Op-Ed

Health Reform Redux: Where Might a Republican Congress Be Heading?

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LET US ASSUME THAT IN *KING V BURWELL*, THE UNITED STATES Supreme Court abandons all canons of statutory construction¹ and overturns federal regulations that make the Affordable Care Act (ACA) premium tax subsidies available in states electing to use the federal health insurance Exchange. (News accounts have raised the possibility that the *King* plaintiffs may lack standing to sue because they have suffered no harm as a result of the subsidies, so the Court could dismiss the case on this ground alone.)

What happens next, if subsidies are eliminated for more than 9 million people in 34 states,² and with open enrollment for 2016 just a few months away?

One possibility would be a temporary patch that restores subsidies in the affected states while some sort of grand bargain is worked out between Congress and the Obama administration, or perhaps the next president. This scenario assumes that enough Republicans in Congress would join Democrats in embracing such a strategy. But this assumption may be optimistic given the strength of Republican support for the *King* plaintiffs, which has been underscored by 56 separate votes in the House to repeal the Affordable Care Act.

The federal government might deem all states as having elected a state-based Exchange, thereby making residents of all states eligible for premium subsidies. But the ACA bars such a move, since it makes the form of Exchange a state decision. Another option might be for all states to quickly establish a state Exchange, but this would not be possible legally or practically. Many state legislatures will not be in session by June, establishing an Exchange takes time and money, and many state lawmakers have made it clear that they will not budge.³

Another solution would be to abandon the more than 9 million residents of 34 states and to allow their individual insurance markets to collapse. But this is a nonstarter for both sides, given the

magnitude of the stakes and the political sensitivities of many affected states (including Texas, Florida, Ohio, and Pennsylvania) on the eve of a presidential election. This brings us back to a presidential/congressional *détente* regarding the fundamental structure and operation of the US health insurance system.

A signal that Republicans have a starting point for just such a grand bargain is a position document developed by Senators Richard Burr (R-NC) and Orrin Hatch (R-UT) (who chairs the Senate Finance Committee, which has jurisdiction over Medicare, Medicaid, the Children's Health Insurance Program, and the tax code, with its refundable credits). This document, known as the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act (<http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>), mirrors an earlier version introduced by Senators Burr and Hatch and former Senator Tom Coburn in 2014, and it provides real insight into Republicans' thinking at this point. Although not yet translated into precise legislation (and lacking cost estimates, which can be calculated only after the actual legislative language is drafted), the CARE Act is sufficiently fleshed out (including its name) to enable preliminary analysis.

In a nutshell, the CARE Act is a vastly degraded version of the ACA, and in the case of Medicaid, CARE would not simply shrink the ACA but would eliminate it entirely, by replacing a public insurance entitlement for low-income and medically vulnerable people with a block grant that would expose states to enormous financial risks. Rather than insuring more people, CARE probably would wipe out the private insurance coverage gains made by millions under the ACA and would eliminate Medicaid coverage for millions more.

CARE's private insurance reforms would essentially eliminate the ACA's guarantee that no one will be denied coverage or face discrimination based on health status. CARE would replace this guarantee with a right to "guaranteed renewal" for people who remain continually insured, with only brief breaks in coverage. People without coverage would be given a one-time, special open enrollment period. Failure to enroll would leave those who cannot or do not get coverage subject to discriminatory exclusion and pricing, apparently for life. CARE would offer no affordability exemption from this lifelong penalty.

CARE would also reduce the number of people with a realistic chance to obtain affordable coverage by capping premium subsidies at 300% of the federal poverty level (FPL), rather than the 400% FPL standard applicable under the ACA, a difference of well over \$10,000 (in 2015 dollars) for a family of 3. Although CARE would subsidize 50- to 64-year-olds at slightly more than twice the level allowed for 18- to-34-year olds (\$4,690 versus \$1,970 in 2015), it also would allow insurers to charge 5 times as much for people in the oldest age group, in contrast to the 3-to-1 differential allowed under the ACA. CARE further would eliminate the ACA's cost-sharing reduction subsidies for people with incomes below 250% FPL, which have made care affordable for lower-income people.⁴

Reforms meant to ensure some basic level of coverage integrity—hardly comprehensive under the ACA—would disappear. Essential health benefits, preventive benefits with no cost sharing, and minimum actuarial value standards would disappear altogether. Insurers could basically offer whatever they wanted as long as their products met state law standards. Ironically, the driving force behind the ACA's federal reforms was the fact that states had been so ineffectual at regulating insurers' practices, given their fears that meaningful regulations would lead to market abandonment.

As for Medicaid, CARE simply would end it as a legal entitlement for the poor and medically vulnerable, replacing it with a block grant whose upward-adjustment formula in later years would fall well behind the growth in population and health care costs in an aging society. CARE would bar states from using federal funds to cover low-income adults, instead restricting coverage to traditional groups. Low-income adults would get the premium tax subsidy, which would be worth only a fraction of the cost of an individual health plan and lack cost-sharing assistance.

Despite this depressing picture, CARE does offer 2 ideas with some potential. The first is an upper limit on tax-free employer contributions to employee health benefits, which would begin to address the economic distortions caused by the current employer exclusion, which favors the most affluent Americans. CARE actually may be more generous than the ACA's "Cadillac tax" provision on employer plans, which has generated cost-sharing hikes in order to reduce plan value.

The second is a proposal to replace the coverage mandate with default enrollment coupled with the right to opt out. Opting out would,

of course, carry its own penalty in the form of a risk of lifelong discrimination by insurers. But given the backlash engendered by the ACA's tax penalties (which frankly seem kinder and gentler), a penalty approach might be worth a look.

References

1. Greenhouse L. The Supreme Court at stake: overturning Obamacare would change the nature of the Supreme Court. *New York Times*. February 5, 2015. http://www.nytimes.com/2015/02/05/opinion/overturning-obamacare-would-change-the-nature-of-the-supreme-court.html?_r=0. Accessed February 25, 2015.
2. Blumberg L, Buettgens M, Holahan J. The implications of a Supreme Court finding for the plaintiff in *King vs. Burwell*: 8.2 million more uninsured and 35% higher premiums. Washington, DC: Urban Institute; January 8, 2015. <http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf>. Accessed February 25, 2015.
3. Bagley N, Jones DK, Jost TS. Predicting the fallout from *King v Burwell*—exchanges and the ACA. *New Engl J Med*. 2015;372:101-104. <http://www.nejm.org/doi/full/10.1056/NEJMp1414191>. Accessed February 25, 2015.
4. Claxton G, Panchal N. ACA subsidies reduce cost sharing for people with lower incomes. Menlo Park, CA: Kaiser Family Foundation; February 2015. <http://kff.org/private-insurance/>. Accessed February 25, 2015.

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