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# Johnson Health Plan Would Unravel Much of Health Reform

## Would Render Millions Uninsured and Drive Up Individual-Market Premiums

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A majority of Republican senators have co-sponsored a bill introduced by Sen. Ron Johnson (R-WI) that has been promoted as a measure to delay the elimination of subsidies to purchase health insurance in the federal insurance marketplaces, and thereby avoid disrupting coverage for millions of Americans if the Supreme Court strikes such subsidies down. In fact, however, the Johnson proposal goes far beyond that, effectively unraveling large swaths of the Affordable Care Act (ACA). The result would be to add millions to the ranks of the uninsured and cause health insurance premiums to rise very substantially.

The bill (S. 1016), which Sen. Johnson introduced in April with 31 Republican co-sponsors, would extend subsidies through August 2017 for current enrollees in the federal marketplace if the Supreme Court eliminates those subsidies. What has received less attention is that the bill also would repeal or undermine critical components of the ACA. Specifically, the bill would:

- **Eliminate marketplace subsidies for new enrollees in *all* states — including states with *state*-based marketplaces that otherwise would be unaffected by a Supreme Court decision.** As a result, people in states with state-run marketplaces whose incomes decline in the future, making them eligible for subsidies under the ACA, would indeed be shut out. In addition, existing *federal* marketplace enrollees would lose their subsidies after August 2017.
- **Expand the ranks of the uninsured — and raise premiums — by repealing the ACA's individual and employer mandates.** Eliminating the requirement that most people have health insurance or pay a penalty would result in substantial coverage losses, as fewer uninsured people would enroll in marketplace plans, job-based coverage, Medicaid, the Children's Health Insurance Program (CHIP), and other sources of health coverage. In particular, with neither the individual mandate nor subsidies for new enrollees, healthier and younger individuals would be much more likely to remain uninsured, leaving the pool of people enrolled in individual-market coverage less healthy — and hence more costly to cover. That would cause premiums to rise substantially. The bill also would end the ACA requirement for large employers to pay a penalty if they fail to offer adequate, affordable, coverage to their workers. Some employers could drop coverage or offer coverage that some of their workers couldn't afford. Moreover, employees who lost their job-based coverage

would be ineligible for marketplace subsidies under the bill — because they would be *new* marketplace enrollees. As a result, many of them would become uninsured as well.

- **Undermine the ACA's market reforms and consumer protections by giving insurers, particularly those in the individual and small-group markets, much more leeway to sell plans that place many consumers at risk.** The bill creates a loophole that appears to allow insurers to deem many more plans as "grandfathered" and thereby enable insurers to offer plans that deny coverage to people with pre-existing conditions, base premiums on health status, or charge women higher premiums than men. It appears that insurers also could allow *new enrollees* into such plans, which the ACA prohibits. Since these plans would primarily attract healthier, low-cost individuals, this would drive up premiums for plans that continued to comply with ACA market reforms and consumer protections.
- **Bring back the coverage gaps and skimpy benefit packages common in the individual insurance market before health reform.** The bill also allows insurers to sell plans that do not meet the ACA's "essential health benefit" standards. Insurers could decide, for example, not to provide maternity coverage or prescription drug benefits, as often occurred in the pre-ACA market.

## Bill Would End Federal Subsidies for New Enrollees in All States

The Johnson bill would, in the event of a Supreme Court ruling ending subsidies in states with federally run marketplaces, maintain subsidies for current enrollees in those states through August 2017. But the bill apparently would not allow subsidies to be provided to *new* marketplace enrollees in *any* state, including states with state-based marketplaces.

Thus, in addition to ending subsidies by August 2017 for the 6.4 million people now receiving them who purchased coverage through a federal marketplace, the bill would bar millions of people who haven't enrolled yet through a marketplace from obtaining subsidies even if they reside in a state with a state-based marketplace.

Cutting off subsidies for new enrollees would have a widespread, immediate impact on the marketplaces. New enrollees constitute a significant portion of the expected marketplace enrollment for 2016; research indicates there is significant "churn" into and out of marketplace plans, even within a given year, due to changes in families' income, size, and employment. The Urban Institute has estimated that in any given year, well over one-third of subsidized marketplace enrollees will move into other sources of coverage and be replaced by new marketplace enrollees who previously were eligible for Medicaid or otherwise ineligible for subsidies.[1] As a result, if new marketplace enrollees are barred from receiving subsidies, marketplace enrollment will begin to dwindle fairly quickly.

