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Senate Republican Health Plan Would Likely Result in More Uninsured and Fewer Protections for Consumers

By Edwin Park

Senate Republicans Richard Burr (NC), Tom Coburn (OK), and Orrin Hatch (UT) announced in January a plan to repeal all of health reform except for certain Medicare provisions — and to replace it with an insurance system that converts much of Medicaid into block grants and creates a new tax credit for people to buy health insurance primarily in the individual market.[1] The plan has large gaps and lacks many essential details, and its authors have provided no additional information or legislative language. But based on the public information available, the Burr-Coburn-Hatch plan likely would:

- Add substantially to the ranks of the uninsured and the underinsured by causing millions of people to lose their existing coverage and by making (or leaving) coverage unaffordable for many people of limited means through changes that would cause their premiums, co-payments, and other out-of-pocket charges to climb significantly;

- Lead to states facing large shortfalls in federal Medicaid funding that could cause many low-income beneficiaries to become uninsured and go without needed care; and

- Eliminate or significantly weaken health reform's consumer protections and market reforms, especially for people with pre-existing conditions.

Adding to the Ranks of the Uninsured and Underinsured

The Burr-Coburn-Hatch plan would repeal health reform's Medicaid expansion, under which the federal government will pick up nearly the full cost of covering individuals up to 138 percent of the poverty line. (Twenty-six states and the District of Columbia have taken up the expansion to date.) The estimated 13 million people who now stand to gain Medicaid coverage would lose out, along

[1] "The Patient Choice, Affordability, Responsibility, and Empowerment Act: A Legislative Proposal," January 2014, http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=871b0ef8-7705-4f72-aef2-e81d01b9c009. See also "The Patient Choice, Affordability, Responsibility, and Empowerment Act: Frequently Asked Questions," January 2014, http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=a7d4414d-3405-472d-9367-6c2f4ed1d581. The plan would appear to leave health reform's Medicare provisions in place except for the provisions establishing the Independent Payment Advisory Board and those related to the Medicare payroll tax, which it would repeal.

with those people eligible for Medicaid even without the expansion who could lose coverage because of the likely federal funding shortfalls from the block grant as discussed below.

The plan would also eliminate the new health insurance marketplaces (also known as exchanges), which allow individuals to make an informed choice among an array of private plans and thus encourage insurers to compete on price and quality. In addition, it would repeal health reform's premium tax credits and cost-sharing reductions, which make buying private coverage through the marketplaces much more affordable for low- and moderate-income people.[2] That would result in millions of people who are newly enrolled in marketplace plans losing such coverage.

While repealing the Medicaid expansion and marketplace subsidies, the plan would establish a new tax credit for individuals who don't work for a larger employer (one with more than 100 workers) and have incomes below 300 percent of the poverty line. They could use the credit to buy coverage through either their small employer (if offered) or in the individual market. The credit amount would differ by age group, but all individuals below 200 percent of the poverty line in a given age group would receive the same credit, regardless of their income. The plan expects tax credits to equal about $1,560 for individuals aged 18-34, $2,530 for individuals aged 35-49, and $3,720 for individuals aged 50-64.[3] The credit would phase out between 200 and 300 percent of the poverty line. This design raises serious concerns:

- People with incomes between 300 percent and 400 percent of the poverty line, who can receive premium tax credits under health reform, would receive no help. Similarly, legal immigrants — who are eligible for health reform's premium tax credits — would be ineligible for the Burr-Coburn-Hatch plan's tax credits. Unlike under health reform, individuals who work for larger employers that do not offer coverage (or offer coverage that is not affordable or comprehensive) would also receive no assistance.

- The tax credit is set at a fixed amount irrespective of the actual cost of decent-quality coverage or whether coverage would be affordable to the individual. Under health reform, in contrast, marketplace subsidies are based on the cost of the second-lowest-cost "Silver" plan actually available to an individual, and individuals' share of the premium is capped at a percentage of their income. For example, under health reform, individuals with incomes at 150 percent of the federal poverty line can use premium tax credits to buy marketplace coverage and pay no more than 4 percent of their income in premiums for such a Silver plan.

- The tax credit amount also doesn't adequately account for differences in people's premiums based on their age. As noted below, insurers could charge older people five times as much (or even more if their state permits it) as younger people. Yet the credit for people aged 50-64 is only 2.4 times larger than the credit for people aged 18-34.

