THE CENTURY FOUNDATION

How to Build on the Affordable Care Act

OCTOBER 8, 2019 — DAVID NEXON

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Executive Summary

The Affordable Care Act (ACA) was a giant step forward toward the true goal of universal health care: to make health care a right for all, not a privilege based on ability to pay. The ACA dramatically reduced the number of the uninsured, it defined a basic set of essential health benefits to which all Americans were entitled, and it protected low-income Americans against excessive out-of-pocket costs. Pre-existing exclusions in insurance were banned, and yearly and life-time limits on benefits were eliminated. Out-of-pocket costs for covered services were capped in all insurance policies. Studies have demonstrated improved access to health care and better health outcomes among the newly insured. But while the ACA was a giant achievement, it has still fallen short of the ultimate goal of universal health care.

Despite the ACA, 25 million Americans remain uninsured. The Trump administration has taken a number of steps that have undermined the program. Health insurance premiums remain unaffordable or unduly burdensome for millions of Americans. Excessive cost-sharing—especially high deductibles and high caps on out-of-pocket spending—means that many insured individuals and families still face major financial barriers to care or unaffordable costs.

The standards for large employer-provided health insurance are weaker than those for care in the individual market. These standards neither guarantee coverage of essential benefits, nor ensure that coverage is affordable. A special problem is the so-called family glitch, which defines affordable employer-provided coverage in terms of the cost of individual coverage rather than family coverage. While employer coverage in practice is generally good, there are some outliers providing substandard coverage. Moreover, many employer plans have excessively high deductibles, and the cost of care and premiums can be too high for low-income workers even when it is reasonable for most workers.

Fourteen states have not expanded Medicaid coverage as envisioned by the ACA, leaving millions of the poorest Americans without any coverage. There are some gaps in Medicaid coverage even for those who have it, and at least one major important health service—adult dental coverage—is omitted from the ten essential benefits defined by the ACA.

The first step in any health care reform is obvious: undo the damage caused by the Trump administration's attempts to undermine the ACA and Medicaid by a whole series of

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administrative actions. But after that, a program building on the ACA could address the problems above and ensure that affordable health care is indeed a right for all Americans. Enacting such a program would be challenging but achievable—if it becomes a priority for progressives and the health policy community. The key components of such a program are:

- Assure the affordability of premiums and care.
    - o Enrich the current premium subsidies for those below 400 percent of poverty and cap the premium obligation as a percent of income for those over this threshold.
    - o Reduce cost-sharing obligations by eliminating high deductible plans, reducing out-of-pocket caps, expanding cost-sharing subsidies above 250 percent of poverty, and linking subsidies to a plan that pays more of the cost of covered services than the current silver plan.
    - o Eliminate indexing of the percent of income used to cap premium and cost-sharing obligations.
- Expand employer requirements to assure affordable and comprehensive coverage for workers.
    - o For all workers: require coverage of the essential benefits, limit high deductible plans, improve the required proportion of costs covered by the employer plans, eliminate the "family glitch," and lower the affordability threshold required of employers to parallel the revised individual market standard.
    - o For low- and moderate-income workers: improve premium and cost-sharing to parallel the protection in exchange plans. The cost of these improved protections could be achieved either by requirements on employers or by subsidies through the tax system either directly to workers or to employers as a pass-through to workers.
- Expand Medicaid in all states through attrition or additional incentives and penalties or by federal assumption of responsibility for the expansion population in states that have failed to expand coverage.
- Expand essential health benefits to cover adult dental care, make key optional Medicaid benefits mandatory, and provide a mechanism for expanding required benefits as needed.
- Move closer to universality of coverage by restoring the financial penalty for being uninsured or provide for opt-out rather than opt-in coverage.

This program could be adopted in steps, or as a single legislative action. Enactment of the program will be challenging, but it is an incremental improvement to the ACA rather than establishment of a whole new structure. As such, enactment should be less difficult than the original passage of the ACA.

It is time to finish the job the ACA started. Every American deserves affordable, quality health care. It is time to assure that, once and for all, health care is a right, not a privilege.

