
Revised February 6, 2015

Republican Health Plan Would Cause Millions to Lose Current Coverage and Add to the Ranks of the Uninsured and Underinsured

By Edwin Park

Senator Orrin Hatch (R-UT), Representative Fred Upton (R-MI), and Senator Richard Burr (R-NC) proposed yesterday to repeal most of health reform (the Affordable Care Act or ACA), convert Medicaid into a program whose federal funding is capped and no longer responds to changes in the costs of medical care, and create a modest new tax credit for people to buy health insurance in a largely unregulated individual market.¹ The plan lacks many essential details; there is no legislative language, and the bill's sponsors say they have no plans to produce it for the foreseeable future, thereby leaving the proposal vague in important respects.² Nevertheless, it seems clear the plan would:

- Result in millions of people losing their existing coverage through the marketplaces and Medicaid by repealing all of health reform's coverage expansions;
- Make coverage unaffordable for substantial numbers of low- and middle-income individuals through changes that would significantly raise their premiums, deductibles, and co-payments, likely adding millions of people to the ranks of the uninsured and underinsured;
- Eliminate or significantly weaken health reform's consumer protections and market reforms, especially for people aged 50-64 and many people with pre-existing health conditions, thereby placing 50-64 year-olds with modest incomes and people with serious medical conditions at risk of facing high insurance premiums they may not be able to afford;
- Leave states with shortfalls in federal Medicaid funding that could cause many poor beneficiaries to become uninsured or underinsured over time; and

¹ The Patient Choice, Affordability, Responsibility, and Empowerment Act, <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>.

² Erin Mershon, "Key GOP Lawmakers Outline an Obamacare Replacement Plan," *Politico*, February 4, 2015, <https://www.politicopro.com/story/healthcare/?id=43482>.

- Jeopardize employer-based coverage for some people who work at firms with fewer than 100 employees.

Loss of Existing Health Coverage for Millions

Many congressional Republican critics of the Affordable Care Act pounced last year on the fact that under it, a modest share of individuals who were already insured in the individual market wouldn't be able to maintain their existing coverage. In most cases, this was because their existing coverage was too restrictive to meet the ACA's basic standards of adequacy.

Under the Hatch-Upton-Burr plan, much larger numbers of people would lose their current coverage. They generally would end up with more limited coverage and, in many cases, would pay more out-of-pocket for that lesser coverage due to reductions in consumer protections and subsidies to help people afford coverage, elimination of the ACA's Medicaid expansion, and cuts in federal Medicaid funding.

For starters, the plan would eliminate all of the existing federal and state health insurance marketplaces (also known as exchanges), which allow individuals to make informed choices among an array of private plans and encourage insurers to compete on price and quality. It also would repeal all of the ACA's cost-sharing reductions and would replace the ACA's premium tax credits — which make buying private coverage through the marketplaces much more affordable for many low- and middle-income people — with tax credits that both are smaller and cut off at 300 percent of the poverty line (rather than at 400 percent, as under the ACA). Some 85 percent of the people who enrolled in marketplace plans during the 2014 open-enrollment period qualified for premium credits.

These changes would cause a large share of the 9.5 million people who were enrolled in marketplace plans for 2015 as of last month to lose such coverage, since the marketplaces and the health plans offered through them would no longer exist.³

The plan also would repeal health reform's Medicaid expansion, under which the federal government picks up nearly the full cost of covering newly eligible individuals with incomes below 138 percent of the poverty line. Twenty-eight states and the District of Columbia have taken up the expansion to date, and millions of people have gained coverage under it. In November 2014, nearly 9 million more people were enrolled in Medicaid in the expansion states than had been enrolled in 2013.⁴

Most of these people would lose that coverage. In its place, they would receive only the plan's relatively modest tax credit to help them purchase coverage in the individual market, where they generally would receive much less comprehensive coverage than under Medicaid. Given their limited incomes, most such people would have difficulty affording needed health care services that the narrower coverage in the individual market wouldn't provide. Moreover, they often would have

³ Department of Health and Human Services, "Nationwide 9.5 million consumers are signed up for Health Insurance Marketplace coverage," January 27, 2015, <http://www.hhs.gov/news/press/2015pres/01/20150127b.html>.

⁴ Centers for Medicare & Medicaid Services, "Medicaid & CHIP: November 2014 Monthly Applications Eligibility Determinations and Enrollment Report," February 2, 2015, <http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-november-2014-application-eligibility-and-enrollment-report.pdf>.

difficulty using even the health services their new insurance did cover, since they would receive no assistance whatsoever with deductibles or cost-sharing charges despite their low incomes.

