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Republican Study Committee Health Plan Would Likely Result in Many More Uninsured and Fewer Consumer Protections

By Edwin Park and Jeannie Biniek

The Republican Study Committee (RSC) recently unveiled the latest version of its health plan (H.R. 2653), which would repeal the Affordable Care Act (ACA) in its entirety, eliminate the tax exclusion for employer-sponsored insurance, and establish a new standard tax deduction for health insurance, whether offered by an employer or in the individual market.[1] If enacted, the RSC plan would pose serious challenges to the U.S. health insurance system.

- It would likely add substantially to the ranks of the uninsured and the underinsured by causing millions of people to lose their existing coverage and by making coverage unaffordable for many people of limited means through changes that would cause their premiums, co-payments, and/or other out-of-pocket charges to climb significantly.
- It would eliminate or significantly weaken health reform's consumer protections and market reforms, especially for people with pre-existing conditions. In addition, it would risk rolling back various longstanding state regulations designed to protect consumers in the individual and small-group health insurance markets that were in effect before the ACA.

Adding to Ranks of the Uninsured and Underinsured

By repealing the ACA, the RSC plan would eliminate health reform's Medicaid expansion, under which the federal government picks up nearly the full cost of expanding Medicaid to cover individuals up to 138 percent of the poverty line. (Twenty-eight states plus the District of Columbia have adopted the Medicaid expansion to date.) This would jeopardize coverage for the 14 million low-income people whom the Congressional Budget Office (CBO) estimates will gain coverage as a result of the Medicaid expansion.[2]

The RSC plan also would eliminate the ACA's health insurance marketplaces (also known as exchanges), through which millions of people have purchased coverage, and repeal health reform's

[1] See Republican Study Committee, "American Health Care Reform Act Section-by-Section Summary," http://rsc.flores.house.gov/UploadedFiles/AHCRA_-_Section_by_Section.pdf.

[2] Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act — CBO's March 2015 Baseline," March 2015, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

premium tax credits and cost-sharing reductions, which make buying coverage and accessing care affordable for people of modest means.[3] These changes would cause millions of people who have enrolled in marketplace plans to lose their coverage; 85 percent of those enrolling in marketplace plans this year qualified for premium tax credits.[4]

In addition to repealing the Medicaid expansion and marketplace subsidies, the plan would end the tax exclusion for employer-based coverage, under which employers' contributions to the cost of their workers' health insurance are exempt from income and payroll tax for the employees. The RSC plan would replace the exclusion with a standard tax *deduction,* for purposes of both income and payroll taxes, of $7,500 for individuals and $20,500 for families who buy coverage on their own or through their employer. (If an individual's or family's health insurance coverage cost less than the standard deduction, their taxable income — and hence taxes — would fall relative to current law; if their coverage cost more than the standard deduction, as it would for many people, their taxes could rise.[5]) The amount of the standard deduction would rise each year by the annual increase in the Consumer Price Index (CPI), which historically has been lower than the annual increase in health care premiums and costs.

The standard tax deduction would do little to help most uninsured people gain coverage. Prior to health reform, at least 90 percent of the uninsured were in the 0, 10, or 15 percent income tax bracket; half of the uninsured had income below the federal poverty line and likely had no federal income tax liability at all.[6] That means that the overwhelming majority of the uninsured would receive an income tax benefit of no more than 15 cents for every $1 they can deduct (most would receive less than that), along with a payroll tax benefit of 7.65 cents per dollar earned — not enough to make coverage (other than flimsy coverage) affordable.

People who lose their jobs and have no earned income would receive *no* benefit. A single poor adult earning $10,000 would receive no income tax benefit and a payroll tax benefit of about $574 a year — far below the cost of a health insurance plan.

Moreover, the standard deduction would not account for differences in people's premiums based on their age. As discussed below, insurers in the individual market would be allowed to charge older people far more than younger people (up to whatever limit, if any, their state has set). Had the RSC plan's tax deduction been in place last year, a single 64-year-old with income of twice the poverty line — $23,340 — would likely have received a total tax benefit of no more than about $1,530. This is vastly below what the individual would have to pay for health coverage and only about one-quarter the size of the tax credit that health reform provided in 2014. (The ACA's premium tax credits are much more ample for people with low incomes. They also are effectively adjusted for

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[3] The plan would also repeal health reform's individual mandate.

[4] Centers for Medicare and Medicaid Services, "March 31, 2015 Effectuated Enrollment Snapshot," June 2, 2015, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.