More than 85 percent of marketplace enrollees receive premium subsidies and the vast majority of them could not afford coverage without this assistance.[2] The American Academy of Actuaries has

[1] Matthew Buettgens, Austin Nichols, and Stan Dorn, "Churning Under the ACA and State Policy Options for Mitigation," Urban Institute, June 2012, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412587-Churning-under-the-ACA-and-State-Policy-Options-for-Mitigation.PDF.

[2] Premium subsidies provide, on average, $268 per person per month and cover 72 percent of the overall premium cost, according to the Kaiser Family Foundation. If they were eliminated, former recipients would face an average increase of

said that proposals that fail to make subsidies available to new enrollees "would lead to lower overall enrollment in the individual market, as some individuals would transition out of coverage but few would transition in."[3]

A large-scale exodus from the marketplaces would leave millions more people uninsured relative to current law. And because insufficient enrollment would likely create an unstable risk pool (discussed further below), the marketplaces likely would not remain viable over time.

## Repealing Individual and Employer Mandates Would Reduce Coverage and Raise Premiums

The Johnson bill would repeal the ACA's requirement that most individuals have health insurance or pay a penalty. This would significantly expand the ranks of the uninsured relative to current law. Without the individual mandate, many fewer people would enroll in job-based coverage, subsidized private coverage through the marketplaces, Medicaid, CHIP, or other sources of health coverage. The Congressional Budget Office (CBO) previously estimated that repeal of the individual mandate would result in 16 million more uninsured people in 2021, relative to current law.[4] The actual number would likely be far greater under the Johnson bill, because CBO's estimate assumes that federal marketplace subsidies continue for all eligible enrollees.[5]

Moreover, without the individual mandate, healthier people would be the ones most likely to drop or otherwise go without coverage. Losing healthy people from the risk pool would push up premiums for everyone else, by making those still enrolled in marketplace plans sicker and costlier to cover, on average. Rising premiums, in turn, would push more healthy people out of the pool over time, driving premiums still higher — a dynamic known as adverse selection.[6] CBO has previously estimated that a five-year delay of the individual mandate would raise premiums in the individual market by 10 to 20 percent by 2018.[7] The increase under the Johnson bill would likely be

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265 percent in the amount they must pay for premiums. Larry Levitt and Gary Claxton, "Insurance Markets in a Post-King World," Kaiser Family Foundation, February 25, 2015, http://kff.org/health-reform/perspective/insurance-markets-in-a-post-king-world/.

[3] "Implications of Proposed Changes to the ACA in Response to King v. Burwell," American Academy of Actuaries Issue Brief, May 2015, http://actuary.org/files/HPC_Imp_Prop_Changes_ACA_KvB_052715.pdf.

[4] Jessica Banthin, "Effects of Eliminating the Individual Mandate to Obtain Health Insurance: Presentation at RAND BGOV Event on the Individual Mandate," Congressional Budget Office, March 20, 2012, http://www.cbo.gov/sites/default/files/RAND_BGOV_EliminatingIndividualMandate03-20.pdf. See also Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011 (Revenues-Option 32, pp. 199-200), https://www.cbo.gov/sites/default/files/03-10-reducingthedeficit.pdf.

[5] The CBO estimate of 16 million more uninsured people is similar to estimates from outside analysts at institutions such as the Urban Institute, RAND, and the Lewin Group. See Edwin Park, "Delaying the Individual Mandate Would Result in Millions More Uninsured and Higher Premiums," Center on Budget and Policy Priorities, updated October 30, 2013, http://www.cbpp.org/research/delaying-the-individual-mandate-would-result-in-millions-more-uninsured-and-higher-premiums.

[6] American Academy of Actuaries.

[7] Congressional Budget Office, "Estimate for H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014," March 12, 2014, http://cbo.gov/sites/default/files/cbofiles/attachments/hr4015withCampAmendment.pdf.

considerably larger, given the lack of subsidies for new marketplace enrollees, without which few will enroll.