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[2] The plan would also repeal health reform's individual mandate, which spurs the uninsured to enroll in the insurance options now available — through their jobs and public programs like Medicaid and the Children's Health Insurance Program (CHIP), as well as subsidized coverage through the marketplaces, which the plan would repeal.

[3] The plan states that the age-adjusted amounts would be larger for families: $3,400 for families aged 18-34, $6,610 for aged 35-49 and $8,810 for families aged 50-64. It is unclear what this means, as families would likely include adult family members of different ages. It is also unclear what the credit amount would be for children under age 18.

- As a result, the tax credit is considerably less generous than the premium tax credits under health reform. For example, for a single 64-year-old with income at 150 percent of the federal poverty line, the amount of the Burr-Coburn-Hatch plan's tax credit would be $3,720 — about 46 percent less than the credit available under health reform ($6,916, on average).

- As discussed below, uninsured people with pre-existing health conditions would face substantial difficulties obtaining coverage and might have to pay higher premiums or buy costly coverage through a high-risk pool, without any corresponding increase in their tax credit.

- The plan would not replace health reform's cost-sharing reductions, thus offering no help with plan deductibles, co-payments, and co-insurance for people with incomes below 250 percent of the poverty line. Even if low- and moderate-income people could afford to pay the premiums for health coverage after applying their tax credit, they would likely face deductibles and other cost-sharing charges they often could not afford. Moreover, the plan does not limit total annual out-of-pocket costs generally, unlike under health reform.

  As noted below, the health coverage also would likely include significant gaps in benefits, such as prescription drugs or maternity coverage, as health insurance in the individual market would no longer have to provide a comprehensive array of benefits. As a result, even if low- and moderate-income people gained coverage, many of them would likely forgo some needed care and would lack meaningful financial protection for catastrophic illness.

- Since the plan would repeal health reform's medical-loss ratio requirement that insurers spend at least 80 percent of their premiums on health services rather than overhead and profit, individuals would likely pay higher premiums for less coverage. Moreover, insurers would no longer be subject to federal or state review of proposed annual premium rate increases of more than 10 percent in order to determine whether or not such increases were reasonable, making such premium increases more likely.

In addition, the bill would also repeal health reform's excise tax on high-cost employer-sponsored plans and instead cap the tax exclusion under which contributions to the cost of health insurance are exempt from both income and payroll taxes. (Employees can also often pay their share of the cost of job-based coverage on a pre-tax basis; the cap would appear to apply to the total cost of the plan including *both* the employee share as well as the employer share.) The cap would be set at "65 percent of the average market price for an expensive high-option plan."[4] The bill does not specify what constitutes such a plan.

An outside analysis of the plan touted by the plan's sponsors, however, assumed that the cap would be set at $5,400 for individual coverage and $11,250 for family coverage in 2013 dollars, adjusted annually by inflation plus 1 percent.[5] That's far below the thresholds for health reform's

[4] See "Patient CARE Act, Making the Tax Code More Fair and Efficient for All Americans," January 2014, http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ee64bd80-5830-4c9b-acd5-b4225cbc1cd8.

[5] See Center for Health and Economy, "The Patient Choice, Affordability, Responsibility, and Empowerment Act," January 30, 2014, http://healthandeconomy.org/the-patient-choice-affordability-responsibility-and-empowerment-act/.

excise tax which, starting in 2018, applies to employer plans whose total cost exceeds $10,200 for individual coverage and $27,500 for family coverage, with additional adjustments for age and gender, retirees and workers in high-risk jobs. According to the Kaiser Family Foundation, average premiums for employer-sponsored insurance in 2013 were $5,884 for individual coverage and $16,351 for family coverage, which indicates that a substantial share of employers would likely be affected if the bill's cap on the tax exclusion were set at the thresholds that the friendly analysis of the bill assumes.[6]

As a result, this provision could result in a significant share of employers with fewer than 100 workers no longer offering coverage to their employees — particularly firms with older workers in poorer health and firms located in higher-cost areas that face greater premium costs — on the assumption that their workers could instead use the plan's tax credits to purchase health insurance in the individual market. As noted, however, that individual-market insurance often would come with large coverage gaps especially for older workers and many people with pre-existing conditions, as further explained below. Unlike under current law, the plan would *not* include an employer responsibility requirement to penalize employers with more than 50 full-time-equivalent employees that do not offer affordable, comprehensive coverage to their workers. Many people who now have job-based coverage could be at risk of losing that coverage.