Introduction

The Affordable Care Act (ACA) was a great step forward toward the goal of a true program of universal health care. As the result of the ACA, more than 20 million previously uninsured Americans have gained coverage.[1] The proportion of the uninsured nonelderly population dropped from almost 17 percent in 2012, just before the bulk of the ACA went into effect, to slightly above 10 percent in 2017.[2] Insurance policies are required to cover an expansive set of essential health benefits, and low-income Americans are protected against excessive out-of-pocket costs.[3] The ACA banned pre-existing exclusions in insurance and eliminated yearly and lifetime limits on benefits. It capped out-of-pocket costs for covered services.

Studies have demonstrated improved access to health care and better health outcomes among many of the newly covered.

But while the ACA was a giant achievement, it has still fallen short of the ultimate goal of universal health care: making health care a basic human right for all, not a privilege based on ability to pay. Approximately 25 million Americans remain uninsured.[4] Furthermore, even among those with coverage, many do not have affordable access to the care they need because of excessive cost-sharing or failure of their insurance to cover needed benefits.

What is needed is a plan that achieves the goal of universal health care by building on the ACA. Specifically, the plan outlined in this report addresses four key gaps in the ACA:

1. ***Improving the affordability of coverage and care.*** Currently, under the ACA, the insurance options available to many Americans come with unaffordable premiums that price coverage out of the reach of some families and create excessive financial burdens even for those with coverage. Because of inappropriately high cost-sharing, especially in the form of high deductibles and high out-of-pocket limits, many insured families go without needed care, delay needed care, or are faced with crippling bills for the care they receive.

2. ***Eliminating gaps in essential benefits, including those provided through Medicaid.*** There are still important health care services not adequately covered under the ACA's requirements nor under Medicaid's benefits.

3. ***Eliminating problems in employer-provided coverage.*** The ACA currently has an employer loophole, which leaves some workers without access to affordable insurance, enrolled in substandard coverage, or without the financial protections provided in exchange plans.

4. ***Continuing Medicaid expansion.*** The failure to expand Medicaid in fourteen states leaves millions of very-low-income families and individuals without the protection they need.

In addition, ways to bring insurance coverage closer to universality beyond assuring that coverage is affordable are briefly discussed.

This report analyzes the gaps in the ACA in these four areas and outlines the improvements that are necessary for it to truly achieve universal health care for all. These areas overlap a bit, of course. For example, the problems with employer-provided care involve both affordability and benefits, so some issues are referred to in more than one section.

Enacting these improvements will be challenging, but not impossible if they become a priority for progressives and the health policy community. The report also contains a section with some thoughts on the political feasibility of enacting such a plan.

When the ACA was originally proposed, it included a public option. In this original proposal, the public option was simply a government-operated insurance program offered through the exchanges. The plans offered and the requirements for those plans, including actuarial value, premium, and cost-sharing subsidies, would be the same as the exchange plans offered by private insurers. Several new versions of a public option have recently been proposed, such as, for example, by presidential candidate Joe Biden[5] and by experts at the Urban Institute.[6] As with the plan outlined in this report, these proposals for a public option provide for the improvement of premium and cost-sharing subsidies in exchange plans. These proposals, like the original ACA proposal, would establish a public plan option offered through the exchanges; unlike the original ACA plan, these two proposals would allow anyone to enroll in the public option, even people with employment-based coverage. These proposals for a public option could provide a way of addressing the problems of inadequate employment-based plans that might be an alternative to the approach advanced in this report. The Century Foundation has already recommended a public

option.[7] While not discussed in this report, a public option along the lines of the original ACA plan could be integrated with the recommendations in this report.

The first step in any health care reform is obvious: undo the damage caused by the Trump administration's attempts to undermine the ACA and Medicaid by a whole series of administrative actions. Any new administration can, by administrative actions of its own, reverse most of what Trump has tried to do. The Trump initiatives that need to be overturned are described in detail in Appendix A of this report. But more fundamental reforms are needed if the ACA is to provide access to quality, affordable health care for all.

1. Improving Affordability of Coverage and Care

The chief goal of the Affordable Care Act was to take a giant step toward universal health care by making health insurance coverage both affordable and universal, and by seeking to assure that care for all those who are insured is affordable. Unfortunately, for many Americans, barriers still remain in the form of the high cost of purchasing coverage (unaffordable premiums), and also in the high cost of using that coverage to obtain medical treatment (excessive cost-sharing). Moreover, the Republican Congress's repeal of tax penalties for failing to secure insurance further undercuts the goal of universal coverage.