Millions of additional people with coverage through either their employer or the individual market outside the marketplaces also would likely see their coverage disrupted as insurance companies — no longer subject to most of the ACA's consumer protections and market reforms — substantially altered their plans.

Higher Premiums, Deductibles, and Other Out-of-Pocket Costs

In place of the marketplaces and the Medicaid expansion, the Hatch-Upton-Burr plan would establish a new tax credit that people with incomes below 300 percent of the poverty line could use to purchase coverage in the individual market, which would come *without* many of the ACA's measures to protect consumers. The credit amount would differ for three age groups (ages 18-34, 35-49, and 50-64), but everyone in a given age group below 200 percent of the poverty line would receive the same credit, regardless of their specific income. The credit amount for an age group would phase out between 200 and 300 percent of poverty. People with incomes between 300 and 400 percent of poverty (between \$35,010 and \$46,680 for an individual), who are now eligible for the ACA's premium credits, would receive no help. In addition, while *legal* immigrants with modest incomes are eligible for the ACA's premium credits, they would be ineligible for the tax credit under the Hatch-Upton-Burr plan.

In still another significant change, the new tax credit would *not* be based on the cost of decent-quality coverage actually available to an individual in his or her place of residence, but instead would be uniform nationally, even though premiums vary considerably across the country. Nor would the tax credit fully account for differences in people's premiums based on their age. Insurers could charge older people *five times as much as younger people, even though the plan's tax credit for people aged 50-64 would be only 2.4 times larger than the credit for people aged 18-34.*

As a result, the tax credit for people aged 50-64 would be much smaller and less adequate than the premium credits provided today under health reform. For example, for a single 64-year-old with income at 150 percent of the poverty line, the new credit would be *one-third — or \$2,381 — smaller* than the average credit available under health reform, with the reduction being even larger in areas of the country with higher-than-average premiums. Many people in this age bracket would likely find coverage unaffordable.

The plan also would repeal health reform's cost-sharing reductions, which provide help with deductibles and co-payments for people with incomes below 250 percent of the poverty line, and not replace them with other assistance. Even if low- and moderate-income people could afford the premiums for health coverage after applying their tax credits, they often would face high deductibles and other cost-sharing charges they had serious difficulty affording. Moreover, the plan generally fails to place any limit on the total annual out-of-pocket costs a beneficiary can incur — another departure from health reform.

People with Pre-Existing Conditions at Particular Risk

The Hatch-Upton-Burr plan would place people with pre-existing conditions at particular risk. It would bar insurers from varying premiums based on health status *only* for people who, before

seeking coverage, previously had coverage through an employer or through the individual market for at least 18 consecutive months. Thus, if an individual with medical conditions had a break in coverage of a few months, this protection would not apply; insurance companies could charge such people much higher premiums, which many of them likely wouldn't be able to afford.

Consider, for example, a modest-income individual in a rural or suburban area who must drive to get to work but whose car breaks down and requires an expensive repair. If forced to forgo paying premiums for a few months in order to repair the car so he or she can keep their job, the individual could face a choice between paying premiums he or she can barely afford or going without insurance.

The plan also could jeopardize employer-based coverage at some firms with up to 100 employees. Its new tax credit would be available to all employees of these firms with incomes below 300 percent of the poverty line, who could use the credit to help purchase coverage in the individual market. Some employers with disproportionate numbers of low-wage workers might stop offering coverage on the assumption that their employees could use the credit instead.⁵ In addition, young, healthy employees whose employers continue offering coverage might find the credit attractive and leave their firm's plan. Those remaining in the employer plan then would tend to be older and less healthy, on average, causing its premiums to rise, perhaps quite substantially. That could ultimately lead the employer to cut back on the plan's coverage or drop the plan altogether. (Unlike under current law, the Hatch-Upton-Burr plan would not penalize employers with more than 50 full-time-equivalent employees that do not offer affordable, comprehensive coverage.)

Overall, many low- and middle-income individuals would lose their current marketplace or Medicaid coverage and face substantially higher premiums, deductibles, or other out-of-pocket costs than under the ACA. Many would likely find coverage unaffordable and either become uninsured or purchase very limited coverage and become underinsured. Millions more people would likely be uninsured or underinsured than under the ACA.

Substantial Medicaid Funding Shortfalls for States

The Hatch-Upton-Burr plan fundamentally alters the federal financing structure for Medicaid, under which the federal government now pays a fixed percentage of states' Medicaid costs (the percentage varies by states and averages 57 percent). The plan appears to do so in two ways, both of which represent radical changes in the Medicaid program.

