, Avik Roy, and more) – December 2015

Transcending Obamacare – Avik Roy – August 2014

The Prescription for Conservative Consumer-Focused Health Reform – Governor Bobby Jindal – April 2014

The Patient Choice, Affordability, Responsibility, and Empowerment (Patient CARE Act) – Sen. Burr, Sen. Hatch, Rep. Upton – March 2015

When Obamacare Fails –Thomas Miller – December 2012

A Winning Alternative to Obamacare – James Capretta/2017 Project – January 2014

Blueprint for a New Administration – Heritage Foundation – 2016

A Comprehensive Policy Agenda for a New Administration in 2017 – Heritage Foundation – 2016

A Federal Budget for 2017 – Heritage Foundation – 2016

Preparing a Smooth Transition for the Repeal of Obamacare – Heritage Foundation – 2016

Empowering Patients First Act (H.R. 2300) – Rep. Tom Price – May 2015

HR 2653: American Health Care Reform Act of 2015 – Republican Study Committee – June 2015

Healthcare Accessibility, Empowerment, and Liberty Act – Sen. Bill Cassidy and Rep. Pete Sessions – May 2016

Patient Freedom Act of 2017 – Senators Bill Cassidy and Susan Collins – January 2017

Federal Policy – Review of Major Proposals

I. Insurance Market Coverage and Reforms

1. Tax Credits

ACA Provision:

Consumers are determined eligible for tax credits based on the following factors: county of residence, size of household, age of individuals in the household and household income. To adjust for local health care costs, tax credits are benchmarked to the second lowest Silver Plan available to the consumer and are set on sliding scale so that premium contributions are capped as a percentage of household income:

- Up to 133% FPL: 2% of income
- 133 – 50% FPL: 3 – 4% of income
- 150 – 200% FPL: 4 – 6.3% of income
- 200 – 250% FPL: 6.3 – 8.05% of income
- 250 – 300% FPL: 8.05 – 9.5% of income
- 300 – 400% FPL: 9.5% of income

Tax credits are currently available on an advanced basis (Advanced Premium Tax Credits), but consumers can opt to accept a partial amount or choose to receive the full tax credit when they complete a tax return. Premium tax credits are only available through an exchange and not portable in the broader individual market.

1.1 Exchange Administered

Transcending Obamacare (Avik Roy) – Page 25

- Permits states to apply for a waiver from HHS to opt-out of a publicly administered exchange if the state can assure that at least two private entities will set up an internet based insurance market in their state.

1.2 Not Exchange Administered

A Better Way (Speaker Ryan) – Page 14

- Provides universal advanceable, refundable tax credit for individuals and families.
- Portable payment, excess money (after premium is paid) can be used in HSA.
- Tax credit will be a fixed amount.

Patient Freedom Act (Senators Collins and Cassidy) – Page 17

- Directs the Secretary of HHS to adopt a formula to be used by the federal government and by states for advanceable, refundable tax credits deposited monthly into Roth HSAs established for enrollees. Tax credits shall be adjusted for an enrollee's age, income, and geographic location.
- For states that decide to opt-out of the ACA, the amount of the tax credits, on average, shall equal 95 percent of the total projected ACA premium tax credits and cost-sharing subsidies received in the state, divided by the number of Roth HSA enrollees in the state. In states that did not expand Medicaid, the total available for the Roth HSA tax credits will be increased to reflect federal expenditures that would have been made if the state had expanded Medicaid.
- Allows "patient-grant" electing states to increase tax credits to match amounts enrollees would have received if their current ACA coverage had continued.
- Allows low-income enrollees with employer-sponsored coverage to receive partial tax credits, adjusted by the value of the tax benefit to the enrollee of the employer's contribution.
- Phases-out the Roth HSA tax credits beginning at $90,000 for single enrollees ($150,000 for married couples).
- Requires that federal expenditures for the market-based health insurance system under Option 2 (Roth HSA) be budget-neutral relative to the ACA.

HR 2300 (Rep. Price) – Page 5

- Provides advanceable tax credits that are adjusted for inflation. Individuals would be eligible for tax credits based on age:
  - $900 for under 18 years
  - $1,200 for 18-34 years
  - $2,100 for 35-49 years
  - $3,000 for 50 years and above
- The tax credits are to be used to purchase qualified health insurance, defined as health insurance coverage (other than excepted benefits as defined in section 9832(c)), which constitutes medical care.
- The Health and Human Services (HHS) Secretary would implement a program for making payments to providers of qualified health insurance, including a process for individuals to apply and receive certification that they are eligible for the tax credit.
- The providers of qualified health insurance must submit to the HHS Secretary information of covered enrollees, including information on premiums paid.
- Individuals eligible for Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) can elect to receive the tax credit.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 4

- The following categories would be eligible for age-adjusted, advanceable, refundable tax credits: 1) Individuals working for a small business with 100 or fewer employees and 2) individuals working for a small business or large employer that offers coverage. The tax credit would be administered by a new health financing office at the Treasury.
- The tax credit would be limited to 300% FPL, taper down between 200-300% FPL and be indexed to the growth in CPI+1.
  - Age 18-34, Individual $1,970, Family $4,290
  - Age 35-49, Individual $3,190, Family $8,330
  - Age 50-64, Individual $4,690, Family $11,110
- Permits states to auto-enroll consumers into a default plan for those individuals that do not proactively choose a plan. Suggests that states can work with insurers to design default options that are covered by the tax credit and set appropriate deductibles. Allows for individuals to make an active plan change after default enrollment as well as opt-out of coverage altogether.