Altogether, the plan would likely disrupt existing health insurance coverage — through Medicaid, the marketplaces, and employer-sponsored insurance — for millions of people, while making it much more difficult for millions more who are without health insurance today to gain it in coming years as is now projected to occur. Low- and moderate-income income individuals would likely face much higher premiums, deductibles, and other out-of-pocket costs than under health reform, especially poor and near-poor individuals who would otherwise be eligible for Medicaid and people in their 50's and early 60's who would otherwise buy subsidized coverage through the marketplaces. Many would likely find coverage unaffordable, and as a result, many more people would be uninsured or underinsured than under current law.

Weakening Medicaid

While this aspect of the Burr-Coburn-Hatch plan has received relatively little attention, the plan apparently would convert much of Medicaid into a block grant and fold the Children's Health Insurance Program (CHIP) into that block grant.[7] States would receive fixed federal Medicaid funding to cover pregnant women, children, and low-income families. They would receive a separate block grant to provide long-term care services and supports to seniors and people with disabilities.

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[6] Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2013 Annual Survey," August 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf.

[7] 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.

Medicaid's existing financing structure would remain for acute care services furnished to "dual eligibles" (low-income Medicare beneficiaries also on Medicaid) that Medicare doesn't cover, and for low-income people with disabilities who aren't eligible for Medicare. It is unclear how the plan would treat the current Medicaid assistance that helps dual eligible beneficiaries pay their Medicare premiums and/or cost-sharing charges, which many of these individuals otherwise can have considerable difficulty affording.

State block grant allotments likely would not reflect individual states' actual spending needs. While total federal funding would be based on *total* states' historical Medicaid spending, *each state's* share of the block grant funds would reflect its share of the number of poor people in the country, not its historical Medicaid costs. Moreover, after the first year, federal funding for states for both of the two block grants would grow annually at the rate of overall inflation plus 1 percent, not enough to keep pace with the expected growth in health care costs.

Total federal funding would also be adjusted in some unspecified way to reflect population as well as other demographic changes. But those adjustments likely would not fully account for the aging of the population, which will lead to significantly higher health care costs over the long run. For example, seniors' per-beneficiary long-term care costs will grow more rapidly than in the past as the baby-boom generation moves from young-old age to old-old age, and seniors in Medicaid become older on average and hence have greater health and long-term care needs.

Moreover, if Medicaid enrollment rises due to an economic downturn or if overall health care costs rise faster than expected, federal funding would not automatically increase as it does under the current financing structure. CHIP funding also would likely be lower than under current law.[8]

As a result, states would face significant risk of federal funding shortfalls relative to current law, and the shortfalls likely would grow over time. Assuming that the population factor was set at the projected growth in the U.S. population, the percentage increase in the block-grant funding levels from one year to the next would average nearly 1.5 percentage points less per year than what the Congressional Budget Office (CBO) now expects to be the Medicaid program's overall average expenditure growth rate over the coming decade under current law (outside of health reform's Medicaid expansion).

As the CBO analysis of the Medicaid block grant in the 2012 House-passed budget plan concluded, states may be able to use their flexibility under a block grant to make their programs more efficient, but:

> [T]he magnitude of the reduction in spending . . . means that states would need to increase their spending on these programs, make considerable cutbacks in them, or both. Cutbacks might involve reduced eligibility for Medicaid and CHIP, coverage of fewer services, lower

[8] Because the plan would repeal all of health reform's coverage expansions, it would appear to also eliminate the CHIP funding for 2015 provided under a two-year extension of CHIP (for 2014 and 2015). The current CBO baseline also assumes that CHIP will be reauthorized for 2016 and beyond but at a reduced annual funding level of $5.7 billion, which is well below current CHIP spending levels.

payments to providers, or increased cost-sharing by beneficiaries — all of which would reduce access to care.[9]

In other words, unless states come up with substantial new sums to offset the large losses in federal funding, they would be compelled to institute deep Medicaid cuts. And under a block grant, states would likely be allowed to cap Medicaid enrollment and turn away eligible families and individuals — in contrast to current law, under which all eligible individuals who apply must be allowed to enroll. Many poor Medicaid beneficiaries would likely end up uninsured or underinsured, and without needed care.