⁵ The plan also allows funds held in Health Savings Accounts (HSAs) to be used to pay premiums for HSA-eligible, high-deductible health insurance plans, which would further increase the risk that some employers drop health coverage. Because HSA contributions are tax-deductible, this would allow individuals to effectively deduct the premium cost of their high-deductible plans whether offered through an employer or the individual market. A large body of research finds that allowing a tax deduction for the purchase of coverage in the individual market would likely lead some employers to no longer offer coverage to their employees. Moreover, the value of a tax deduction rises with one's tax bracket, and a smaller firm may be more likely to drop coverage on the assumption that the owner and other highly compensated employees could make tax-deductible HSA contributions and use those funds to pay individual-market premiums (while lower income workers could use the tax credit). See, for example, Edwin Park and Jeannie Biniek, "Republican Study Committee Health Plan Would Likely Result in Many More Uninsured and Fewer Consumer Protections," Center on Budget and Policy Priorities, September 23, 2014, <http://www.cbpp.org/cms/index.cfm?fa=view&id=4209>.

Capping Funding for Health Care for Parents and Children

The plan would repeal the ACA's Medicaid expansion and generally bar states from using federal Medicaid funds to cover any poor adults, other than the elderly and people with serious disabilities, who aren't raising children. It also would apparently end the current financing structure for covering parents, children, and pregnant women by placing a cap on the amount of federal funds per beneficiary that a state may receive. It also would apparently end the Children's Health Insurance Program (CHIP) and fold it into the newly capped Medicaid program.

If a state's actual costs in providing covered health services to these groups exceeded the federally imposed per-beneficiary cap, the state would have to pay 100 percent of all costs above that limit.

The per-capita ceiling amounts imposed on states would likely prove inadequate, especially over time, because they generally would not keep pace with health care costs. The per-beneficiary cap amounts would grow from year to year at a rate equal to the increase in the Consumer Price Index plus 1 percentage point, which would fall significantly short of expected growth in federal Medicaid costs per beneficiary for these beneficiary groups under current law, as estimated by the Congressional Budget Office.

The shortfalls in federal funding that states would face would be still larger if Medicaid costs per beneficiary rose faster than anticipated, due to factors such as an epidemic (like the HIV-AIDS epidemic that first hit in the 1980s) or the development of new blockbuster drugs or other treatments that save lives but carry high costs. Under current law, federal Medicaid funding rises automatically when such developments occur; the federal government and the states *share* in such costs. Under the Hatch-Upton-Burr plan, by contrast, federal funding would no longer respond to such developments, making the potential federal Medicaid funding reductions larger for states and likely leading states to impose substantial Medicaid cuts.

Block Grant for Long-Term Care

In addition, federal Medicaid funding for long-term care services and supports would apparently be converted into a block grant under which states would receive a fixed annual amount to provide long-term care services and supports to seniors and people with disabilities.⁶ While *total* federal block-grant funding for long-term care would appear to be based initially on the historical level of Medicaid spending on long-term care nationally, each state's individual share of the block grant funds would reflect its number of poor people (it's unclear whether this entails the number of all state residents living in poverty, poor seniors, or some other measure), not the state's actual Medicaid long-term care costs. Long-term care costs vary across states, so this formula would cause particularly large disruption in areas with above-average long-term care costs.

Federal funding under the long-term care block grant would be adjusted in some unspecified way to reflect general inflation, population growth, and other demographic changes. Those adjustments,

⁶ For background on Medicaid block grant proposals, see Edwin Park, "Medicaid Block Grants or Funding Caps Would Shift Costs to States, Beneficiaries, and Providers," Center on Budget and Policy Priorities, January 6, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3363>, and Edwin Park and Matt Broaddus, "Medicaid Block Grant Would Shift Financial Risks and Costs to States," Center on Budget and Policy Priorities, February 23, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3409>.

however, are unlikely to fully account for the aging of the population or increases in long-term care costs. For example, over the next several decades, Medicaid expenditures per beneficiary for elderly individuals will grow more rapidly than in the past because the large baby-boom generation will move from “young old-age” to “old old-age,” when average health and long-term care costs are considerably higher. Average Medicaid costs for seniors aged 85 and older are more than 2.5 times higher than those for seniors aged 65-74, due in large part to greater long-term care needs.

In short, under both the per-capita cap for pregnant women, children and parents and the block grant for long-term care services and supports, states would face significant risk of sizeable Medicaid funding shortfalls that likely would grow over time. As a result, states would either have to contribute more of their own funds or, more likely, use the increased flexibility they would be given under the per-capita cap and the block grant to cut back eligibility, benefits, and payments to health care providers. Substantial numbers of poor Medicaid beneficiaries could end up uninsured or underinsured.