A Winning Alternative to Obamacare (James Capretta) – Page 3

- Tax credits would be based on age and indexed to 3% annual growth:
  - $900 for under 18 years
  - $1,200 for 18-34 years
  - $2,100 for 35-49 years
  - $3,000 for 50 years and older.
- Eligible individuals include those purchasing in the individual market, employees of small group employers buying in the individual market, and those eligible for Medicaid opting to purchase private insurance.
- Unused tax credit is deposited into an HSA. Author believes this would unleash consumer-driven health care that would cause providers to become more price transparent.
- Explicitly favors a tax credit and not a tax deduction.

Improving Health and Health Care (AEI) – Page 21

- Provides tax credits as fixed dollar amounts based on age. The tax credits would be based on the levels set in HR 2300 (Price).
- Defers to Congress to determine whether the age-based tax credits should be means-tested.
- Suggests an alternative, “cost-based subsidy structure” that adjusts the tax credits for the varying costs of care and insurance that consumers experience in the market (i.e., responsive to both age and geography). Suggests structuring the tax credit as a uniform fixed percentage of premium costs, which would provide all consumers the same subsidized discount rate. A ceiling could be set to reduce the

incentive for overspending and additional subsidies could be provided for more economically and medically vulnerable populations.
- To receive the tax credit, individuals need to purchase qualified health insurance that provides coverage for medical care above an out-of-pocket maximum for consumer spending.
- Would allow enrollees currently in ACA plans and receiving tax credits and subsidies under the ACA rules to continue remaining enrolled, but have the choice to opt into the new tax credits and insurance plan options. The goal would be that individuals would increasingly transition to the new system.

When Obamacare Fails (Thomas Miller – AEI) – Page 17

- Would eliminate the employer tax exclusion of health benefits and instead provide a refundable, universal credit for the under-65 population.
- As part of moving Medicaid to a defined contribution model, this proposal would provide a larger tax credit to Medicaid beneficiaries with low incomes.
- The refundable tax credits would have an average value that is fixed, but subject to some degree of risk adjustment.
- The likely average value of the credit might approximate the current average tax subsidy for job-based coverage—in the range of about $5,000 to $6,000 per family. Forgoing the tax credit would be greater than the penalty imposed by the individual mandate.
- Because this approach may be disruptive to ACA provisions of coverage, the author suggests that the pace and scope could be adjusted based on practical limits.

Healthcare Accessibility, Empowerment, and Liberty Act (Senator Cassidy/Rep. Sessions) – Page 26

- Provides the following universal, advanceable tax credits to individuals covered by creditable coverage: $2,500 for each adult and $1,500 for each qualifying child. Creditable coverage is defined in title XXVII of the Public Health Service Act.
- Would require the Treasury to implement an “Advanced Payment Program” that operates under similar rules as the ACA for the purpose of determining eligibility for tax credits. The advanced tax credits would be payable on a monthly basis either directly to an insurer or into a Roth HSA, up to the amount the individual pays premiums or into the Roth HSA.
- Tax credit is reduced for those enrolling in limited benefit plans.
- The tax credit is adjusted by the Secretary by age and geography. The adjustment would take into account the ratio of the average cost of typical individual health insurance coverage for an individual of such age and residing in such area to the national average cost of

such typical health insurance. The aggregate amount of the tax credit would not be changed by these adjustments.
- On an annual basis, the tax credit would be reduced by any income or payroll tax subsidies (provided by employer-sponsored coverage) that exceed the amount of the tax credit. This reconciliation would not apply to employers that opt to provide health coverage subject to current tax exclusions for employer health benefits, in which case the tax credit would not be available.
- Similar to the ACA, the advanced tax credits would be reconciled at tax filing time and subject to caps on repaying any excess advance payments.
- Allows individuals to continue receiving the ACA's income-based tax credits, but would not allow these individuals to simultaneously receive the universal tax credit.
- Allows for states to use one-quarter of unclaimed tax credits for residents of their states to finance indigent care.

1.3 Adjustment Mechanism (e.g., by age and not cost of health insurance)
- In development.

1.4 Advanced Credit and/or Refundable

A Better Way (Speaker Ryan) – Page 14

- Provides universal advanceable, refundable tax credit for individuals and families.

Patient Freedom Act (Senators Collins and Cassidy) – Page 17

- State Alternative (Option 2)
  - States would make deposits in Roth HSAs that can be used to pay for both premiums and cost-sharing.
  - If the state does not want to carry out these functions, then the subsidies would be available as a refundable tax credit.

HR 2300 (Rep. Price) – Page 5

- Provides advanceable tax credits that are adjusted for inflation. Individuals would be eligible for tax credits based on age:
  - $900 for under 18 years
  - $1,200 for 18-34 years
  - $2,100 for 35-49 years
  - $3,000 for 50 years and above

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 4

- Following categories would be eligible for age-adjusted, advanceable, refundable tax credits: 1) Individuals working for a small business with 100 or fewer employees and 2) individuals working for a small business or large employer that offers coverage. The tax credit would be administered by a new health financing office at the Treasury.

Healthcare Accessibility, Empowerment, and Liberty Act (Senator Cassidy/Rep. Sessions) – Page 26

- Provides the following universal, advanceable tax credits to individuals covered by creditable coverage: $2,500 for each adult and $1,500 for each qualifying child. Creditable coverage is defined in title XXVII of the Public Health Service Act.
- Would require the Treasury to implement an "Advanced Payment Program" that operates under similar rules as the ACA for the purpose of determining eligibility for tax credits. The advanced tax credits would be payable on a monthly basis either directly to an insurer or into a Roth HSA, up to the amount the individual pays premiums or into an HSA.

1.5 Portability

A Better Way (Speaker Ryan) – Page 14

- A portable payment available at the beginning of every month could be taken from job-to-job and into retirement years.

1.6 Ability to opt-out of MEC programs (e.g. Medicare, Medicaid, TRICARE, employer-sponsored) and retain eligibility for tax credits to be applied on other markets.