Unaffordable Premiums

The ACA provides premium subsidies for individuals and families with incomes up to 400 percent of the federal poverty level (FPL). In 2019, these annual income levels are about $50,000 for an individual and $103,000 for a family of four.

For families below the 400 percent threshold but above the level for Medicaid eligibility, the ACA established a premium subsidy schedule. The ACA established four levels of plans: bronze, silver, gold, and platinum. Bronze plans cover 60 percent of the actuarial value of coverage. That means that, of the services covered by the plan, the plan would pay, overall, 60 percent of the cost of services supplied, while enrollees would pay the rest through various forms of cost-sharing. Silver plans cover 70 percent of the cost of coverage, gold plans 80 percent, and platinum plans 90 percent. The subsidies are tied to premiums for silver plans and, to encourage price competition by plans, are set based on the cost of the second-lowest-cost silver plan in a geographic area.

Table 1 below shows the 2019 cap on the percentage of income that a family of four and an individual would have to pay for the second-lowest-cost silver plan coverage. That cap generates a dollar amount of subsidy that could then be used to purchase any exchange plan. If the plan the family or individual chose were less expensive than the benchmark silver plan premium, the amount the purchaser would pay would be a lower percentage of income, and the converse would be true if a more expensive plan were chosen.[8] Unlike cost-sharing subsidies (discussed below), premium subsidies can be used to purchase any metal level plan, not just a silver plan.

Of the 25 million people currently uninsured, almost 8 million—approximately 30 percent—are eligible for premium subsidies. Conversely, there are 9.9 million people currently receiving subsidies enrolled in the exchange plans.[9]

Of those eligible for exchange coverage but still uninsured, the uninsured rate is similar for those below 200 percent of the federal poverty level and those from 200 to 400 percent of the FPL. For those below 200 percent of poverty it is 24.2 percent, while for those from 200–400 percent of the FPL, it is 22.2 percent.[10] Actual participation in the exchange is heavily skewed toward the lower-income group, with household income below 250 percent of the FPL accounting for 71 percent of enrollees, and those at 251–400 percent of the FPL for 19 percent.[11] A single mother and child with a pretax income level just over 250 percent of the FPL—about $41,000 a year in 2019—would have to pay more than 8 percent of pre-tax income for coverage.

TABLE 1

Limits on Premium Contribution by Income Level		
Income		*Required Premium Contribution*
Income as a percentage of the federal poverty level	*Annual income amount (in dollars)*	*Percentage of income*
Family of four		
100-138	$25,100-$34,638	2.08-3.42
138-150	$34,638-$37,650	3.42-4.15
150-200	$37,650-$50,200	4.15-6.54
200-250	$50,200-$62,750	6.54-8.36
250-300	$62,750-$75,300	8.36-9.86
300-400	$75,300-$100,400	9.86
Individual		
100-138	$12,140-$16,753	2.08-3.42
138-150	$16,753-$18,210	3.42-4.15
150-200	$18,210-$24,280	4.15-6.54
200-250	$24,820-$30,350	6.54-8.36
250-300	$30,350-$36,420	8.36-9.86
300-400	$36,420-$48,560	9.86

Source: Updated from January Angeles, "Making Health Care More Affordable: The New Premium and Cost Sharing Credits," Center on Budget and Policy Priorities, May 19, 2010, cited in John McDonough, Inside National Health Reform (Oakland, Calif.: University of California Press, 2011).

An obvious gap in the subsidy schedule is the lack of any protection against high premiums for families over 400 percent of poverty. These families account for 20 percent of the uninsured population.[12]

Average premiums for people at the low end of the unsubsidized income group, in particular, can be unaffordable or perceived as unaffordable. For example, the average premium for the lowest-cost silver plan in 2019 would eat up 11 percent of the pre-tax income of a 40–year-old with an income just above the subsidy cutoff level. And since the ACA allows plans to vary premium prices by age (within limits), for a 60-year-old, the average premium cost would be 23 percent of income.[13]