[5] Their taxes would go up because any employer contributions to their health premiums would count as taxable income paid to them, as would any increased wages they would receive if their employer replaced employer contributions to health premiums with higher wages. If the increased amount of taxable income exceeded the amount of the new standard deduction, their taxes would rise.

[6] Kaiser Family Foundation State Health Facts, "Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL)," http://kff.org/uninsured/state-indicator/distribution-by-fpl-2/.

age, as they are based on the premium for the second lowest cost "silver-level" plan available to a person of that age.)

Nor would the standard deduction reflect the geographic variation in health insurance costs. Unlike the ACA's premium credits, which, as noted above, are based on the second lowest cost "silver-level" plan available *in the area in which an individual or family lives*, the standard deduction would be a "one-size-fits-all" national amount, set without regard to the actual cost of health insurance in the taxpayer's area. Average annual premiums for single coverage under a silver plan in the federally facilitated marketplace (before premium tax credits) range from $3,000 a year in Utah to $7,824 a year in Alaska,[7] which is similar to the variation in premiums in the individual market before the ACA (although the scope of the coverage is not comparable).[8]

The primary benefit of the tax deduction would go to people in the top income tax brackets — those who least need help in affording health insurance and are the most likely already to have coverage. The highest-income individuals, who face a marginal income tax rate of 39.6 percent, would receive a far greater income tax benefit from the new standard deduction than lower-income individuals, who are more likely to be uninsured. Each dollar of the deduction would provide an income tax benefit of nearly 40 cents for those at the top of the income scale, but only 0 to 22.65 cents for low- and moderate-income people (taking into account the deduction's effect on payroll taxes as well).

Moreover, as discussed below, uninsured people with pre-existing health conditions would face substantial difficulties obtaining coverage and might face much higher premiums than they could afford, without a corresponding increase in the size of their tax subsidy.

The RSC plan would provide *no* replacement for health reform's cost-sharing reductions, which simply would be repealed. The plan thus offers no help with deductibles, co-payments, and co-insurance for people with incomes below 250 percent of the poverty line (the income level up to which cost-sharing reductions are provided under the ACA). Many low- and moderate-income people who managed to pay the premiums for health coverage in the individual market with the help of the standard deduction could face unaffordable deductibles and other cost-sharing charges and consequently could forgo needed care.

In addition, the RSC plan (unlike the ACA) places *no* limit on the total out-of-pocket costs that a beneficiary can incur in a year. And, the health coverage purchased in the individual market would likely often have significant gaps in benefits (such as for coverage of prescription drugs or maternity coverage), because the ACA's requirement that insurers provide comprehensive coverage would be jettisoned.

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[7] Arpit Misra and Thomas Tsai, "Health Insurance Marketplace 2015, "Average Premiums After Advance Premium Credits Through January 30 in 37 States Using the Healthcare.Gov Platform," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 19, 2015, http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf.

[8] America's Health Insurance Plans (AHIP), "Individual Health Insurance 2009, A Comprehensive Survey of Premiums, Availability, and Benefits," October 2009, http://www.ahip.org/Individual-Health-Insurance-Survey-2009/.

As a result, even if some low- and moderate-income people gained coverage with the aid of the standard deduction, many would likely forgo some needed care because the care wouldn't be covered, the deductibles or cost-sharing charges would be more than they could afford, or they lacked meaningful financial protection against the costs of catastrophic illness.

Finally, the plan would repeal the ACA's medical-loss ratio requirement that insurers spend at least 80 percent of their premiums on health services rather than overhead and profit.

Taken together, these various factors mean that many individuals would likely pay higher premiums for less coverage.

Changing the Tax Treatment of Employer-Based Coverage

As noted, the RSC plan would eliminate the tax exclusion under which employer contributions to the cost of health insurance are exempt from income and payroll taxes. While the tax exclusion is inefficient — the tax benefits are largest for those with high incomes — it does encourage employers to offer health insurance coverage to their workers. Of particular importance, as CBO has noted, "[B]y pooling risks within groups of workers and their families, and by reducing the administrative costs of marketing insurance policies and collecting premiums, employment-based health insurance is a relatively efficient way to provide coverage."[9]

Removing the tax exclusion while establishing a standard deduction that could be used for both individual market and employer-sponsored insurance would likely result in a substantial number of employers, particularly small and medium-size employers, no longer offering coverage to their employees (as analyses by CBO, the Joint Committee on Taxation, and the Lewin Group have found).[10] Such employers would expect their workers to use the plan's standard deduction to purchase health insurance in the individual market. But many modest-income workers who lost employer-based insurance, especially those who are older or in poorer health, likely wouldn't be able to find affordable coverage in the individual market.