HR 2300 (Rep. Price) – Page 5

- Individuals eligible for Medicare, Medicaid, or SCHIP can elect to receive the tax credit.

2. Cost Sharing Reduction Payments

ACA Provision:

A consumer's out-of-pocket costs at the point of care are reduced if they qualify for cost-sharing reduction (CSR) payments and select the enhanced Silver plan. CSRs are a discount that lowers the amount a consumer pays for deductibles, copayments, and coinsurance as well as a lower out-of-pocket maximum. Effectively, CSRs increase the actuarial value of Silver plans according to the consumer's income level:

- 100-150% FPL: 94%
- 150-200% FPL: 87%
- 200-250% FPL: 73%
- 250-400% FPL: 70%

3. Deductibility of Premium

In development.

4. Enrollment Periods

ACA Provision:

The annual open enrollment period is the time of year when a consumer can apply for tax credits, enroll or renew coverage, or switch plans. If a consumer misses the open enrollment period, they may enroll through a special enrollment period if they have a qualifying life event. Enrollment periods are defined by the federal government.

4.1 Open Enrollment

A Better Way (Speaker Ryan) – Page 22

- A one-time open enrollment for individuals to join the health care market if they are uninsured, regardless of health status.
- If individuals do not enroll, they would forfeit continuous coverage protections, which would expose them to medical underwriting and higher premiums.

Patient Freedom Act (Senators Collins and Cassidy) – Page 31

- Requires states to have uniform annual and clear special enrollment periods, including an initial open enrollment period that is no less than 45 days.

HR 2300 (Rep. Price) – Page 153

- Open Enrollment Periods are no less than 30 days and the time between open enrollment periods cannot exceed 24 months.
- For special enrollment periods, the proposal allows for typical qualifying life events such as new dependents and loss of coverage and will last at least 60 days from the qualifying event.

Transcending Obamacare (Avik Roy) – Page 31

- Reform open enrollment to be a six-week event that takes place every two years. Individuals would relinquish the benefit of guaranteed issue and community rating if they did not participate in the open enrollment.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton)– Page 3

- One-time open enrollment for individuals to purchase coverage regardless of health status or pre-existing conditions. Otherwise, individuals can purchase during their "creditable coverage window" (e.g., those with continuous coverage transitioning from job-based coverage to the individual market).

A Winning Alternative to Obamacare (James Capretta) – Page 10

- Creates a one-year buy-in period for young adults that would exempt them from medical underwriting. The buy-in period starts either on their 18th birthday or after they cease becoming a dependent when they turn 25, whichever comes first.
- Creates a one-year buy-in period for newborns.
- Creates a two-month window for those transitioning from employer-based coverage to the individual market to be exempt from medical underwriting as long as the individual had maintained continuous coverage for at least a year.
- Would allow those switching plans in the individual market to be exempt from medical underwriting if they had maintained continuous coverage for at least a year.

Improving Health and Health Care (AEI) – Page 21

- To increase insurance coverage without a mandate, as well as to reach difficult to reach populations, states should be permitted to auto-enroll individuals eligible for a refundable tax credit to several default options (on a random basis) if they fail to sign up for coverage on their own.
- The premium for the default plan would need to be fully covered by the tax credit. To give plans the flexibility in meeting this requirement, they can set deductibles accordingly. The intent is to ensure that

uninsured individuals are protected against catastrophic medical expenses and maintain continuous coverage so that they can later avoid medical underwriting.

When Obamacare Fails (Thomas Miller – AEI) – Page 39

- A one-time enrollment period to allow people who have not maintained continuous coverage to receive protections against pre-existing condition exclusion periods and medical underwriting. These individuals would still be charged somewhat higher rates than those that had maintained continuous coverage.

Healthcare Accessibility, Empowerment, and Liberty Act (Senator Cassidy/Rep. Sessions) – Page 16

- Permits states to enroll uninsured residents in a default plan and establish a Roth HSA for them, as long as consumers can opt-out.
- The default plan is:
  - A High Deductible Health Plan (HDHP) with prescription drug coverage limited to generic drugs for a limited number of chronic conditions (commonly referred to as Tier 1).
  - Meets requirements to qualify for the payment of plan premiums from an HSA.
  - Has a provider network for covering benefits that is adequate.
  - Provides for coverage of childhood immunizations without cost-sharing requirements.
  - Meets other requirements specified by the state.

4.2 Special Enrollment Periods

ACA Provision:

A Special Enrollment Period is a time when a consumer can sign up for health insurance if they have had a qualifying life event, such as losing health coverage, moving, getting married, or having a baby. If a consumer experiences a qualifying life event, they will generally have 60 days following the event to enroll in a plan. The Center for Medicare and Medicaid Services (CMS) is conducting a pilot that will test the impact of the pre-enrollment verification of special enrollment period eligibility on compliance, enrollment, continuity of coverage, the risk pool and other outcomes.

Patient Freedom Act (Senators Collins and Cassidy) – Page 31

- Requires states to have uniform annual and clear special enrollment periods, including an initial open enrollment period that is no less than 45 days.

HR 2300 (Rep. Price) – Page 154

- For special enrollment periods, the proposal allows for typical qualifying life events such as new dependents and loss of coverage. The special enrollment period is 60 days.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 3

- One-time open enrollment for individuals to purchase coverage regardless of health status or pre-existing conditions. Otherwise, individuals can purchase during their "creditable coverage window" (e.g., those with continuous coverage transitioning from employer-based to individual market).

A Winning Alternative to Obamacare (James Capretta) – Page 10

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- Creates a one-year buy-in period for newborns.
- Creates a two-month window for those transitioning from employer-based coverage to the individual market to be exempt from medical underwriting as long as the individual had maintained continuous coverage for at least a year.
- Would allow those switching plans in the individual market to be exempt from medical underwriting if they had maintained continuous coverage for at least a year.