Moreover, looking at the average cost of premiums hides steep barriers that people face at the extremes. In Grant County, Nebraska, for example, a 60-year-old would have to pay 32 percent of his income just to buy the lowest-cost bronze plan.[14] Perhaps reflective of the need for protection against high premium costs for those over 400 percent of poverty is the fact that this is the only income group for which the proportion uninsured actually grew between 2015 and 2017.[15] Moreover, while this group is far less likely to be uninsured than the less affluent, the drop in the proportion uninsured as the result of the ACA was significantly less for this group than for the other income categories: the percentage of all adults 18–64 years old who were uninsured dropped 40.5 percent between 2013 and 2016, while for those in the group who had incomes over 400 percent of the FPL, it dropped 27 percent.[16]

For people ineligible for employment-based coverage, failure to secure coverage through the exchanges or from private non-group coverage outside the exchanges can have multiple causes, but lack of affordability clearly ranks at the top of the list.[17] A Commonwealth Fund survey found that, by the spring of 2015, one-quarter of working-aged adults had visited a marketplace to shop for health insurance. Of those who did not enroll, more than half said they could not find an affordable plan—and the largest group of these were actually subsidy-eligible. Excluding those who visited the marketplace but subsequently found coverage elsewhere, more than half—54 percent—were eligible for premium subsidies because they had incomes between 100 and 400 percent of the FPL; 26 percent had incomes below 100 percent of the FPL, but were residents of states that did not expand Medicaid, making them ineligible for marketplace subsidies; and 11 percent were above 400 percent of the FPL, and therefore not subsidy-eligible.[18]

Further evidence of the inadequacy of the ACA's premium subsidy structure was provided by another question in the Commonwealth survey. When those who were enrolled in marketplace plans were asked how easy or difficult it was to afford the premiums, 46 percent of those with incomes below 250 percent of poverty—the group receiving the most generous subsidies—said that it was very difficult or somewhat difficult. Similarly, 49 percent of those above 250 percent of poverty also said that affording premiums was very difficult or somewhat difficult. Equally telling was that, among those below 250 percent of the FPL, who were eligible for cost-sharing subsidies if they enrolled in a silver-level plan, one in four enrolled in bronze-level plans that offer cheaper premiums. As described below, not only are cost-sharing subsidies not available for bronze-level plans, but the coverage provided is substantially less generous.[19]

The inadequacies of the premium subsidy structure are exacerbated by the fact that the percent of income required to be spent on premiums at each level of income before subsidies kick in is indexed and increases every year.[20]

As discussed further in the section on employment-based coverage, the standards for the affordability of premiums charged employees are also problematic. While employers generally try to assure that premiums for the insurance they offer are affordable for their employees, low-wage workers may be left out. The ACA establishes a standard for "affordability" of plans offered by employers. If coverage is not affordable by the ACA standard, workers can enroll in an exchange plan. In 2019, the affordability standard is defined as providing that the cost to the employee of coverage in the lowest-cost plan offered by the employer is less than 9.86 percent of the employee's household income.[21] As shown in Table 1, this is a less generous standard of affordability for workers earning less than 300 percent of the FPL than for a similar individual enrolled in an exchange plan, and a far less generous standard than for a similar individual below 200 percent of the FPL.

An additional problem with the employer-provided insurance affordability standard is the so-called family glitch. The measurement of the affordability of the employee share of the premium cost is based on a policy providing coverage for just the worker (self-only coverage), not coverage for the worker and his dependents (family coverage). Family coverage typically costs more than twice the rate for individual coverage. As a result, premiums for workers who want to obtain coverage for their families can cost significantly more than the 9.86 percent of income standard, but these workers would still be ineligible for exchange coverage.[22]

Of the uninsured, 2.7 million are offered insurance by an employer that is deemed "affordable" by the ACA standard, but do not accept it[23]—presumably because they see it as unaffordable in reality.