Eliminating the employer tax exclusion and providing a standard deduction also could drive up the per-beneficiary cost of employer-based coverage at firms that retained such coverage, because it would almost certainly result in "adverse selection." Healthier employees (especially well-paid,

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[9] Congressional Budget Office, "Options for Reducing the Deficit: 2014 to 2023," November 2013, http://www.cbo.gov/budget-options/2013/44903.

[10] See Congressional Budget Office, "Appendix C: The President's Proposal for a Standard Tax Deduction for Health Insurance," in "An Analysis of the President's Budgetary Proposals for Fiscal Year 2008," March 2007, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/78xx/doc7878/03-21-presidentsbudget.pdf; Joint Committee on Taxation, "Estimating the Revenue Effects of the Administration's Fiscal Year 2008 Proposal Providing a Standard Deduction for Health Insurance: Modeling and Assumptions," March 20, 2007, http://www.jct.gov/x-17-07.pdf; and John Sheils and Randy Haught, "President Bush's Health Care Tax Proposal: Coverage, Cost and Distributional Impacts," The Lewin Group, January 2007, http://www.lewin.com/~/media/Lewin/Site_Sections/PressReleases/BushHealthCarePlanAnalysisRev.pd. See also Edwin Park, "Administration's Proposed Tax Deduction for Health Insurance Seriously Flawed," Center on Budget and Policy Priorities, July 31, 2007, http://www.cbpp.org/cms/?fa=view&id=557. As CBO's November 2013 report on federal deficit-reduction options indicated, substantially scaling back the tax exclusion for employer-based coverage "would lead fewer employers to offer health insurance." Congressional Budget Office, "Options for Reducing the Deficit: 2014 to 2023," *op cit.*

healthy employees in higher tax brackets) would be the most likely to find that they could use the standard deduction to buy a policy in the individual market that is less expensive than staying in their employer-based plan — because the premiums for their employer-based plan would reflect the higher cost of the less-healthy individuals with whom they are pooled. As healthy individuals opted out of employer-sponsored insurance, the pool of workers remaining in employer plans would become sicker, on average. That, in turn, would drive up the per-beneficiary cost of the employer-sponsored plans, raising the premiums for the workers remaining in those plans and inducing still more healthy workers to abandon them.[11]

Altogether, the RSC 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 lack insurance today to gain it in coming years, as is projected to occur under the ACA. Low- and moderate-income individuals would likely face substantially higher premiums, deductibles, and other out-of-pocket costs than under health reform. Poor and near-poor individuals who otherwise would be eligible for Medicaid — and people in their 50s and early 60s who otherwise could buy marketplace plans with age-adjusted premium subsidies — would be particularly severely affected.

Many people would likely find coverage unaffordable. As a result, many more people likely would be uninsured or underinsured than under current law.

Eliminating or Weakening Consumer Protections and Market Reforms

The RSC plan also would eliminate nearly all consumer protections and market reforms that have taken effect under health reform. It would allow insurers once again to:

- set annual and lifetime dollar limits on the coverage they provide;
- require cost-sharing charges for preventive care;
- place no annual limit on beneficiaries' 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 $6,600 for individuals and $13,200 for families in 2015);
- limit the children whom parents can include on their plans to those 21 and younger, rather than those up to age 26;
- charge people higher premiums in the individual and small-group markets based on their health status;
- charge older people premiums that are more than three times what they charge younger people in the individual and small-group markets (the limit under health reform is 3 to 1);
- charge women higher premiums than men in the individual and small-group markets; and
- leave sizeable gaps in the coverage they offer, since the requirement that plans cover important basic benefits (such as prescription drug coverage or maternity care) would be repealed, thereby allowing plans to omit such benefits (as they were able to do in many states prior to health

[11] See Joint Committee on Taxation, *op. cit.*

reform). (Under the ACA, by contrast, plans in the individual and small-group markets must cover a package of "essential health benefits," determined by their state in accordance with federal standards.)