In response to the worsening risk pool and declining marketplace enrollment, many insurers likely would focus on selling plans with scaled-back benefits — the type of plan that's most likely to attract healthier people who cost less to cover, as well as people with modest incomes who couldn't afford more comprehensive coverage due to the lack of premium subsidies. The Johnson bill would allow insurers to sell plans with skimpy benefits, as explained below. As a result, people with medical conditions would be at a significant disadvantage when trying to obtain affordable insurance in the individual market, and comprehensive coverage would be harder to come by — and more expensive — for everyone.

The Johnson bill would also repeal the ACA's employer "shared responsibility" provision, which requires employers with more than 50 full-time-equivalent employees to provide affordable, comprehensive coverage to their workers or pay a penalty. Without this requirement, some employers, particularly relatively small ones, may cease offering coverage that their lower-income employees can afford (or stop offering coverage altogether). As a result, more workers could end up uninsured, especially because they wouldn't be eligible for marketplace subsidies under the bill. While CBO and other researchers, such as the Urban Institute, have previously estimated that repealing or delaying the employer mandate would produce relatively modest increases in the number of uninsured — up to 500,000 people — those estimates assumed the continued availability of subsidies in all marketplaces and for both current and new enrollees, which would not occur under the Johnson bill.[8]

## "Grandfathering" Provision Would Undermine ACA Market Reforms and Consumer Protections

The Johnson bill would apparently allow insurers to greatly expand the number of "grandfathered" health insurance plans that don't have to comply with the ACA's market rules, coverage standards, or consumer protections. Under current law, grandfathered plans are those that existed before the ACA's enactment. If a pre-ACA plan changes significantly, however, as defined by federal rules, it loses its grandfathered status.[9] If a person with a grandfathered plan in the individual market leaves that plan for other coverage (for example, ACA-compliant marketplace coverage currently eligible for federal subsidies), he or she can no longer enroll in the grandfathered plan in the future. Finally, grandfathered plans generally cannot be sold to new enrollees.[10] As a

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[8] Linda J. Blumberg, John Holahan, and Matthew Buettgens, "Why Not Just Eliminate the Employer Mandate?" Urban Institute, May 9, 2014, http://www.urban.org/research/publication/why-not-just-eliminate-employer-mandate, and Edwin Park, "Delaying Health Reform's Employer Responsibility Requirement No Reason to Delay Individual Mandate," Center on Budget and Policy Priorities, February 12, 2014, http://www.cbpp.org/blog/delaying-health-reforms-employer-responsibility-requirement-no-reason-to-delay-individual.

[9] The purpose of the ACA's grandfathering provision was to ensure that plans people had prior to enactment of the ACA could continue. A plan that changes significantly, as defined by federal rules, would no longer be considered the same plan.

[10] There are some limited exceptions. Grandfathered employer plans can continue to accept new enrollees as workers are hired and they and their family members become eligible for the coverage, and family members of current enrollees may join grandfathered individual-market plans.

result, many plans originally deemed as grandfathered no longer exist. Insurers are expected to phase out the remaining grandfathered plans over time.

But the Johnson bill charts a different course. It broadens the definition of grandfathered plans to *any* plan in the individual or group markets in which an individual was enrolled at *any point between March 23, 2010* (when the ACA was enacted) *and December 31, 2017*. This would ensure that current grandfathered plans could continue — without meeting ACA standards — even if they underwent significant changes. The Johnson bill also appears to allow insurers to deem as grandfathered any non-ACA-compliant plan offered at any point during the nearly seven-year time window (2010-2017) that the bill specifies, including plans not offered until after the ACA's enactment, and to sell such plans to *new* enrollees through 2017.[11]

As a result, the Johnson bill would appear to allow insurers to revive old grandfathered plans that no longer exist, as well as to modify existing ACA-compliant plans so they no longer comply with some or all ACA standards and consumer protections.