5. Rating Factors

ACA Provision:

The ACA allows for premiums to vary based on the following factors: age (limited to a 3:1 ratio), geography, household composition (self vs. family), and tobacco use (limited to 1.5:1 ratio). California does not allow premiums to vary based on tobacco use.

A Better Way (Speaker Ryan)

- Changes the age rating factors from 3:1 to 5:1, but allow states to narrow or expand.

Transcending Obamacare (Avik Roy) – Page 26

- Maintains that insurers do not rate based on gender and health status, but permits an age band of 6:1.
  - Because the proposal caps the share of income spent on premiums, this may mitigate the cost of premiums for subsidy eligible consumers.
  - Provides those between 317-600% FPL transitional premium assistance for costs above 10% of income. This transitional assistance would wind down by 2027.

Patient CARE Act – Page 2

Changes the age band to 5:1. This would be a federal baseline and states are permitted to adopt age and family rating rules that are more narrow or broader.

6. Guaranteed Issue

ACA Provision:

The ACA requires that a health plan must accept an applicant regardless of health status, age, gender or other factors that might predict the use of health services.

HR 2300 (Rep. Price)

- Eliminates guaranteed Issue.

Patient Freedom Act (Senators Collins and Cassidy) – Page 7

- Maintains guaranteed issue.

Transcending Obamacare (Avik Roy) – Page 31

- Maintains guaranteed issue.

7. Penalty for Non-Coverage

ACA Provision:

If an individual can afford health insurance, but chooses not to buy it, they must pay an "individual shared responsibility payment." In 2017, the fee for not having coverage is either 2.5% of household income or $695 per adult ($347.50 child), whichever is greater. States can potentially require residents to have health insurance or be responsible for a shared responsibility payment.

Patient Freedom Act (Senators Collins and Cassidy) – Page 6

- Repeals the individual mandate.

Improving Health and Health Care (AEI) – Page 22

- Repeals the individual mandate.

Transcending Obamacare (Avik Roy) – Page 31

- Repeals the individual mandate.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton)– Page 3

- Repeals the individual mandate.

8. Risk Stabilization Funding (High-Risk Pools)

ACA Provision:

The ACA authorized and funded Pre-Existing Condition Insurance Plans (PCIP) that established a new state or federally run high-risk pool in every state. All PCIP coverage ended on April 30, 2014 with enrollees transitioning to Exchange plans. States currently have the ability to operate a high-risk pool where enrollees need to meet existing eligibility guidelines.

A Better Way (Speaker Ryan) – Page 21

- $25 billion annually for high-risk pools that is to be divided among the states.

HR 2300 (Rep. Price) – Page 71

- Provides $1 billion annually that is to be divided among the states for a qualifying high-risk pool or a reinsurance pool or other risk-adjustment mechanism for subsidizing the purchase of private insurance.

- The Secretary of HHS will set aside a portion for bonus payments that can fund the following:
  - Providing guaranteed availability of individual coverage to those in formerly in group coverage.
  - Reducing premium trends, actual premiums, or other cost-sharing requirements.
  - Expanding or broadening the pool of high-risk individuals.
  - Adopting the Model Health Plan for Uninsurable Individuals Act of the National Association of Insurance Commissioners.
- Premiums for high-risk individuals would be set as follows:
  - For household adjusted gross income (AGI) that does not exceed the poverty line, 2% of income.
  - For household adjusted gross income that does exceed the poverty line, the sum of the following: 2% of income below the poverty line and 10% of income above the poverty line.
- Out-of-pocket maximums (including premiums)
  - Proposes that there should be a limitation on out-of-pocket expenses (including premiums) or a mechanism equal to twice the maximum allowable premium charged (does not provide more details).
- Defines "high-risk population" as individuals who:
  - Because of their medical history or condition receive a rate which is at least 150% of the standard risk rates (in a non-community, non-guaranteed issue state).
  - Individuals who are provided health coverage by a high-risk pool.

<u>Improving Health and Health Care (AEI) – Page 23</u>

- Initial funding is capped at $10 billion per year.
- Suggests that definition of high-risk be specific enough to prevent it from turning it into an "all risk pool." Suggests that this could be mitigated through caps on federal financing or establishing the types of health risks and above average premium offers that would be covered by federal subsidies to state high-risk pools.

<u>The Prescription for Conservative Consumer-Focused Health Reform (Governor Bobby Jindal) – Page 9</u>

- Provides $100 billion in federal funding over 10 years for states to establish and maintain a high-risk pool, reinsurance fund, or some other risk transfer mechanism.
- States can use some of this allotment to fund the costs of covering high-risk individuals.

A Winning Alternative to Obamacare (James Capretta) – Page 11

- Allocates $7.5 billion annually for state-run high-risk pools that serve those with expensive pre-existing conditions.
- Allows states to set premiums, which could be set at a percentage above the average cost for a policy for a person without a pre-existing condition in that same geographic area (suggests 150%, 200%, or 250% of FPL).
- No one is denied coverage into the high-risk pool.

HR 2653 (Republican Study Committee)

- Allows states that have not set up a high-risk pool to receive grants up to $5 million for creation and initial operations
- Requires verification of citizenship or lawful presence for participation.

When Obamacare Fails (Thomas Miller – AEI) – Page 32

- Should be limited to covering the most likely highest-risk individuals, as identified before enrollment.
- Suggests that high-risk pools be better designed, robustly funded, and more narrowly targeted.
- Would not require individuals to first exhaust their COBRA coverage when transitioning from employer-based coverage to the individual market. Suggests states impose limits on underwriting for this group of consumers.
- Cap the premiums charged to high-risk customers at some fixed level—at or somewhat above applicable standard rates in the individual market, regardless of income, for those who do not have previous continuous coverage.
- State governments can consider providing supplemental sliding scale subsidies to lower income consumers.
- To discourage insurers from steering high-risk consumers to the high-risk pools, the proposal suggests having a third party determine eligibility for subsidies and imposing penalties if the insurer makes too many failed claims.

