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Cassidy-Collins Proposal Would Weaken ACA's Coverage and Consumer Protections

Bill Would Leave Millions Uninsured or Underinsured

By Sarah Lueck

Senators Bill Cassidy and Susan Collins say their legislation to replace the Affordable Care Act (ACA) would allow people who like the coverage they have to keep it and states that support the ACA to maintain it. In reality, however, their bill would almost certainly take health insurance and access to care away from many millions who now rely on ACA health coverage, especially those with low incomes and pre-existing health conditions.

Under the Cassidy-Collins bill, states would be assigned by default into a plan that would repeal most of the ACA's market reforms, benefit standards, and consumer protections and eliminate the individual and employer mandates. The default plan would also cap and cut the funding available for subsidies to purchase coverage in the individual market and encourage states to opt for a capped amount of federal funds in exchange for dropping (or never adopting) the ACA's Medicaid expansion.

The bill would give states the option to reinstate the ACA, but they would likely have to pass new state legislation to do so. Even if states were able to overcome considerable political and practical obstacles to restore the ACA coverage provisions, Cassidy-Collins would provide reduced federal resources, and current marketplace enrollees could find coverage increasingly unaffordable. As a third option, the Cassidy-Collins bill would let states reject all federal assistance for coverage, effectively repealing the ACA with no replacement.

Moreover, the bill, especially the default plan, would rely heavily on a new type of Health Savings Account (HSA) that people could draw upon to purchase health insurance or pay out-of-pocket costs. The "Roth HSAs" that the Cassidy-Collins bill proposes as replacements for the ACA's premium and cost-sharing subsidies would do little to help low- and moderate-income people afford adequate health insurance. Their main effect would be to greatly expand tax-sheltering opportunities for high-income people.[1]

[1] Edwin Park *et al.*, "Roth HSAs in Cassidy-Collins Plan: Little for Most Workers, Tax Shelters for the Top," Center on Budget and Policy Priorities, February 2, 2017, http://www.cbpp.org/research/health/roth-hsas-in-cassidy-collins-plan-little-for-most-workers-tax-shelters-for-the-top.

How the Cassidy-Collins Proposal Would Work

The plan offers states three options:

1. An "alternative" option, under which most ACA market rules and consumer protections would be eliminated, allowing individual-market insurers to again charge higher premiums to people with pre-existing conditions (if they don't maintain continuous coverage), drop or limit coverage of essential health benefits such as maternity care and prescription drugs, and charge unlimited deductibles, co-insurance, and co-payments. In "alternative" states, the marketplace subsidies that people now receive would be replaced with a capped amount to be contributed to a new type of HSA.
2. A state could opt to reinstate the ACA, including the marketplace subsidies, the market protections for consumers, and the individual and employer mandates, but with reduced funding. The bill would cap marketplace subsidies at 95 percent of what they would have been under the ACA.
3. A state could refuse all federal funds. Most ACA market rules and consumer protections would be eliminated in these states, but Cassidy-Collins would require them to abide by a limited set of federal insurance standards (such as prohibiting pre-existing conditions, a ban on annual and lifetime limits, and requiring plans to cover people on their parents' plans until age 26).

If a state does nothing, it would default to the "alternative" option. The bill sponsors have said they would expect most states to select this option. While the bill's effective date is January 2018, Sen. Cassidy said he expects states to spend 2018 and 2019 choosing an option and implementing it, or letting the default take effect, so that the new structure is in place by 2020.[2]

Bill's Default Option Would Repeal Most ACA Consumer Protections and Coverage Provisions

Under the Cassidy-Collins bill's default "alternative" for all states, the plan would drop or roll back most of the ACA's market reforms and consumer protections that now apply, eliminate the individual and employer mandates, and repeal the ACA's marketplace subsidies one year after date of enactment. Cassidy-Collins would:

- **Weaken consumer protections.** While the bill would maintain the requirement that virtually all insurance plans offer coverage to adults up to age 26 on their parents' plans, the ban on pre-existing condition exclusions, and the prohibition on lifetime and annual limits, it would again permit insurers to charge many people higher premiums because they have a pre-existing condition (as discussed further below). Moreover, the bill would drop the requirement that individual-market and small-group plans cover "essential health benefits," which means that insurers would no longer have to cover services such as prescription drugs and maternity care

[2] "Affordable Care Act Replacement," news conference by Senators Bill Cassidy and Susan Collins, C-SPAN, January 23, 2017, https://www.c-span.org/video/?422476-1/senators-cassidy-collins-propose-alternative-affordable-care-act.

