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Select Affordable Care Act Replacement Plans and Implications

No single strategy to replace the Affordable Care Act (ACA) has yet emerged. However, there are several ideas that seem to have considerable support among those in health care leadership roles in President Trump's Administration and Congress. The following summarizes the key features of the most developed full repeal and replacement plans offered to date. See CHRT's companion piece, *ACA Repeal and Replacement: Proposals and Action*, for a one-page summary of the plans and tentative process.

Provision	*A Better Way* (Rep. Paul Ryan)[1]	*Empowering Patients First Act* (Rep. Tom Price)[2]	*The Patient Choice, Affordability, Responsibility, and Empowerment Act* (Sen. Richard Burr, Sen. Orrin Hatch, and Rep. Fred Upton)[3]	Who is Primarily Affected	Implications
Replace the Individual Mandate with a Continuous Coverage Requirement	In an initial open enrollment period, all individuals can enroll in an individual market plan without medical underwriting or denial; those with continuous coverage are exempt from medical underwriting and pay standard rates. The length of continuous coverage needed is unspecified.	During select open and special enrollment periods, individual market coverage is available without medical underwriting or denial; enrollees with less than 18 months of prior continuous coverage may face a 50% surcharge of the standard rate for up to 24 to 36 months.	During an initial open enrollment period, all individuals can enroll in an individual market plan without medical underwriting or denial; after this period, enrollees must have 18 months of prior continuous enrollment to receive an age-adjusted rate. Otherwise, the policy will be medical underwritten.	Individual market enrollees and those that experience spells of uninsurance would be most affected. Over 14 million Americans had 1-3 months without health insurance in 2014.[4] Coverage gaps are also more common for lower income individuals.[5]	A continuous coverage requirement has the same goal as the individual mandate: to encourage a mix of healthy and sick individuals to obtain insurance coverage. Requiring continuous coverage is intended to encourage enrollment because individuals who delay getting coverage would face serious penalties in the form of premium surcharges and medical underwriting for health status in the event they become sick. However, the effectiveness of such a requirement will depend on the policy's details, such as offering exemptions for people who non-voluntarily lose coverage, and whether individuals accurately perceive the potential costs of not enrolling in coverage during open enrollment.[6] Other proposed alternatives include premium surcharges for those who delay coverage, automatic enrollment, and lock outs of coverage for a period of time after an initial open enrollment. These ideas also rely on an individual's perception of risk of non-coverage.
Change Tax Subsidies	Implement refundable tax credits based on age (not income or cost of coverage) that can be used to purchase any individual market policy (not only through the Marketplace).	Implement refundable tax credits based on age (not income or cost of coverage) that can be used to purchase any individual market policy (not only through the Marketplace).	Implement refundable tax credits based on age and income (up to 300% federal poverty level; not adjusted for cost of coverage); individual market enrollees and small group employees (at firms up to 100 workers) would be eligible; states could auto-enroll people who receive a tax credit.	Nearly 9.4 million people (approx. 85% of those enrolled in Marketplace plans) received a premium tax credit through the ACA in 2016 to purchase a Marketplace plan.[7]	Altering the tax credit formula to adjust credit amounts for only age would result in higher net premiums for many low-income enrollees and potentially lower premiums for higher-income, older enrollees. If the tax credit increase was slower than premium growth and the credit was not adjusted to reflect the change in premiums, enrollees would bear a larger share of premium costs over time.
Expand Health Savings Accounts (HSAs)	Eliminate ACA regulations on HSAs; remove restrictions on HSAs for people with VHA and IHS coverage; allow spouses to make catch-up contributions to the same account.	Encourage HSAs with one-time refundable tax credit of $1,000; raise maximum tax-free contribution to $5,500.	Eliminate ACA regulations on HSAs; remove restrictions on HSAs for people with VHA and IHS coverage; allow spouses to make catch-up contributions to the same account.	There were 13.8 million HSA accounts nationwide with an average balance of over $1,900 at the end of 2014.[8]	Most households that claim HSA deductions have incomes greater than $100,000 per year, since the tax advantage is greater at higher incomes.[9] Providing one-time tax credits to create an HSA could require significant resources to assess eligibility and distribute funds accordingly.
Allow Adult Dependents up to Age 26 to Stay on Their Parents' Plan	The ACA's adult dependent coverage provision would be preserved.	Eliminate the ACA's adult dependent coverage provision without replacement.	The ACA's adult dependent coverage provision would be preserved.	More than 3 million young adults gained health insurance coverage through a parent's plan due to this provision.[10]	The ACA's adult dependent coverage requirement increased coverage and access to care to young adults who would otherwise age-out of their parents' plan.[11] Prior to the ACA, adults in this age range had some of the highest rates of uninsurance.
Replace the ACA's "Cadillac Tax" with a Cap on the Tax Exclusion for Employer-Sponsored Insurance	Tax exclusion for employer-sponsored insurance would be capped at unspecified amount.	Tax exclusion for employer-sponsored insurance would be capped at $8,000 for an individual and $20,000 for a family.	Tax exclusion for employer-sponsored insurance would be capped at $12,000 for an individual and $30,000 for a family and adjusted annually (CPI+1).	There were nearly 160 million people enrolled in an employer-based health insurance plan in 2015.[12]	These proposals would likely affect more individuals than the ACA's Cadillac Tax. 45% of private-sector employers offered health insurance coverage in 2015.[13] According to the Kaiser Family Foundation, 22% of employers would offer at least one plan that would be subject to the Cadillac Tax by 2023.[14] The tax exclusion for employer-sponsored insurance has disproportionate benefits for high-income households and costs the federal government over $250 billion per year in forgone revenue. According to CBO, setting a cap at $7,000 for single and $17,000 for family coverage would reduce the deficit by $60 billion per year but would reduce employer-based enrollment by 6 million.[15]
Medicaid Block Grants/Per Capita Cost Limits	Medicaid funding for all eligible populations would be converted to a per capita allotment based on each state's average per capita expenditures; grants	The ACA's Medicaid expansion would be eliminated. No reference to block grants or per capita cost limits.	Medicaid funding for most eligible populations would be converted to a per capita allotment based on prior year cost and the number of eligible	There were over 74 million enrolled in Medicaid or the Children's Health Insurance Program in November 2016.[16]	Many plans to block grant or fund Medicaid with per capita allotments are designed to limit federal spending growth, so the cost above the cap will be borne by either states providing more funding or narrowing eligibility and/or benefits for low-income residents. According to the Center for Budget and Policy Priorities, Medicaid federal expenditures would be 33% lower than current