Pre-Existing Conditions

Another step backward would occur from the RSC plan's abandonment of ACA provisions that prohibit insurers in the individual market from refusing to cover people with pre-existing medical conditions. The RSC plan would allow insurers to deny coverage in such cases, except for people who have had continuous coverage (through an employer or in the individual market) for at least 18 months.[12]

This protection is a limited one. Some 36 percent of Americans aged 4 to 64 — 89 million people — had at least one month without health insurance between 2004 and 2007 (with about one-quarter of those losing coverage more than once).[13] Thus, an uninsured individual without access to job-based coverage who has previously been denied coverage in the individual market because of cancer or diabetes would likely remain uninsured under the RSC plan, because insurers would be allowed to deny coverage to such people based on their pre-existing conditions.

People not qualifying for this limited protection could face difficult circumstances. Insurers generally would be able to charge them whatever premiums the insurers wished, if they offered coverage to such people. Many such people likely would be able to purchase coverage only through a high-risk pool, if at all.[14] And that coverage often wouldn't be affordable, either.

High-risk pools, by their nature, pool sick people with even sicker people rather than pooling sick and healthy people together as regular insurance does. They consequently tend to charge extremely high premiums.[15] In an assessment of high-risk pools, a Commonwealth Fund study concluded that relying on such pools to provide coverage would be "extremely expensive and likely unsustainable."[16]

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[12] That's only a modest improvement over the deeply flawed situation prior to health reform, which generally provided protection only for those with continuous coverage in employer-based coverage under the Health Insurance Portability and Accountability Act of 1996. The HIPAA continuous coverage protection also applied to government-sponsored plans and church-based plans.

[13] 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.

[14] Even those who qualify for the continuous coverage protection would generally be able to purchase individual market coverage only in two ways, depending on their state: (1) they could buy coverage from any individual market carrier (or just from plans offered by Blue Cross and Blue Shield), though insurers would generally be able to charge whatever premiums they wished, or (2) they would have the option to purchase coverage through a high-risk pool.

[15] Kaiser Family Foundation, "Non-Group Coverage Rules for HIPAA Eligible Individuals," January 2012, http://kff.org/other/state-indicator/hipaa-rules/.

[16] 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. See also Deborah Chollet, "Expanding Individual Health Insurance Coverage: Are High-Risk Pools the Answer," *Health Affairs* (web exclusive), October 23, 2002.

Indeed, experience with state high-risk pools shows that unless government financial support both is substantial and increases significantly over time, the pools 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. Nevertheless, the RSC plan fails to provide *any* secure stream of federal funding for high-risk pools.

The bill merely authorizes Congress to appropriate money for this purpose. Yet Congress might never appropriate such funds, especially given the austere caps the Budget Control Act sets on overall funding for appropriated programs, which have been shrunk even further by sequestration. Total funding for non-defense discretionary programs, the part of the budget from which new funding for high-risk pools would have to come, is slated to shrink by fiscal year 2016 to its lowest level as a share of gross domestic product since Dwight D. Eisenhower was President.

Other Consumer Protections

The RSC plan also would weaken consumer protections in other ways. It would likely result in the rollback of various state consumer protections and market reforms that were in place *before* the Affordable Care Act. Premiums for less-healthy individuals, and for small businesses with workforces that are older or otherwise in poorer health, would tend to rise as a result.

- The RSC plan would permit out-of-state insurers to sell insurance within a state *without* having to comply with the state's consumer protections, including (1) protections that limit the degree to which insurers can charge higher premiums based on age, gender, or health status; 2) a requirement to offer coverage to people with pre-existing conditions if a state had adopted that protection prior to health reform; and 3) requirements to cover certain benefits. The out-of state plans would need to comply only with whatever consumer protections are required in the state in which they're licensed. Many such plans would seek licensure in a state that has very weak regulations and consumer protections (and in which insurance companies exert substantial political influence).

  The out-of-state plans would primarily attract healthy people with low health care costs; these are people with less need for their state's consumer protections such as premium rating rules and benefit requirements. Meanwhile, sicker-than-average people would generally opt to remain in plans offered by *in*-state insurers. The result would be to push up premiums for the in-state plans by saddling them with sicker beneficiary pools.

