
December 1, 2016

HHS Secretary Nominee Price's Health Plan Would Severely Weaken Health Coverage and Consumer Protections

By Edwin Park

President-elect Trump's selection of House Budget Committee Chairman Tom Price for Secretary of Health and Human Services should focus attention on Price's health plan,¹ which to date has received little scrutiny. Like other Republican congressional health plans, it would repeal the Affordable Care Act (ACA) and replace it with highly inadequate financial help to enable families and individuals to buy health coverage — likely leaving many of the 20 million people who have gained coverage under the ACA uninsured or without needed care.²

By repealing the ACA, the Price plan would eliminate its market reforms and consumer protections and even likely result in states having weaker insurance regulations than before the ACA. It would let insurers once again exclude coverage of many people's pre-existing conditions and charge them much higher premiums. And it would likely seriously disrupt employer-based coverage by encouraging employers to drop coverage on the assumption that workers would buy it on their own. Finally, as explained below, the Price plan includes a series of misguided proposals, such as expanding high-risk pools, expanding Health Savings Accounts, allowing insurers to sell coverage across state lines, and expanding Association Health Plans.

Eliminating Market Reforms and Consumer Protections

The plan would eliminate the ACA market reforms guaranteeing that a broad array of people — including those with pre-existing health conditions — can buy insurance that meets minimum coverage standards in the individual and small-group private health insurance markets. Those markets would effectively revert to pre-ACA rules, meaning, among other things, that insurers could once again:

- charge higher premiums to people who have health conditions, are women, or for another reason such as their industry or profession;

¹ Empowering Patients First Act, <http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%20300%20Empowering%20Patients%20First%20Act%202015.pdf>.

² For CBPP blog posts on various provisions of these plans, see <http://www.cbpp.org/previewing-a-house-gop-leaders-health-plan>.

- drop or severely limit benefits such as maternity care and prescription drugs, which they now must cover as “essential health benefits”;
- reinstate annual and lifetime limits on their reimbursements for an enrollee’s health care costs; and
- charge deductibles, co-insurance, and co-payments without limits.

Providing Inadequate Subsidies to Buy Individual-Market Coverage

Under the ACA, people with low or modest incomes can receive premium tax credits to help defray the cost of private coverage they buy through the marketplaces. The Price plan would replace the ACA credit, which is based on family income, with a modest tax subsidy that varies by age — *not* by income. As a result, lower-income people would have to pay a much greater share of their income on premiums than they do now — and a greater share than people with modestly higher incomes would pay. The poor and near-poor who now qualify for coverage under the ACA’s Medicaid expansion (which the Price plan would repeal) and generally pay little if any premiums now would be hit especially hard, and many of them would likely end up uninsured.

Moreover, unlike under the ACA, the credit wouldn’t be based on what decent-quality coverage costs where the recipient lives; it would be uniform nationally. It wouldn’t adjust for the higher premiums that people in poorer health would now have to pay under the Price plan. Nor would it fully account for differences in people’s premiums based on their age, as insurers in the individual market could charge older people much more, relative to younger people, than under the ACA.

Finally, the Price plan would eliminate the ACA’s cost-sharing reductions, which help cover deductibles and co-payments for those with lower incomes, and would provide no financial assistance for cost-sharing charges, even for people below the poverty line who now qualify under the Medicaid expansion and pay only very modest co-payments. As a result, even if some low- and moderate-income people were able to obtain coverage through the Price plan’s tax credit, many would likely forgo some needed care because they couldn’t afford the deductibles or cost-sharing charges or they lacked coverage of critical benefits.

Weakening Protections for People With Pre-Existing Health Conditions

The ACA prohibits insurers from denying coverage to people with pre-existing health conditions, charging them higher premiums, or refusing to cover benefits related to a pre-existing condition. The Price plan would again allow insurers to exclude coverage of a pre-existing condition for lengthy periods of time or charge much higher premiums unless individuals had maintained continuous coverage for at least 18 months. This would protect people far less than under the ACA and only modestly more than the rules in place before the ACA.

Many people would fall through the cracks. Some 36 percent of Americans aged 4 to 64 — 89 million people — went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once.³ Consider, for example, a mother with

³ Pamela Farley Short *et al.*, “New Estimates of Gaps and Transitions in Health Insurance,” Commonwealth Fund, August 3, 2012, <http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance>.

diabetes whose work hours are reduced in the summer and decides to go without health insurance for the rest of the year to afford basics such as food and rent. Insurers could deny coverage of her diabetes and charge a much higher premium than she likely would be unable to afford.

Expanding High-Risk Pools

In part to help people with pre-existing conditions and significant medical expenses who *don't* have continuous coverage, the Price plan would expand high-risk pools. Experience shows, however, that high-risk pools are a failed approach to providing affordable coverage. Because they pool sick people with even sicker people rather than pooling sick and healthy people together, as regular insurance does, they tend to charge extremely high premiums that people can ill afford.

States' experience with state high-risk pools before the ACA shows that even the high premiums that the risk pools charged covered only about half of the cost of operating the pools. The rest had to come from public support, such as state general revenues or premium assessments on insurers. Unless that support was substantial and rose significantly over time, states eventually had to scale back these pools to keep costs from spiraling out of control. States sharply restricted enrollment in the high-risk pools, set premiums further above what many families could afford, and/or scaled back coverage. Only a little over 200,000 people in the entire country were enrolled in such pools in 2011.