Recommendations for Making Coverage More Affordable:

- *Improve premium subsidies to ensure affordability.* As described earlier in this report, high premium costs discourage participation and place an inappropriately heavy burden on many who do enroll. Premium subsidies for low-income

TABLE 2

Potential Revised Premium Tax Credit Schedule	
Income (Percentage of the Federal Poverty Level)	*Cap on Percent of Income Spent on Premiums*
100–138	0–1.0
138–150	1.0–2.0
150–200	2.0–4.0
200–250	4.0–6.0
250–300	6.0–7.0
300–400	7.0–8.5
≥ 400	8.5

Source: Linda J. Blumberg, John Holahan, Matthew Buettgens, Robin Wang, "A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs," Robert Wood Johnson Foundation and Urban Institute, December 18, 2018, https://www.urban.org/research/publication/path-incremental-health-care-reform-improving-affordability-expanding-coverage-and-containing-costs/view/full_report.

households should be expanded, and the premium obligation for those over 400 percent of the FPL should be capped at a percentage of income that would ensure affordability. The indexing of the caps on the percentage of income that would be expected to be paid at different levels of income should be eliminated.A group of health policy experts at the Urban Institute has proposed a new schedule that would cap the premium obligation at about one-third to one-half of the present limits. Table 2 below shows their proposed schedule.

For those over 400 percent of the FPL, the cap would be 8.5 percent of income under their proposal.

- *Eliminate the family glitch.* Applying the premium affordability standard to family coverage under employment-based insurance would eliminate the family glitch. In other words, the revised cap on the percentage of income that the employee would have to pay for coverage before being eligible for marketplace insurance would be the same for individual and family coverage.
- *Make employer-provided insurance as affordable as exchange policies.* Improve the standard of affordability for employer-provided insurance by setting the share of income that would be considered affordable for workers at different incomes at a level parallel to the exchange or achieve a comparable benefit through the tax system

These last two recommendations are discussed in more detail in the section on eliminating gaps in employer-provided coverage.

Excessive Cost-Sharing

Insurance coverage is a necessary but not sufficient condition for universal access to quality care. The insurance must also ensure that care is affordable and that care-seeking is not discouraged by financial considerations. Unfortunately, the ACA's current cost-sharing structure is inadequate to achieve this objective in exchange plans, and there are significant issues with employer-provided insurance as well.

As noted above, while premium subsidies are tied to the cost of the second-lowest-priced silver plan in an area, they can be used by enrollees to purchase any metal level plan. Cost-

TABLE 3

Cost-Sharing Subsidies and Out of Pocket Maximums in 2019		
Type of Plan or Subsidy	*Actuarial Value*	*Out-of-Pocket Maximum for Individual/Family*
Standard Silver Plan	70%	$7,900/$15,500
Subsidized: % of the FPL		
100–150% of the FPL	94%	$2,600/$5,200
150–200% of the FPL	87%	$2,600/$5,200
200–250% of the FPL	73%	$6,300/$12,600
Unsubsidized		
Over 250% of the FPL	70%	$7,900/$15,500

Source: Adapted from Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies," November 20, 2018, www.kff.org/healthreform/issue-brief/explaining-health-care-reform-questions-about-health.

sharing subsidies, however, are available only for silver plan enrollees.

Under the ACA's formula, cost-sharing subsidies increase the standard 70 percent actuarial value of silver plan coverage for individuals and families with income below 250 percent of the FPL and below. For people between 100 and 150 percent of the FPL, the actuarial value of the plan is set at 94 percent; for 150–200 percent of the FPL, it is set at 87 percent; for 200–250 percent of the FPL, it is set at 73 percent. The effect of these changes is to reduce out-of-pocket costs that would otherwise be required under the plan, as the plan must alter its cost-sharing structure for these individuals and families so that it meets the actuarial value standard.

OUT-OF-POCKET MAXIMUMS

The ACA sets an annual out-of-pocket maximum that, in 2019, is $7,900 for an individual and $15,800 for a family (as with the premium subsidies and the employer affordability standard, the out-of-pocket maximum is indexed and goes up every year). The out-of-pocket maximum is reduced for those at 250 percent of the FPL and below. For example, in 2019, the maximum is $2,600 for an individual and $5,200 for a family at 150–200 percent of the FPL.

Once the out-of-pocket maximum is established, the individual insurer is free to set other aspects of cost-sharing—the deductible and coinsurance or copayments for services—in any mixture it chooses, so long as the plan overall achieves the appropriate actuarial value for each income level.

Table 3 shows the out-of-pocket maximums and actuarial values for individuals and families at different levels of income.