  CBO has previously found that if insurers can offer out-of-state plans, premiums will rise for people expected to have relatively high health care costs, and the number of people with high health care costs who have insurance will decline.[17] The New America Foundation similarly concluded that this type of proposal "would lower premiums for the healthiest Americans, but

[17] Congressional Budget Office, "Cost Estimate for H.R. 2355 Health Care Choice Act of 2005," September 12, 2005, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6639/hr2355.pdf.

it would raise premiums and reduce coverage options for everyone else…. Individuals with troublesome health histories would have to pay more, or go without coverage."[18]

- The RSC plan also would allow the establishment of "Association Health Plans" (AHPs) that could offer health insurance to individual and small business members, and that would be *exempt* from most state regulations applying to the individual and small-group markets (except for a small number of standards such as those related to financial solvency). Like plans offered across state lines, AHPs would primarily attract individuals and small firms whose workforces are healthier than average and least in need of strong consumer protections and market reforms. Such individuals and firms could secure lower premiums through AHPs because they would be separating themselves from plans whose coverage pools contain less-healthy beneficiaries along with healthy ones and thus must charge higher premiums. The result would be to drive up premiums for *non*-AHP coverage, as CBO has explained.[19] Because AHP proposals would effectively undermine state regulations for the small-group market, the National Governors Association has opposed such legislation in the past.[20]

Expanding Health Savings Accounts

In addition to adding millions to the ranks of the uninsured and underinsured and undermining health reform's market reforms and consumer protections, the RSC plan would significantly expand the substantial tax benefits of Health Savings Accounts (HSAs). Under current law, individuals enrolled in a high-deductible health plan (one with a deductible of at least $1,300 for individuals and $2,600 for family coverage) that meets other federal requirements may establish a HSA.

HSAs offer unprecedented tax sheltering opportunities for high-income taxpayers. The accounts have three tax benefits: (1) contributions are tax deductible, with participants now able to contribute up to $3,350 for individual coverage and $6,650 for family coverage in tax year 2015; (2) contributions may be placed in stocks, bonds, or other investment vehicles, with the earnings accruing tax free; and (3) withdrawals are tax exempt if used for out-of-pocket medical or long-term care costs. *No other savings vehicle offers all three;* for example, 401(k) contributions and earnings are tax-free but withdrawals are taxed. Moreover, because the value of a tax deduction rises with an individual's tax bracket, HSAs provide the largest tax benefits to high-income individuals. And since there are no income limits on HSA participation, affluent individuals whose incomes are too high to qualify for IRA tax breaks or who have "maxed out" their 401(k) contributions can use HSAs to shelter additional funds.[21]

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[18] John Bertko, Len Nichols, and Elizabeth Carpenter, "Across State Lines Explained: Why Selling Health Insurance Across State Lines is Not the Answer," New America Foundation, October 2008, http://www.newamerica.net/files/nafmigration/Policy_Paper_Across_State_Lines_Explained.pdf.

[19] See Statement of James R. Baumgardner before the House Committee on Small Business, Congressional Budget Office, February 16, 2000.

[20] See, for example, National Governors Association, "NGA Opposes Association Health Plans," March 31, 2004, http://nga.org/cms/sites/NGA/home/news-room/news-releases/page_2004/col2-content/main-content-list/title_nga-opposes-association-health-plans.html.

[21] See, for example, Edwin Park, "GAO Study Again Confirms Health Savings Accounts Primarily Benefit High-Income Individuals," Center on Budget and Policy Priorities, May 19, 2008, http://www.cbpp.org/research/gao-study-again-confirms-health-savings-accounts-primarily-benefit-high-income-individuals.

The RSC plan would nearly double the maximum annual HSA contribution amounts and thus dramatically expand the ability of higher-income taxpayers to shelter this income; if the RSC plan were in effect in tax year 2015, taxpayers would now be able to contribute up to $6,450 if they had individual coverage and up to $12,900 if they had family coverage. The plan would also permit taxpayers to transfer withdrawals they must begin making at age 70 ½ from certain retirement accounts (including IRAs and 401(k)s), which are treated as taxable income, into their HSAs on a *tax-free* basis. If those transferred funds were later used for out-of-pocket medical expenses, they would never be taxed; this provision would therefore provide an additional tax windfall to high-income retirees.

Conclusion

The RSC plan claims to expand coverage and lower costs as a replacement for the Affordable Care Act. In reality, it would cause millions of people who have gained coverage under the ACA's coverage expansions to lose it, and it would effectively block millions of people who are uninsured today — but whom CBO and other analysts expect to gain coverage in coming years under the ACA — from obtaining that coverage. It likely would also disrupt coverage for millions of people who rely on employer-based coverage today, causing many to become uninsured or underinsured.

In a nutshell, it would move the United States backward — to individual and small-group health insurance markets that likely would function even less well than they did prior to health reform.