as federal law currently requires.[3] Insurers would be allowed to revert back to the pre-ACA individual market, when many plans lacked key benefits: In 2011, 62 percent of enrollees had plans without maternity coverage, 34 percent had plans without substance abuse services, 18 percent had plans without mental health care, and 9 percent had plans without prescription drugs.[4] They could also charge unlimited deductibles, co-payments, and co-insurance. In particular, plans would no longer be required to cap consumers' yearly out-of-pocket spending, affecting people in individual-market plans and those with employer coverage, millions of whom had plans prior to the ACA that did not protect them from catastrophically high costs. The bill would also repeal the requirement that each insurer in the individual and small-group market pool together all its enrollees in each market when pricing its plans. This would allow insurers to once again set the base price for a plan based on whether it is expected to attract a healthier population (making it cheaper) or a group with higher health costs.

- **Replace the ACA's comprehensive protections for people with pre-existing conditions with a harsh "continuous" coverage requirement, which might not even protect those who meet it.** The bill would make the individual market much less accessible than it is today for people with health conditions because it would fail to protect the millions of people in this group who experience gaps in coverage, and might even fail to protect those who don't.

  Under the Cassidy-Collins bill, people who have "continuous coverage" — defined as 18 months with a break of no more than 63 days — would not be subject to higher premiums due to their health status, nor would they face pre-existing condition exclusions. But people who do not meet the continuous coverage standard would be guaranteed access only to a high-deductible plan that meets minimal federal standards, including coverage of generic drugs for a "limited number of chronic conditions," coverage of childhood vaccines, and an "adequate" network of health care providers. Such plans would not have to cover brand-name drugs, maternity care, or the full set of preventive services required by the ACA.

  The concept of reducing protections for people who don't have continuous coverage is meant to encourage people to maintain health insurance even when they are healthy — in place of the ACA's individual mandate, which the Cassidy-Collins bill would eliminate. But continuous coverage requirements are likely to be less effective than the mandate in ensuring a broad risk pool and keeping coverage affordable because, to motivate young and healthy consumers to sign up for coverage, they rely on the threat of restrictions and penalties that would apply only if a person gets sick in the future. Meanwhile, continuous coverage requirements harshly penalize people who have health issues and have difficulty maintaining gap-free coverage (for example because they have limited incomes and no access to employer-sponsored health benefits).[5] Significant numbers of people would likely run afoul of the continuous coverage requirement because short gaps in coverage are quite common, including

[3] The bill would require insurers in the individual and small-group markets to continue to cover substance use disorders and services related to "serious" mental illness, but not the full array of mental health conditions plans must cover today. The legislation does not define "serious" mental illness.

[4] "Essential Health Benefits: Individual Market Coverage," Assistance Secretary for Planning and Evaluation, Department of Health and Human Services, December 26, 2011.

[5] Linda J. Blumberg and John Holahan, "The New Bipartisan Consensus for an Individual Mandate," April 2015, http://www.urban.org/research/publication/new-bipartisan-consensus-individual-mandate.

among people who have pre-existing health conditions.[6] And Cassidy-Collins would make it very difficult for a person to regain "continuous coverage" status once they have experienced such a break.

Meanwhile, if insurers are allowed to charge healthy people *lower* premiums based on their health status — as the Cassidy-Collins bill appears to permit — then even people with pre-existing conditions who *do* maintain continuous coverage could find themselves without affordable options. Among the people who have maintained continuous coverage, healthy people will volunteer to have insurers consider their health status in order to obtain a cheaper premium. Insurers will then price their products factoring in the assumption that anyone who does not choose to undergo medical underwriting has an expensive pre-existing condition. As a recent American Academy of Actuaries paper notes, this would return the market to a "pre-ACA environment," in which healthier people (including those who have been uninsured or had gaps in coverage) would be able to access affordable coverage, while sicker people could have less generous, very expensive, or no coverage options.[7]

- **Replace marketplace subsidies with tax credits deposited in HSAs.** In place of the ACA's marketplace subsidies that now help millions of people pay their premiums and out-of-pocket medical costs, the federal government would offer a tax credit to be contributed to a new type of HSA, which could be used for both premiums and cost-sharing. (See below for more on these "Roth HSAs.") But the tax credits would be 95 percent of the funds the ACA would have provided for subsidies — and this lesser amount would be spread among a much larger group of people, including individuals at higher income levels than currently qualify for marketplace subsidies (Cassidy-Collins would extend eligibility up to $190,000 for individuals and $250,000 for couples). People with access to employer-based coverage would also be eligible.