How affordable is this structure for families with high medical costs? How well does it achieve the goal of assuring that care is affordable, and prompt access is not deterred? The answer, unfortunately, is not very well. To begin with, the annual limits are quite high. For example, 250 percent of the FPL for a family of three is $53,325 in 2019. A family just above that income level would have to spend almost 30 percent of its pre-tax income before it hit the out-of-pocket cap—at a time when 40 percent of American families say they do not have enough savings to cover $400 in unexpected costs.[24] Even families who receive cost-sharing

TABLE 4

Average Medical Deductible for Silver Plan with Combined Medical and Drug Deductible, 2018	
Cost-Sharing (actuarial value of Silver Plan)	*Average Deductible*
No cost-sharing reduction (70% actuarial value)	$4,034
Incomes 200–250% of the FPL (73% actuarial value)	$2,973
Incomes 150–200% of the FPL (87% actuarial value)	$817
Incomes 100–150% of the FPL (94% actuarial value)	$234

Source: "Cost-Sharing for Plans Offered in the Federal Marketplace for 2018," Kaiser Family Foundation, Figure 4, http://files.kff.org/attachment/Slideshow-Cost-Sharing-forPlans-Offered-in-the-Federal-Marketplace-for-2018.

subsidies could face a substantial burden. A family of three at 150 percent of the FPL would have to pay one-quarter of its income to meet the out-of-pocket cap. This problem is exacerbated by the fact that the cap is reset every year—there are no lifetime limits—so families with someone facing a drawn-out or chronic illness, or a second person who gets sick in a subsequent year, would continue to face very large costs relative to income.

Actual out-of-pocket maximums in silver plans average close to the maximum allowed by the ACA. For gold plans, they come in at about 72 percent of the limit ($4,935 for an individual), and for platinum plans, they are about 39 percent of the limit ($2,694).[25] As discussed below, out-of-pocket maximums are typical substantially lower in large employer plans.

One of the major functions of health insurance is to protect people against economic hardship resulting from high medical costs. This is the reason that the ACA has an out-of-pocket cap, as well as a requirement prohibiting insurers from placing annual or lifetime limits on medical benefits. Excessively high out-of-pocket maximums undermine this central goal of the ACA, as well as the general concept of the protection insurance is supposed to provide.

DEDUCTIBLES

A major factor driving high out-of-pocket costs is the prevalence of high deductible plans. High deductibles are a feature of virtually all ACA marketplace plans at every metal level except platinum, and are becoming much more common in employer plans as well. In 2018, for plans that had a combined medical and prescription drug deductible, the average deductible for a single person was $6,002 for a bronze plan, $4,034 for a silver plan, $1,194 for a gold plan, and $52 for a platinum plan. As one would expect, the average medical deductible was modestly lower for plans with separate medical and drug deductibles—$3,999 for a silver plan, for example.

For people eligible for cost-sharing subsidies—that is, with incomes of 250 percent of the FPL or less—silver plans are required to reduce the cost-sharing obligations that otherwise apply. Insurers have flexibility in how they change the mix of out-of-pocket limits, deductibles, and other cost-sharing to achieve the actuarial targets they are mandated to hit (although out-of-pocket limits are capped, as described earlier). Table 4 shows how the average silver plan achieves this at various income levels.

Note that even with these reductions, single individuals at 225 percent of the federal poverty level ($27,315 in 2018)

would have to spend 16 percent of their income before they received any benefits beyond the limited services provided without reference to the deductible. Taking into account their premiums, they would have to spend $6,535 (23 percent of income) before they received any benefits. By the time they hit the out-of-pocket maximum, they would have spent 21 percent of their income on health care, and 28 percent of their income on health care plus premiums.[26] At 251 percent of the FPL—just over the level where cost sharing subsidies would apply—a single individual would have to pay over 13 percent of her income for covered health benefits before she received any help with medical expenses.[27]

At the average silver plan premium, even with premium subsidies, a 40-year-old individual with income at this same level—251 percent of the FPL—would have to pay an additional 7 percent of her income for coverage—resulting in a total expenditure of 20 percent of income spent before any help with health expenses was available. Even for someone well above the 400 percent of the FPL cutoff for premium assistance, these deductibles would be burdensome. A 40-year-old single individual with an income of $70,000—560 percent of the FPL—would spend 8 percent of their income for the average silver plan premium. With a $4,034 deductible, they would spend a total of almost 13 percent of their pre-tax income before they received any medical benefits.[28]