9. Benefit Deign

9.1 Essential Health Benefits

ACA Provision:

The ACA requires individual and small group market plans to have an essential benefits (EHB) package that covers the following 10 categories of benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care
- If a state requires additional mandated benefits, states must defray the cost

<u>HR 2300 (Rep. Price)</u>

- Makes EHB requirement less prescriptive (cites example of insurers being required to cover many brand-name drugs because they are in a certain class). If states want to go above the federal benchmark, then they would pay for the cost of benefit mandates.
- EHB regulations would be modified so that consumer driven options, such as HDHPs and HSAs are not limited from meeting the EHB standard.

<u>Patient CARE Act (Senators Burr and Hatch, and Rep. Upton)</u>

- Eliminates mandated EHBs.

<u>A Winning Alternative to Obamacare (James Capretta)</u>

- Eliminates mandated EHBs.

9.2 Standard Tiers

ACA Provision:

In addition to covering EHBs, the ACA requires four defined metal tiers, as well as a catastrophic or "minimum coverage" plan for those under the age of 30 or experiencing a specific hardship. The four metal tiers vary cost-sharing based on actuarial value: Bronze (60% AV), Silver (70% AV), Gold (80% AV) and Platinum (90% AV). The ACA only requires plans to offer the silver and gold metal tiers. Covered California requires all individual market plans to have all four metal tiers, as well as a catastrophic or "minimum coverage" plan.

Transcending Obamacare (Avik Roy) – Page 25

- Maintains the metal tier structure to allow consumers to compare financial value, but reforms the actuarial value ranges to the following:
  - Bronze 40%, Silver 55%, Gold 70%, and Platinum 85%
  - Subsidies are benchmarked to the Gold metal tier.

Improving Health and Health Care (AEI) – Page 24

- In lieu of the ACA's metal tiers, suggests an approach such as the one taken by the Federal Employees' Health Benefits Program.

Senator Cassidy/Rep. Sessions – Page 23

- Would eliminate the requirement for health plans to cover EHBs, but provides states flexibility in implementing EHBs.

9.3 Drug Coverage

In development

10. Health Savings Accounts

ACA Provision:

Health Savings Accounts are available only to consumers enrolled in a high deductible health plans (HDHP). A consumer enrolled in a HDHP that has at least 60% actuarial value and covers EHBs can meet the minimum essential coverage requirement. While the ACA does not provide financial contributions to HSAs, consumers in the individual market can voluntarily establish an HSA if their plan meets the thresholds for deductibles established by the IRS.

A Better Way (Speaker Ryan) – Page 13

- Allow spouses to make catch-up contributions to the same HSA account.
- Allow qualified medical expenses incurred before the HSA-qualified coverage begins to be reimbursed from an HSA as long as the account is established within 60 days.
- Set the maximum contribution to an HSA at the maximum combined and allowed annual deductible and out-of-pocket expense limits.
- Expand accessibility for HSAs to certain groups, such as individuals receiving services through the Indian Health Service (IHS) and TRICARE.

Patient Freedom Act (Senators Collins and Cassidy) – Page 46

- Creation of Roth HSA:
  - In addition to their federally funded credit, consumers can also annually contribute up to $5,000 per insured individual. Individuals age 55 or older may contribute an additional $1,000 annually.
  - Roth HSA contributions are not tax deductible, but balances grow tax-free.
- HSA Use:
  - Health insurance premiums
  - Out-of-pocket expenses such as deductibles and co-pays.
  - Long-term care insurance
  - Direct Primary care (which shall not be regulated as insurance)
  - Roth HSA funds used for non-qualified purchases are included in income and are subject to a 10 percent penalty (which does not apply to individuals reaching age 65 or who die or become disabled)
  - Funds may be rolled over tax free from an individual's Roth HSA to an account beneficiary's Roth HSA
  - Tax-deductible HSA contributions are phased out

HR 2300 (Rep. Price) – Page 22

- If a consumer does not fully use the tax credit, the excess is deposited into an HSA and can be rolled over. HSA funds can also be rolled over to family members.
- Allows individuals with FSAs and HRAs to also be considered eligible individuals that can deduct expenses towards these accounts. Appears to allow distributions from FSAs and HRAs to HSAs. Appears to allow individuals to contribute FSA balances at year-end to an HSA.
- Eliminates the tax for not maintaining enrollment with a HDHP.

- Allows expenses that occurred prior to establishing an HSA to count as a qualified expense as long as it occurred during the tax year or prior to the individual filing taxes for the previous year or if the individual had been enrolled in a HDHP at the time.
- Renames HDHPs to HSA Qualified Plans.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 6

- Repeals ACA limitation on purchasing over-the-counter (OTC) medications through FSAs, HSAs, HRAs, and MSAs.
- Expands the use of HSA funds for COBRA and HSA-qualified policies. Removes restriction on veterans, service members, and individuals receiving care through the Indian Health Service from having an HSA. Allows spouses to make catch up contributions to the same HSA account.

A Winning Alternative to Obamacare (James Capretta) – Page 12

- Provides a one-time tax credit of $1,000 to anyone who opens an HSA in the individual market.