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	would grow slower than current law; states that expanded Medicaid could maintain it but federal assistance for this population would decline over time; states could also opt out of per capita allotments and receive a traditional block grant instead.		individuals below the poverty level; the per capita amount would be adjusted for cost growth (CPI+1) and demographics.		law after 10 years and enrollment could drop by 25% or more.[17]
Implement High-Risk Pools	Encourage states to establish high-risk pools with federal grant funding support of $25 billion over 10 years.	Encourage states to establish high-risk pools for individuals with premiums more than 150% of standard rate; federal grant support of $3 billion over 3 years to states.	Encourage states to establish high-risk pools with federal funding support (exact amount not yet determined).	Prior to the ACA, between 11.6 and 19.1 million uninsured people had a chronic condition.[18] Overall, the Kaiser Family Foundation estimated that 27% of all adults under 65 have pre-existing conditions as defined under pre-ACA underwriting rules.[19]	High-risk pools were in effect under the ACA prior to the coverage expansions in 2014. Fewer than 200,000 were enrolled, 5% of those eligible. The pools were chronically underfunded.[20] According to the Commonwealth Fund, it would cost over $178 billion per year to subsidize high-risk pools for people with chronic conditions who were uninsured prior the ACA.[21]
Loosen Benefit Design Requirements	The ACA's prohibition on lifetime limits would be preserved; states would regulate other benefit design requirements.	Eliminate the ACA's essential health benefit requirement, lifetime and annual limits requirements, preventive health benefit requirement, and mental health parity for individual and small group markets.	The ACA's prohibition on lifetime limits would be preserved; states would regulate other benefit design requirements.	Most of the ACA's benefit design requirements focus on the individual and small group markets which had 32.7 million people in 2015. The preventive services and annual limits requirements apply to virtually the entire private insurance market.	Eliminating the ACA's essential benefits requirements could substantially narrow individual market coverage, which may lower premiums but reduce coverage. Prior to the ACA, more than half of individual market enrollees lacked maternity benefits and a third lacked comprehensive mental health coverage.[22]
Widen Age Bands	Implement a default 5:1 age band and allow states to set their own more or less restrictive standards.	Eliminate the ACA's 3:1 age band without replacement.	Implement a default 5:1 age band and allow states to set their own more or less restrictive standards.	There were 17.4 million people in the individual market and 15.3 million with small group coverage in 2015 that had age band restrictions on premiums.[23]	Expanding the age bands from 3:1 to 5:1 could encourage more younger people to sign up for coverage, since they would have lower premiums. However, according to the Urban Institute, the premium increases for older adults would outweigh the decreases for younger adults.[24]
Permit Association Health Plans	Allow for the creation of individual and association (small group) health pools that would be prohibited from denying coverage or charging higher rates to sick patients.	Allow for the creation of individual and association (small group) health pools that must meet federal standards but would be preempted from state rating laws.	Small group employers would be allowed to group together to negotiate small group plans.	There were 17.4 million people in the individual market and 15.3 million with small group coverage in 2015 that could potentially join an association health plan.[25]	Small groups can already band together to offer coverage within states. Many small groups purchase their coverage through Chambers of Commerce or other such organizations. Association health plans would be able to self-insure and avoid many state regulations. However, it is not yet clear how these plans would be regulated to avoid adverse selection in the individual and small group markets.[26]
Permit Interstate Insurance Sales	States would be allowed to enter multi-state compacts that would facilitate the sale of individual market plans across state lines.	Individual market insurers can sell policies outside their primary state under the regulations of their primary state.	States would be allowed to enter multi-state compacts that would facilitate the sale of individual market plans across state lines.	The ACA already permits multistate plans and interstate compacts, but very few of these arrangements are currently offered.	Interstate insurance sales could expand plan options for individual market enrollees, but insurers may only offer plans through states with the least regulations and disrupt risk pools by enrolling the healthiest enrollees. There is no data to support that there would be cost savings from these plans.[27]
Reform Medical Liability	Place caps on non-economic damages; encourage states to develop alternative systems, including health courts and proportional liability.	Limit lawsuit rewards; establish state health care tribunals to review cases and make decisions; state courts could still hear cases if parties are not satisfied.	Place caps on non-economic damages and attorney fees from malpractice cases; encourage states to develop alternative systems, including health care tribunals.	Health care providers purchasing medical liability insurance and patients who sue providers for damages.	The Congressional Budget Office estimated that a typical package of medical liability changes would reduce total U.S. health care spending by 0.5%.[28]

ENDNOTES

[1] http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf
[2] http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf
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