Family deductibles are even higher—generally around twice the individual deductible—so that if more than one person in a family has significant health expenses, health care is even less affordable. The impact of high deductibles is moderated somewhat by most silver plans by exempting certain services from the deductible. According to a 2016 study, 80 percent exempted primary care office visits and generic drugs, 64 percent exempted office visits to specialists and preferred brand name drugs, and 63 percent exempted mental health outpatient visits. In addition, ACA requires that certain preventive services have no associated cost-sharing. These exemptions are helpful and make initial care-seeking less burdensome, but they are not universal and they do not solve the problem of someone who has a health problem that is more serious than can be solved by a simple doctor's visit or requires higher cost brand name drugs.[29]

As discussed further in the section on employment-based insurance, high deductible plans are increasingly prevalent among those gaining insurance through a job, creating problems for this group of insured as well.

Assessing the Impact and Prevalence of Excessive Cost-Sharing

Beyond the financial burden that high deductibles create, they are, not surprisingly, a significant barrier to care, especially for lower-income patients. A recent study comparing a matched group of women switched to high deductible plans between 2004 and 2014 with a control group found that patients in high deductible plans suffered significant delays in breast cancer diagnosis and treatment, including delays in first imaging, biopsy, diagnosis, and chemotherapy. The differences were most marked in lower-income women—with a potentially life-threatening delay between diagnosis and treatment of 8.7 months compared to the control group.[30] Even for higher-income women, however, there was a delay of 5.7 months compared to the control group. A high deductible plan was defined, for the purpose of the study, as a plan with a deductible of $1,000 or more, with the mean high deductible equaling $1,900. Only 6 percent of the women in the high deductible group had deductibles of $2,500 or greater. Low deductible plans were defined as those with deductibles of $500 or less. Notably, these high deductible levels are far lower than the deductibles typical of a bronze or silver plan. The typical deductible for even a gold plan would fall within the study's definition of a high deductible plan.

Other studies of the impact of high deductible plans found similar impacts: they resulted in delayed or foregone care for patients suffering from a wide variety of illnesses. An article by Emory University health policy and management professor Ken Thorpe and others summarized findings that showed these results as the result of high deductibles among cancer patients, epilepsy patients, and multiple sclerosis patients.[31]

A study in the *Annals of Internal Medicine* found that low-income patients enrolled in high deductible plans were more likely to delay or forgo care than higher-income patients, but both groups had relatively high rates of delayed and forgone care because of costs.[32] Johns Hopkins health policy professor Karen Davis and colleagues analyzed data from the Commonwealth Fund Biennial Health Insurance Survey and concluded that patients with high deductible health plans have significantly greater difficulty in accessing care because of costs. 38 percent of adults enrolled in such plans reported at least one of four cost-related access problems, including not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up, or having a medical problem but not visiting a doctor on time. This was an 81 percent higher rate than among adults with no deductible.[33] An article published in *Health Affairs* systematically reviewed the published literature and found that high deductible health plans "appeared to reduce costs by decreasing the use of both appropriate and inappropriate health services." The authors of that article state that their review is "consistent with a large body of evidence on cost sharing."[34]

The Commonwealth Fund attempted to assess the overall prevalence of excessive cost-sharing and summarize some of its impacts in a study designed to measure what the authors termed "underinsurance." The study defined being underinsured as having out-of-pocket costs (excluding premiums) over the prior twelve months that are equal to 10 percent or more of household income, or equal to 5 percent or more of household income (excluding premiums) for those below 200 percent of the FPL, or a deductible which constitutes 5 percent or more of household income. The first two measures focus on actual expenditures; the last on potential costs. The Commonwealth Fund found that, among people insured continuously in 2018, an estimated 44 million were underinsured. Among the underinsured, 30 percent had problems paying or were unable to pay medical bills. The Commonwealth Fund also documented widespread cost-related access problems as the result of underinsurance. In 2018, 25 percent of the underinsured did not fill a prescription because of cost compared with 13 percent of those who were insured and not underinsured.[35]