Patient Freedom Act (Senators Collins and Cassidy) – Page 26

- Establishes a new category of HSAs referred to as “Roth HSAs,” which are used exclusively for the purpose of paying the qualified medical expenses of the account beneficiary. The account can be transferrable to others upon death.
- Qualified medical expenses are amounts paid for medical care, as long as they are not otherwise compensated by insurance. Except for certain situations (such as long-term care or unemployed individuals), the Roth HSA can only pay for insurance that is creditable coverage. Roth HSAs can also be used to pay for monthly or prepaid amounts for concierge medicine.
- Qualified medical expenses are not taxable. If Roth HSA distributions are made that are not used for qualified medical expenses, the amount would be taxable and subject to a 10% penalty.
- Deposits into Roth HSAs are taxed, but income derived from the Roth HSA would not be subject to taxation. Deductions are not allowed for contributions made to Roth HSAs.
- The monthly limit for contributing to a Roth HSA is 1/12th of $5,000 for each family member covered by “creditable coverage.” The limit for individuals age 55 or older is increased by $1,000 to a total of $6,000. The contribution limit would be reduced if the individual made contributions to other tax-favored health accounts (e.g., Archer MSAs).

- If an individual has a lapse in creditable coverage during the year, their Roth HSA contributions during the period when they lacked creditable coverage would be taxable and subject to a 10% penalty. The proposal provides exemptions for death or disability.
- Individuals can no longer contribute to traditional HSAs after December 31, 2016, unless the HSA is provided by an employer that has elected to provide coverage under the tax exclusion of health benefits (instead of using the tax credit).
- Eliminates the medical expense deduction, except in the case of long-term care premiums.

11. Risk Adjustment

ACA Provision:

The ACA included risk adjustment mechanisms, whereby plans with lower-risk enrollees provide funds to plans with higher-risk enrollee to mitigate financial losses and ensure a level playing field for insurers.

Patient Freedom Act (Senators Collins and Cassidy) – Page 27

- A state may establish a mechanism for risk mitigation or risk adjustment in order to limit volatility in the premiums based on health experience to class average premiums, and a reinsurance and risk-corridor program that involves no Federal funds with respect to coverage both in the individual market and in the small group market.
- Mechanisms and programs may be based on the health status score of each individual enrolled in health insurance coverage in the individual market and not solely based on the aggregate risk of the risk pool with respect to each plan of health insurance coverage.

Healthcare Accessibility, Empowerment, and Liberty Act (Senator Cassidy/Rep. Sessions) – Page 21

- Requires all individual market issuers to participate in a risk adjustment mechanism, regardless of whether or not the coverage is provided through an Exchange.
- The Secretary and the National Association of Insurance Commissioners, as well as other interested parties, will develop a risk adjustment mechanism and will model it based on risk adjustment payments to Medicare Advantage plans.
- As part of the transition to new coverage, the initial mechanism will provide transitional protection, over a three-year period, for coverage that has not been previously marketed.
- A permanent model will be developed to replace the transitional model.

12. Consumer Protections

In development.

12.1 Balanced Billing
In development.

12.2 Network Adequacy
In development.

12.3 Provider Directory
In development.

12.4 General Consumer Protections

A Better Way (Speaker Ryan) – Page 20

- Maintains coverage for dependents up to the age of 26
- Maintains ban on rescissions
- Maintains pre-existing condition protections for consumers that maintain continuous coverage. Modeled after HIPAA, this protection would be available to everyone, whether they are switching from employer-based coverage, or within the individual market

Patient Freedom Act (Senators Collins and Cassidy) – Page 6

- Maintains protections for individuals with preexisting conditions
- Prohibits annual or lifetime caps
- Maintains guaranteed issue and renewability
- Prevents discrimination
- Maintains coverage for mental health and substance use disorders
- Maintains coverage for dependents up to the age of 26

HR 2300 (Rep. Price)

- Eliminates guaranteed issue and community rating.
- A pre-existing condition exclusion period cannot be imposed if the enrollee had at least 18 months of continuous creditable coverage (per HIPAA, section 2701(c)(1)).
- A pre-existing condition exclusion period can be imposed if the enrollee had a condition (physical or mental), regardless of the cause, in which they received medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date:
  - The exclusion period cannot be more than 18 months after the enrollment date.
  - The length of the exclusion period would be reduced by the total months the consumer had been enrolled in creditable coverage, as defined in section 2701(c)(1).

- A break in coverage is defined as the end of the first 63-day period in which the individual was not covered under any creditable coverage.
- During the time of the exclusion, the issuer may charge a premium that does not exceed 150% of the "applicable standard rate" for a period of no more than 24 months. If the issuer does not impose an exclusion, they may charge this premium up to 36 months. Again, the length of the premium surcharge would be reduced by the total months the consumer had been enrolled in creditable coverage.
- The following groups are exempted from the premium surcharge: certain newborns, certain adopted children, and pregnant women (pregnancy as a pre-existing condition).

Improving Health and Health Care (AEI) – Page 21

- Would protect persons with pre-existing conditions from being denied coverage.

The Prescription for Conservative Consumer-Focused Health Reform (Governor Bobby Jindal) – Page 9

- Would create incentive pool for states to provide guaranteed access for consumers with pre-existing conditions.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 2

- Maintains dependent coverage up to age 26, but permits states to opt-out.
- Maintains guaranteed renewability.
- Maintains ban on recessions.
- Changes ban on pre-existing conditions exclusion. Individuals would not be exposed to medical underwriting or denied coverage for a pre-existing condition if they maintain continuous coverage. The requirements for continuous coverage is having at least catastrophic coverage for a period of at least 18 months, without a significant break in coverage, similar to prior HIPAA protections.

Healthcare Accessibility, Empowerment, and Liberty Act (Senator Cassidy/Rep. Sessions) – Page 8

- Maintains ban on lifetime or annual limits
- Maintains dependent coverage up to age 26
- Maintains guaranteed renewability
- Maintains ban on pre-existing condition exclusions
- Maintains ban on discrimination based on health status
- Maintains ban on discrimination based on professional licensure type.