  The plan would thus leave far less help for lower-income people who would be uninsured but for the ACA subsidies that make good-quality coverage affordable. Moreover, it isn't at all clear that the capped amount, to be set by the Health and Human Services (HHS) Secretary, would adequately adjust for higher-than-expected enrollment or premium growth, as the current ACA subsidy structure does. So marketplace enrollees may well find coverage increasingly unaffordable and be even more likely to end up uninsured or underinsured over time.

  States implementing the default "alternative" could also automatically enroll their residents who lack other coverage into a high-deductible plan and set up a new type of (HSA on their behalf.
- **Create fiscal incentives for states that haven't taken the Medicaid expansion not to adopt it and for expansion states to drop it**. States that haven't yet expanded Medicaid would receive additional federal funding as part of their capped amount, with no requirement that they expand coverage. Meanwhile, states that did expand Medicaid would be encouraged to end expansion and instead accept an increase in their capped funding for tax credits.

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[6] Pamela Farley Short *et al.*, "New Estimates of Gaps and Transitions in Health Insurance," *Medical Care Research and Review*, July 24, 2012, http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance. See also U.S. Department of Health and Human Services, "Health Insurance for Americans with Pre-Existing Conditions: the Impact of the Affordable Care Act," January 5, 2017.

[7] American Academy of Actuaries, "An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes," January 2017, p. 22, https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

Specifically, the bill offers these states an increase in their allotments based on what the federal government would have provided under the Medicaid expansion, assuming a permanent 95 percent federal match rate. (Under the ACA, federal funding drops to a 94 percent federal match in 2018 and eventually down to 90 percent in 2020.) States focusing on short-term budget issues could be tempted to take that offer. If they did, the funds would merely be added to the total amount the state would receive in place of ACA marketplace subsidies that would be deposited into state residents' HSAs: they would not be available to continue Medicaid coverage for the expansion population.

For low-income individuals, private coverage with an HSA would be far inferior to Medicaid coverage. Not only would none of the usual Medicaid protections apply, but, because the bill repeals the ACA's individual-market consumer protections (as discussed above), low-income individuals could end up in plans that do not cover mental health, prescription drugs, or maternity care; have unaffordable deductibles and other cost-sharing changes; and charge high premiums to individuals with health conditions if they ever experience gaps in coverage.

States could choose to dedicate the resources they would have otherwise used for expansion to supplementing coverage or increasing tax credits for these individuals, but they would not be required to do so. The additional funds states would receive in their capped allotments would not be earmarked specifically for people who would have otherwise been covered by the Medicaid expansion. States would also be allowed to reduce their own spending on this population, meaning less total assistance going to poor and near-poor individuals; the bill does not appear to require a state match. Moreover, capped federal funding would mean federal funding to states would no longer increase in response to a surge in enrollment or health costs, making it likely that states would reduce already inadequate tax credits under these circumstances.

Bill's Other Options Also Would Worsen Coverage and Affordability

The bill gives states two choices for opting out of its default approach, both of which would worsen coverage and affordability compared to today.

- A state could elect to reinstate the ACA. For a state making this decision, the ACA provisions the bill otherwise rolls back would be left in place, including the market protections for consumers, the mandates, and the marketplace subsidies. The bill, however, doesn't specify what the state must do to elect the option besides providing "written notice." According to a fact sheet issued by the bill's sponsors, state legislatures would have to vote to reinstate ACA provisions.[8] That means that even in states where many leaders strongly support the ACA, bitter political divisions could result in them not taking timely action to reinstate the ACA, leaving the default approach in place.

  Even if a state successfully reinstated the ACA, federal funding for the subsidies would drop significantly. As under the default option, the Cassidy-Collins bill would cap federal funding for marketplace subsidies at 95 percent what would have been spent under the ACA. Moreover, as noted above, this capped amount may not adequately adjust for higher-than-expected enrollment or premium growth, as the current subsidy structure does. In a bid to

[8] "Patient Freedom Act: Better Choices for Affordable Health Care," http://www.cassidy.senate.gov/imo/media/doc/2.14%20One%20Pager.pdf, accessed March 9, 2017.

increase premium affordability, states that otherwise would want to maintain current benefits and out-of-pocket protections may need to scale back marketplace plans' comprehensiveness. Marketplace enrollees may thus find coverage increasingly unaffordable and end up uninsured or underinsured.

In addition, while the individual and employer mandates would remain "binding" on a state taking this option, it isn't clear whether the federal government would continue collecting the necessary information and penalties through the federal tax system as it now does, or whether states would have to take additional measures to implement these mandates within their own borders.