Seniors and people with disabilities who rely on Medicaid for their long-term care needs would be at particular risk under the Burr-Coburn-Hatch block grant due to its inadequate funding, as Medicaid is the nation's primary funder of long-term care. For example, the block grant could mean that fewer seniors and people with disabilities with long-term care needs would receive coverage for services and supports they need to stay in their homes.[10]

Finally, the Burr-Coburn-Hatch proposal would allow Medicaid beneficiaries to forgo Medicaid and instead receive a tax credit (as discussed above) to buy coverage in the individual market. Moreover, states would likely have the flexibility to *require* non-elderly, non-disabled people to use to the tax credit to buy private insurance instead of receiving Medicaid coverage, with the state using Medicaid funding to supplement the tax credit to some extent.[11]

Medicaid currently ensures that coverage is affordable for low-income people by generally not charging premiums and keeping cost-sharing charges modest. (Research shows that premiums and cost-sharing lead many low-income households to remain uninsured or forgo needed care.) Under the Burr-Coburn-Hatch proposal, however, individuals would likely face premiums, deductibles and cost-sharing under their individual market plans that would substantially exceed the charges they currently face, even if some supplemental assistance were provided.

Weakening Consumer Protections and Market Reforms

The Burr-Coburn-Hatch plan would eliminate or scale back many of the consumer protections and market reforms that have taken effect under health reform. For example, under the plans, insurers would be permitted to do the following:

- Set an annual dollar limit on the coverage they provide.

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[9] Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," March 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf.

[10] See January Angeles, "Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities, and Children," Center on Budget and Policy Priorities, May 3, 2011, http://www.cbpp.org/cms/index.cfm?fa=view&id=3483.

[11] See James Capretta and Joseph Antos, "A Senate GOP Health Reform Proposal: The Burr-Coburn-Hatch Plan," *Health Affairs Blog*, February 12, 2014, http://healthaffairs.org/blog/2014/02/12/a-senate-gop-health-reform-proposal-the-burr-coburn-hatch-plan/.

- Require cost-sharing charges for preventive care.

- No longer have an annual limit on out-of-pocket costs. (Under current law, nearly all plans — including large employer and self-insured plans — must cap annual out-of-pocket costs for in-network covered services at $6,350 for individuals and $12,700 for families in 2014.)

- No longer cover adult children up to age 26 on their parents' plans, if the state allows insurers to drop such coverage.

- Charge older people five times what they charge younger people in the individual and small-group markets, and more if the state allows it. (Under current law, insurers can charge older people up to three times as much as younger people.)

- Charge women higher premiums than men in the individual and small-group markets.

- Leave big gaps in coverage offered in the individual and small group markets by omitting critical benefits such as prescription drug coverage or maternity care, as plans in such markets could do before health reform. (Under current law, plans offered in the individual and small-group markets must cover an array of "essential health benefits" determined by the state in accordance with federal standards.)

People with pre-existing conditions would face additional problems. While the plan would prohibit insurers from varying premiums or denying coverage based on health status when people try to buy coverage in the individual market, that would be true *only* for people who had coverage through an employer or already had coverage through the individual market for at least 18 months. And while insurers couldn't *deny* coverage upon renewal because of a person's health status or claims experience, they apparently would be able to charge people much higher premiums to renew their coverage based on those factors, as they did before health reform.

While the uninsured would have a one-time enrollment period in which they couldn't be denied coverage in the individual market outright, the Burr-Coburn-Hatch bill doesn't appear to prevent insurers from charging higher premiums based on a pre-existing condition or health status during this enrollment period (or from not covering a pre-existing condition for some period of time). As a result, many individuals in poor health or with a pre-existing condition might not find the enrollment period meaningful.

The only alternative the bill provides for people with pre-existing conditions is a vague provision to provide an unspecified amount of federal funding for states to operate high-risk pools. (The bill apparently would also 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.) Such coverage is unlikely to be affordable even for individuals eligible for tax credits under the Burr-Coburn-Hatch plan; 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 bill'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.

Most important, relying on pools such as these to provide coverage would be "extremely expensive and likely unsustainable," as the Commonwealth Fund has explained.[12] That's because they 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.

Experience with state high-risk pools prior to health reform demonstrates that unless government financial support for the pools rises significantly over time, they eventually have to sharply restrict enrollment, set premiums further above what many families can afford, and/or scale back coverage by reducing benefits or increasing deductibles and other cost-sharing in order to keep costs from spiraling out of control. There is no indication the Burr-Coburn-Hatch proposal would provide adequate initial funding for the high-risk pools or assure that federal support would be increased over time as needed.

Conclusion

The Burr-Coburn-Hatch plan claims to ensure affordable health care for patients as an alternative to, and 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. The plan would also block millions of people who are uninsured today, but whom the Congressional Budget Office and other analysts expect to gain coverage in coming years under the Affordable Care Act, from doing so. It would move the United States backward, toward the poorly functioning individual market that existed prior to health reform.

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