One credible estimate found that it could easily cost more than \$1 *trillion* over ten years to support an adequately funded national high-risk pool system.⁴ The Price plan doesn't come anywhere close to that amount. It includes just \$1 *billion* annually in seed funding to support existing state high-risk pools and help start new pools for just three years, and no funding for ongoing operations thereafter.

Disrupting Employer-Based Coverage

The Price plan's tax credit to buy individual-market coverage, described above, would be available to anyone not enrolled in other coverage, including those offered job-based coverage. This could encourage employers to drop health coverage on the assumption that their workers could instead buy coverage on their own. (By fully repealing the ACA, the Price plan would eliminate its requirement that large employers offer coverage or pay a penalty.)

Moreover, the tax credit would be available irrespective of income, including to higher-wage workers and the owners or managers who decide whether their firms should continue offering health coverage. This would almost certainly result in "adverse selection," or the separation of healthier and less-healthy people into different insurance arrangements. Healthier employees would be the most likely to find that using the tax credit to buy individual-market coverage would cost less than staying in their employer-based plan, where the premiums reflect the higher cost of the less-healthy individuals with whom they are pooled.

⁴ Robertson C. Williams *et al.*, "An Updated Analysis of the 2008 Presidential Candidates' Tax Plans," Tax Policy Center, September 12, 2008, <http://www.taxpolicycenter.org/publications/updated-analysis-2008-presidential-candidates-tax-plans-updated-september-12-2008>.

As healthy individuals opted out of employer-sponsored insurance, the pool of workers remaining in employer plans would become sicker, on average. That, in turn, would drive up the per-beneficiary cost of the employer-sponsored plans, raising the premiums for the workers still in those plans and inducing still more healthy workers to abandon them for lower-cost plans in the individual market.

The Price plan would also cap the tax exclusion for employer-paid health insurance premiums, which encourages employers to offer coverage to their workers. This would further encourage employers to stop providing health benefits. Many older workers and those in poorer health who lose job-based insurance would be at significant risk of ending up uninsured or underinsured, as they would have to use an inadequate tax credit in a largely unregulated individual market.

Expanding Health Savings Accounts (HSAs)

The Price plan includes several proposals to expand HSAs, which are tax-favored accounts that people with high-deductible health plans can use to save money for out-of-pocket health expenses. HSAs offer unprecedented tax sheltering benefits to high-income individuals. Contributions (up to \$3,350 for individual coverage and \$6,750 for family coverage in tax year 2016) are deductible, earnings grow tax free, and withdrawals are tax exempt if the money is used for health expenses.

The Price plan would dramatically increase HSAs' tax sheltering benefits by raising the annual contribution limit by more than 60 percent. This would primarily benefit high-income individuals, who are more likely to make the maximum annual contributions. They also receive the largest tax benefits from HSAs, since a tax deduction rises in value with an individual's tax bracket. Households with incomes of at least \$100,000 already account for most tax returns claiming an HSA deduction and the large majority of the total amount of HSA contributions, according to data from the Joint Committee on Taxation.⁵

Allowing Insurers to Sell Across State Lines

The Price plan would permit insurers to offer health plans to people or small businesses in other states, even if the plans don't comply with the other states' requirements. The out-of-state plans would need to comply only with consumer protections in the state where they are licensed. That would encourage insurers to seek licensure in states with very weak regulations and consumer protections and where they exert substantial political influence.

The few states that tried to open their markets to out-of-state insurers before the ACA had little to show for it, as insurers had problems establishing networks of providers outside their own states. But, if out-of-state insurers did enter other state markets to a significant degree, less healthy individuals and small businesses whose workers are older or in poorer health would likely face much higher premiums as state consumer protections and market reforms would be effectively undermined. Out-of-state plans would mainly attract healthy people with low health care costs, since they have less need for consumer protections such as requirements to cover certain benefits or limits on insurers' ability to charge higher premiums based on age or gender. Meanwhile, sicker-

⁵ See Edwin Park, "Ways and Means Bill Would Dramatically Expand Health Tax Shelters for High-Income Earners," Center on Budget and Policy Priorities, June 20, 2016, <http://www.cbpp.org/blog/ways-and-means-bill-would-dramatically-expand-health-tax-shelters-for-high-income-earners>.

than-average people would generally remain in plans offered by in-state insurers, which would push up premiums for the in-state plans by saddling them with sicker beneficiary pools.

Establishing Association Health Plans (AHPs)

The Price plan would allow the establishment of AHPs that could offer health insurance to small business members and individuals (though the AHPs for individuals would be called independent health pools) and would be exempt from most state regulations applying to the individual and small-group markets. Like plans offered across state lines, AHPs would primarily attract individuals and small firms whose workers are healthier than average and *least* need strong consumer protections and market reforms. They could secure lower premiums through AHPs because they would be separating themselves from plans whose coverage pools contain less-healthy beneficiaries (along with healthy ones) and thus must charge higher premiums. The result would be to drive up premiums for non-AHP coverage, making coverage less affordable for those who are older and sicker.