- A state could reject any federal assistance. Cassidy-Collins would still require insurers in these states to abide by the ACA rules that would be retained in all states which, as noted, include a requirement for plans to cover people up to age 26 on their parents' plans and a ban on lifetime and annual limits. But all other ACA consumer protections would be repealed, allowing a return to pre-ACA practices including denying coverage based on pre-existing conditions. In addition, there would no longer be an individual or employer mandate in these states, nor any federal subsidies, benefit standards, or other market reforms and consumer protections. Any state that decided to reject all federal funding would be unlikely to take the necessary actions at the state level to create a stable, functioning private market that maintains adequate coverage and protection against out-of-pocket costs to its residents. People in states that chose this option would be much worse off than they are today.

Bill Would Increase Tax Sheltering for the Wealthy Using New Roth HSAs

Existing HSAs are tax-advantaged accounts available to people who have a high-deductible health plan to save money to pay out-of-pocket health expenses. Cassidy-Collins would convert current HSAs into "Roth HSAs," combining elements of current HSAs and Roth Individual Retirement Accounts.[9]

Cassidy-Collins would enable anyone in any state to create a Roth HSA, no matter which option a state chose and, consequently, no matter whether the individual is eligible for subsidies. In addition, the bill would allow anyone with health coverage to set up a Roth HSA, not just those with high-deductible plans — dramatically expanding eligibility for HSAs. Moreover, the bill would sharply increase the amounts that people could contribute to HSAs each year, including high-income people who are most able to contribute the maximum amounts to HSAs today.

The expanded eligibility for Roth HSAs, coupled with the increased contribution limits, would provide major new tax-sheltering opportunities for high-income people. They could make large contributions to these tax-favored accounts year after year and let their savings grow tax-free over time, securing a substantial new tax break. The costs of the Roth HSA proposal would likely swell over time as investments in HSAs accrue without tax and as people make tax-free withdrawals to pay for medical and long-term costs upon retirement that they would have otherwise drawn from taxable income.

Meanwhile, this Roth HSA approach is a highly ineffective way to help low- and moderate-income people afford quality health coverage. Proponents of HSAs as a way for working people to afford

[9] See Park *et al., op cit.*

health care envision workers making contributions to the accounts that will grow over time as tax savings accumulate. But unlike higher-income people, many low- and moderate-income workers are unlikely to have much income to contribute to these accounts. And because many in "alternative" states would use the proposal's inadequate tax subsidies as their primary means to pay for premiums and other health costs, they would likely exhaust their HSA contributions quickly — therefore not benefiting from the future tax savings on investment gains the accounts provide. As a result, the tax savings from accumulations are unlikely to amount to much for low- and moderate-income people, likely making the opportunity for future tax savings a false promise, and coverage less affordable — not more.

Cassidy-Collins Would Present Tough Challenges for States

The Cassidy-Collins bill would require states to revisit their political struggles and administrative challenges over the ACA and act quickly to implement changes, including through legislation, regulation, and/or executive order. The major changes in the bill take effect one year after its passage, though Sen. Cassidy has said at that point that states would spend two years choosing an option and implementing needed changes.

But states are unlikely to be able to act quickly or easily in response to legislation like Cassidy-Collins. They would need significant time to work through the details, even in cases where governors and legislatures agree on what to do. They would need to give insurers that operate in their markets direction about what rules to follow, with additional time needed in states that diverge from the ACA's requirements. As noted, no matter how much a state might want to maintain the status quo, Cassidy-Collins proposes capped and reduced federal funding, making it difficult — or perhaps impossible — for states to follow through on that promise.

Finally, the proposal doesn't do anything to ensure that insurance companies would continue to offer plans in states' individual markets or that they would keep premiums affordable as states shift from the current ACA-based structure to the new one. Passage of Cassidy-Collins would immediately create unprecedented uncertainty in insurance markets, with the rules of the road up for grabs in every state. Without additional, rapid efforts, a state's individual market could unravel before Cassidy-Collins takes full effect. Residents of the state would abandon their coverage, enrollment in the individual market would shrink, and insurers would likely flee if nothing more than Cassidy-Collins were put in place.

So while Senators Cassidy and Collins tout their plan as a way to give states choices to maintain or reject the ACA and let people keep the coverage they have now, it doesn't appear that the plan would achieve those goals. Instead, Cassidy-Collins would undo the Affordable Care Act, which has improved millions of people's access to health coverage and medical services, and leave states to decide what, if any, "replacement" they could establish despite more limited federal resources. The result likely would be less affordable health coverage and many more people uninsured or underinsured than under the ACA.