- Modifies guaranteed availability such that the protection is only available if the consumer had been enrolled in continuous coverage for the prior 12 months. If an individual does not meet this requirement, their premium is increased by 20% for each consecutive full 12-month period in which the individual was not enrolled in creditable coverage. The maximum length of period for these higher premiums is 3 times the length of the most recent time the individual was without coverage. Allows states to submit waivers for this provision if they have an alternative method for continuous coverage.

13. Medical-Loss Ratio

In development.

II. Small Employer Policies

1. Requirement on Exchanges to Offer Small Business Health Options Program (SHOP)

In development

2. Tax Credits

In development

3. Pooling/Purchasing

A Better Way (Speaker Ryan) – Page 16

- Allow small business and voluntary organizations (alumni associations, trade associations, and other groups) to band together to offer small business health plans known as Association Health Plans (AHP). This pooling would allow them to negotiate and have leverage similar to large companies and unions.
- Because consumers with higher risks cannot be denied coverage, the AHPs cannot cherry pick their members. They would also be prohibited from charging higher rates for sicker people, except as allowed under state law.
- For the individual market, consumers can come together for the sole purpose of purchasing health care coverage through individual health pools (IHP). Similar to AHPs, IHPs would exercise the same purchasing power in a reformed individual market that is freed from costly benefit mandates and overhead costs.

4. Mandate

In development.

III. Large Employer Policies

1. Mandate

In development.

2. Cadillac Tax

ACA Provision:

The ACA assesses a 40% excise tax on high-cost employer health plans to help control health care costs and fund the ACA.

Transcending Obamacare (Avik Roy) – Page 33

- Maintains Cadillac tax, but removes special exemptions for labor unions while preserving those for high-risk occupations such as fire and law enforcement.
- Open to the alternative of capping the tax exclusion.

Healthcare Accessibility, Empowerment, and Liberty Act (Senator Cassidy/Rep. Sessions) – Page 39

- Employers have the option to retain the tax exclusion of health benefits, but would be subject to the Cadillac tax.
- The tax exclusion would not be available for new employers and their employees (following the proposal's enactment).

3. Tax Exclusion

A Better Way (Speaker Ryan) – Page 15

- Proposes to cap the amount of employer-paid premiums that is tax-free to workers, but does not specify thresholds.
- Adjusts the cap so someone is not unfairly penalized if they live in a place where health care costs are higher simply because their cost of living is higher.
- Omits employee contributions made on a pre-tax basis to HSAs from counting toward cost of coverage.

HR 2300 (Rep. Price) – Page 49

- Caps the tax exclusion of health benefits to $8,000 for self-only and $20,000 for family coverage.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 9

- Caps the tax exclusion of health benefits at $12,000 for an individual and $30,000 for a family.

A Winning Alternative to Obamacare (James Capretta) – Page 13

- Caps the maximum deduction at the 75th percentile of premiums costs for employer-sponsored plan. This equates to roughly $8,000 for self-only and $20,000 for family coverage.

When Obamacare Fails (Thomas Miller – AEI) – Page 13

- Lower taxes for upper-middle-class and wealthier Americans to offset the net effect of reducing or even eliminating the tax exclusion of employer health benefits. This group disproportionately benefits from this tax subsidy.

IV. Medicaid Payment Changes

1. Expansion Policy Changes

In development.

2. Block Grant/Per Capita Funding

ACA Provision:

The ACA expanded eligibility for Medicaid by increasing income eligibility up to 138% FPL and adding a previous excluded category of adults without dependent children. Between 2014-2016, the federal government fully funded the cost for the Medicaid expansion. Beginning in 2017, federal funding tapers down to 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and beyond.

A Better Way (Speaker Ryan) – Page 28

- Provide states the choice of either a per capita allotment or a block grant.
- States that do not opt into the per capita allotment would be defaulted into a block grant. Funding would be determined using a base year in a manner that would assume states transition individuals currently enrolled in the ACA's Medicaid expansion into other sources of coverage. States would receive the following flexibility:
  - Maximum flexibility in managing eligibility and benefits for non-disabled, non-elderly adults and children. Waiver approval would no longer be required.
  - States determine how much they spend on their Medicaid populations, but would be required to provide required services to the most vulnerable elderly and disabled individuals (mandatory population).
- The amount of the per capita allotment would be the product of the state's per capita allotment for the four major beneficiary categories (aged, blind and disabled, children and adults) and the number of enrollees in each of those four categories. The per capita allotment for each beneficiary category would be determined by each state's

average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the base year, adjusted for inflation.
- Would allow a transition period before applying per capita caps. States that have not expanded Medicaid as of January 1, 2016, would not be able to do so under the per capita cap approach. States that have already expanded Medicaid would be given this increased flexibility.
- For Medicaid expansion states, states would receive the same amount of dollars, but have the flexibility to shift dollars to more needy populations. The enhanced Federal Medical Assistance Percentages (FMAP) for Medicaid expansion would gradually phase down to a state's normal FMAP.
- Maintains the SCHIP program, but benchmarks federal funding to its historical matching rate. This ensures that the program is financed jointly by the federal and state governments. The 23-point increase in the CHIP matching rate under the ACA resulted in 12 states receiving 100% federal financing.
- States would receive the following flexibility:
  - Use Medicaid dollars to provide a defined contribution in the form of premium assistance or a limited benefit to working adults or those preparing to enter the workforce.
  - For non-disabled adults, enforce reasonable premiums and allow adults to use premium assistance if it is cost-effective, without providing the wrap-around services that are required today.
  - Use waiting lists and enrollment caps for non-mandatory populations to help crowd-out of private coverage.
  - For the Medicaid expansion, reduce income eligibility thresholds below the current 138% FPL, or phase out expansion by freezing enrollment but continuing to cover current enrollees.
- Waivers would no longer be required for managed care. Other waivers that have been renewed twice are grandfathered in.