It isn't clear if the legislation's grandfathering provision was intended to be this broad,[12] but as written, the bill would apparently give insurers the ability to use the grandfathering provision to bypass some of the most important consumer protections the ACA established in the individual and small-group insurance markets. For example, insurers could avoid covering preventive care at no cost to enrollees, exclude coverage for one or more of the ACA's "essential health benefits," and impose much higher cost-sharing charges than the ACA allows. Grandfathered plans are also exempt from the ACA's rating reforms, which prohibit insurers from denying coverage to people with pre-existing health conditions, setting premiums based on a person's health status or gender, and charging older people more than three times what they charge younger people due to age. Plans of this nature would be most attractive to healthy, lower-cost individuals. As a result, ACA-compliant plans that insurers continued to offer inside and outside the marketplaces generally would end up with sicker-than-average enrollee pools and hence have to charge substantially higher premiums.

The Johnson bill would also undermine the expanded risk pooling the ACA established to stabilize the individual and small-group markets. The ACA doesn't require grandfathered plans to comply with the ACA's "single risk pool" provision, under which each insurer in the individual and small-group markets must consider *all* of its enrollees in a state together (including those enrolled in plans outside the marketplace) when setting premium levels. This ACA requirement helps to stabilize premium rates over time and to spread the costs of covering people over a broader population than was the case prior to ACA enactment.

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[11] The Obama Administration has permitted some non-grandfathered pre-ACA plans to continue, but only temporarily. Insurers can continue such plans, but only into 2017 and only if their state permits it. The Johnson bill appears to allow insurers to deem these plans as grandfathered and continue them indefinitely. "Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016," Centers for Medicare & Medicaid Services, March 5, 2014.

[12] For a discussion of the possible interpretations of the Johnson bill's grandfathering provision, see Nicholas Bagley, "The Senate's Proposed King Fix is Flawed," Notice & Comment blog, *Yale Journal on Regulation*, April 28, 2015, http://www.yalejreg.com/blog/the-senate-s-proposed-king-fix-is-flawed-by-nicholas-bagley.

In addition, the Johnson bill would exclude more plans from the ACA's permanent risk-adjustment program, which redistributes funding from insurers that enroll people with lower-than-average medical costs to insurers with higher-cost enrollees: the ACA does not subject grandfathered plans to risk adjustment.

Combined with the loss of subsidies for new enrollees and the repeal of the individual mandate, the likely result would be severely destabilized insurance markets in many states — and skyrocketing premiums for ACA-compliant plans. The marketplaces, which can offer only ACA-compliant plans, would no longer be viable.

## Bill Would Repeal ACA's "Essential Health Benefits"

The Johnson bill would repeal the ACA requirements that insurers in the individual and small-group markets cover various categories of "essential health benefits" such as hospital and physician services, maternity care, and prescription drugs. The bill would give states free rein to decide what benefits insurers must cover.[13] Under the ACA, states have some flexibility to define the essential health benefits but must do so consistent with federal requirements.

Moreover, under the bill, if a state didn't define the benefits that insurers must cover in the individual and small-group markets, insurers could make this call for themselves. The bill's supporters have emphasized the increased flexibility it would provide for states that seek to define their own benefit standards. Yet prior to the ACA, the vast majority of states failed to require comprehensive benefit standards of the kind the ACA established.

In fact, plans in the individual and small-group markets in most states commonly excluded or severely restricted coverage of certain health care items or services, which sometimes caused benefit gaps that caught consumers by surprise when they sought certain types of medical care. Undoing the federal "essential health benefits" standards likely would result in a return to pre-ACA conditions — and coverage gaps — in many states.

## Conclusion

The Johnson bill has been portrayed as a plan to extend subsidies temporarily to people in federal marketplaces and thereby delay coverage disruptions if the Supreme Court invalidates the subsidies. Supporters say this would give congressional Republicans time to develop their own health reform plans to replace the ACA. In fact, however, the Johnson bill would disrupt coverage for people in the individual and small-group markets, both inside and outside the marketplaces. It would result in millions more people being uninsured, relative to current law, and in skyrocketing premiums for comprehensive coverage. Over time, the marketplaces would no longer be viable. And many people could lose access to important ACA consumer protections.

In short, the Johnson bill would effectively repeal or undermine much of the health reform law, while doing nothing to replace it, and leave millions of Americans uninsured or underinsured.

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[13] The Johnson bill also indicates that each state could define cost-sharing standards for health plans. The bill does not, however, strike the components of the ACA's "essential health benefits package" that require insurers to cap the out-of-pocket charges that enrollees can be asked pay each year and to offer plans that meet certain actuarial-value standards.