Much Weaker Consumer Protections and Insurance Market Reforms

The Hatch-Upton-Burr plan would allow insurers to impose a number of restrictions not allowed under health reform, such as placing an annual dollar limit on the coverage they provide to a beneficiary and requiring cost-sharing for *preventive* care, which would reduce the use of such care. The plan would also repeal the ACA’s limits on the annual out-of-pocket costs that a beneficiary can incur. (The ACA limits are \$6,600 for individuals and \$13,200 for families in 2015.) Also, while the plan contains a requirement for insurers to cover adult children up to age 26 on their parents’ plans, it would allow states to drop the requirement.

In addition, insurers in the individual and small-employer market could charge women higher premiums than men, as they could before the ACA in many states. As noted, insurers also could charge older people five times (or more, if the state so elected) what they charge younger people, rather than the ACA’s 3-to-1 ratio. And, unlike under the ACA, insurers could offer plans in the individual and small-group markets that leave big gaps in coverage by omitting important benefits such as maternity care or even prescription drug coverage, as plans in such markets could do before health reform.

As explained above, people with pre-existing conditions would face additional problems. Insurers would be barred from varying premiums or denying coverage based on health status only for people who previously had coverage through an employer or through the individual market for 18 consecutive months. Yet some 36 percent of Americans aged 4 to 64 — 89 million people — had at least one month without coverage between 2004 and 2007, and about one-quarter of this group lost coverage more than once.⁷

People who were uninsured at the time the new Hatch-Upton-Burr plan took effect would have a *one-time* initial enrollment period in which they could not be denied coverage in the individual market or charged higher premiums based on their medical conditions. But outside that one-time period, insurers could charge higher premiums based on health status or refuse to cover a pre-existing condition for some period of time.

⁷ See Pamela Short, Deborah Graefe, Katherine Swartz, and Namrata Uberoi, “New Estimates of Gaps and Transitions in Health Insurance,” *Medical Care Research and Review*, Vol. 69:6, December 2012.

The sole alternative the plan provides for people with pre-existing conditions who don't enroll during the one-time enrollment period or who experience a subsequent break of a few months (or more) in coverage is a vague provision to provide an unspecified amount of federal funding for states to operate "high-risk pools." (The plan seems to allow a state to make a high-risk pool the *only* form of coverage that a previously uninsured person with a pre-existing condition could buy during the one-time enrollment period, though that isn't clear.) Such coverage likely wouldn't be affordable even for many individuals eligible for the plan's tax credit. State high-risk pools have typically charged premiums equal to 1.5 times the standard premium for an individual's age, and as noted, the plan's tax credit doesn't fully adjust for differences in premiums based on age, let alone for the higher premium charges for coverage through a high-risk pool.

Moreover, relying on high-risk pools to provide coverage would be "extremely expensive and likely unsustainable," as the Commonwealth Fund has explained.⁸ That's because these mechanisms pool sick individuals *not* with healthy individuals, as regular insurance pools do to keep premiums stable and affordable, but with *even sicker* individuals who cost even more to insure. If only sicker high-cost individuals opt to enroll in these pools because of the large premium costs, that would drive up premiums more, which could eventually discourage enrollment except among the sickest individuals with the highest medical costs.

Unless government financial support for such pools rose significantly over time to compensate, the pools eventually could have to sharply restrict or cap enrollment, set premiums even further above what many families could afford, and/or scale back coverage by reducing benefits or increasing deductibles and other cost-sharing to keep costs from spiraling out of control.

There is no indication that the Hatch-Upton-Burr plan would provide adequate initial funding for the high-risk pools or assure that federal support would grow over time as needed. A recent Commonwealth Fund study estimates that an adequately funded national high-risk pool to cover most of the uninsured with pre-existing conditions and high health costs would cost 40 percent more annually than the annual net cost of all the ACA's coverage expansions combined, while covering 45 percent fewer of the uninsured than under the ACA.⁹

Conclusion

The Hatch-Upton-Burr plan claims to provide affordable coverage and improved access to care as a replacement for the Affordable Care Act. But relative to current law, the plan would likely disrupt existing coverage for millions of people — including many poor beneficiaries who rely on Medicaid today — and cause many of them to become newly uninsured or underinsured. It would move the United States backward, toward the poorly functioning individual market that existed prior to health reform.

⁸ Jean P. Hall and Janice M. Moore, "The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform," Commonwealth Fund, September 2012, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Sep/1627_Hall_PCIP_enrollment_costs_lessons_rb.pdf.

⁹ Jean P. Hall, "Why a National High-Risk Insurance Pool Is Not a Workable Alternative to the Marketplace," Commonwealth Fund, December 2014, http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/dec/1792_hall_highrisk_pools.pdf.