<u>Transcending Obamacare (Avik Roy) – Page 37</u>

- Would migrate acute care Medicaid beneficiaries onto reformed state-based exchanges with 100% federal funding and state oversight.
- Returns to the states over time full financial responsibility for the Medicaid long-term care population.
- Would also migrate dual eligible individuals onto the exchanges, where they receive an insurance benefit of the same actuarial value of their existing Medicaid and Medicare coverage.

<u>Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 6</u>

- Allows Medicaid eligible individuals to opt out and receive the tax credit instead.

- Would change Medicaid funding to "health grants" that allow states more flexibility for administering programs for low-income pregnant women and families. No changes would be made for funding for acute care provided to low-income elderly and disabled individuals. States would also receive a "defined budget" for long-term care services and support for low-income elderly or disabled individuals that are not in a position to use the tax credit.
- Benchmarks the "health grants" to the federal program costs for the previous year and caps the growth of the allotment to CPI+1, as well as demographic and population changes.
- Would reauthorize a former program of the 2005 DRA, which allowed Medicaid beneficiaries to have a "Health Opportunity Account" to pay for out-of-pocket expenses associated with enrollment in a HDHP. States and the federal government could fund these accounts up to $2,500 annually for each adult and $1,000 for each child.

When Obamacare Fails (Thomas Miller – AEI) – Page 21

- As part of moving Medicaid to a defined contribution model, this proposal would provide a larger tax credit to Medicaid beneficiaries with low incomes. Acknowledges that transitioning Medicaid beneficiaries could have several challenges, including that the current spending on non-disabled beneficiaries may not fully cover the cost of premiums and that private coverage will require paying providers more to deliver better care.
- Medicaid funding could supplement the tax credits to pay for more of their remaining premiums and cost-sharing. Allow Medicaid beneficiaries to have the same plan options as workers with higher wages. They would be responsible for additional premiums costs for enrolling in more expensive coverage options.
- Proposes block granting Medicaid, but acknowledges the following hurdles: how the funds are reallocated, the growth rate, and what level of current federal guarantees and minimum standards for Medicaid should be maintained.
- Defined contribution reform should initially target the non-disabled, Medicaid population below age 65 and allow states adopting this option to:
  - Determine their own eligibility categories and income threshold levels for Medicaid.
  - Establish rates and service delivery options.
  - Design benefit packages that best meet the demographic, public health, and cultural needs of each state or region (whether that involves adding, deleting, or modifying benefits).
  - Use cost-sharing as a way to promote individual responsibility for personal health and wellness.

- The proposal cites the following states as potential models for states to replicate:
  - The Rhode Island Medicaid global waiver that implemented an aggregate budget cap but maintains the FMAP.
  - The Florida Section 1115 waiver that coupled the use of managed care practices with customized benefit packages, opt-out provisions, and health-related incentives or enhanced benefits for beneficiaries.

Patient Freedom Act (Senators Collins and Cassidy) – Page 45

- In lieu of Medicaid coverage, beneficiaries can receive an HSA that is funded by the tax credit to cover the cost of coverage.
- Federal financial participation (FFP) funding provided to states would be adjusted to reflect any tax credits provided to Medicaid beneficiaries.

V. Medicare

In development.

VI. Delivery System and Payment Reform

1. QHP/Contracting Processes to Promote Reform

In development.

2. Medicare Payment Changes (e.g., Medicare Access and CHIP Reauthorization Act (MACRA))

In development.

3. Center for Medicare and Medicaid Innovation (CMMI)

In development.

VII. State's Action and Authority

1. 1332 Waiver

In development.

2. State Ability to Set higher Bar

In development.

3. State ability to Set Lower Bar

In development.

4. Purchasing Coverage Across State Lines

ACA Provision:

Section 1333 of the ACA permits states to form interstate compacts to allow insurers to sell policies in any state participating in the compact. Two or more states may enter into compacts under which one or more insurance plans may be offered in such states, subject to the laws and regulations of the state in which it was written.

A Better Way (Speaker Ryan) – Page 16

- Make it easier for states to enter into interstate compacts, which would ease consumer's ability to purchase across state lines.

HR 2300 (Rep. Price) – Page 87

- Association Health Plans for small business to purchase across state lines.
- Allow consumers to shop for insurance across state lines.

Improving Health and Health Care (AEI) – Page 24

- Allow consumers to purchase across state lines.

Transcending Obamacare (Avik Roy) – Page 52

- Allow for reference pricing within and across state lines.

The Prescription for Conservative Consumer-Focused Health Reform (Governor Bobby Jindal) – Page 22

- Allow consumers to purchase across state lines. Requires clear disclosure that insurance will be regulated by another state.

Patient CARE Act (Senators Burr and Hatch, and Rep. Upton) – Page 5

- State can enter into interstate compacts for pooling, which would allow consumers to shop across state lines.

When Obamacare Fails (Thomas Miller – AEI) – Page 43

- "Competitive federalism leads to insurers facing market competition across state lines and would lead to strong incentives to disclose and adhere to policies that encourage consumers to buy their product."

A Winning Alternative to Obamacare (James Capretta) – Page 12

- Allow consumers to shop and purchase insurance across state lines.

VIII. Immigration Issues

1. **Ability for Undocumented Residents to Purchase Insurance on Exchanges**
   In development.

2. **Access to Subsidies**
   In development.

IX. Miscellaneous

1. **Medical Device Tax**
   In development.

2. **Medical Disproportionate Share Hospital (DSH) Funding**
   In development.

3. **Federally Qualified Health Center (FQHC) Reimbursements**
   In development.

4. **Medical Liability**
   In development.

5. **Implications of Policy Change Implementation for 2018 Versus 2019**
   In development.