The Federal Reserve Board's "Report on the Economic Well-Being of U.S. Households in 2017" also identified widespread access issues and financial burdens from health care costs, even among the insured. The Federal Reserve Board found that 25 percent of people with health insurance went without medical treatment due to inability to pay—far better than the 45 percent of people without health insurance who skipped medical treatment, but still high.[36]

Recommendations for Reducing Cost-Sharing:

- *Lower permissible out-of-pocket limits.* As described above, the current limits in the individual market are extremely high in terms of family income, even for those receiving subsidized cost-sharing. Adopting a modification of the standard proposed by the Commonwealth Fund (5 percent of income for those below 200 percent of the FPL and 10 percent for those of higher incomes) would set the limit at a dollar figure approximating 3.5 percent of income for individuals below 150 percent of the FPL (about $570) in 2019; set it at 5 percent for individuals at 150–200 percent of the FPL (about $1,100) and individuals at 201–250 percent of the FPL (about $1,275), and 7.5 percent of income for individuals 251–400 percent of the FPL (around $3,000).[37] The out-of-pocket limit would be capped at 10 percent of income for individuals at 400 percent of the FPL (about $4,800) and would stay at that percentage level for higher incomes. The cap should be indexed to the FPL. An additional refinement would lower the cap for several additional years in families that hit their annual cap, in order to prevent excessive pile-up of costs over time.A more in-depth analysis of what families at various levels of income are actually able to afford might suggest lower limits. The average out-of-pocket limit for gold plans in 2016 was $4,984. For platinum plans, it was $2,694. As noted earlier, the average for large employers was $2,250. This is substantially lower than the cap suggested above for individuals at 400 percent of the FPL or more as well as being lower than the average cap for gold plans. As discussed further

in the section on employer-provided coverage, employers could be required to vary their caps based on income, if their general cap is higher than would otherwise be required for some workers. Alternatively, the tax system could be used to buy down the cap for low-income workers.

- *Eliminate high deductible plans.* High deductible plans in individual and group coverage should be prohibited unless accompanied, in group coverage, by an Health Savings Account or Health Reimbursement Account that will reduce the deductible to an acceptable level. Determining what is an acceptable level is difficult. The goal is to ensure that the deductible does not hinder access to needed services, but, while the literature generally shows that high deductibles do have this effect, there is no good data on where a high deductible leaves off and a reasonable deductible begins.One approach might be to set the maximum deductible at $1,000 per individual and $2,000 per family, slightly below the 2018 average deductible for gold plans ($1,194). This figure is certainly too high for low-income families and should be set at a lower figure for those families in exchange plans. In addition, the practice currently followed by a majority of silver plans of excluding office visits, mental health outpatient visits, and generic and on-formulary brand-name drugs from the deductible should be made universal.How to handle the issue of lowering the deductible for low-income families in employer plans is more complicated, but comparable limits should be set there as well. Like the issue of premiums and out-of-pocket caps in employer plans, this recommendation is discussed in more detail in the section on employer-provided coverage.

- *Adjust plan actuarial values and extend limitations on cost-sharing.* Lowering the out-of-pocket limits and eliminating high deductible plans would need to be accompanied by raising the actuarial value of the base plan to which both premium and cost-sharing subsidies are tied. Otherwise, other forms of cost-sharing and premiums would increase. Based on the discussion above, the value of the new base plan would need to be somewhat higher than the actuarial value of the current gold plans. In addition, the actuarial value of coverage for lower-income groups would need to be comparably increased in order to keep routine cost-sharing—such as co-payments and coinsurance after the deductible but before the out-of-pocket cap is reached—affordable and not a deterrent to seeking care.

2. Eliminating Gaps in Essential Benefits, Including Those Provided through Medicaid

The ACA requires coverage of ten categories of essential health benefits in individual plans and, effectively, in small employer plans. These categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. While these categories cover a broad range, they are also general, and thus do not by themselves indicate the scope of coverage within each category. Moreover, plans are generally allowed to put limits on days of treatment or number of visits for these services, although not dollar limits.

The ACA addresses this issue by directing the U.S. secretary of health and human services to "ensure that the scope of essential health benefits is equal to the benefits provided under a typical employer plan." There are also some other directives to the secretary—for example, that the benefits take into account health needs of diverse populations—that suggest that the requirement that the scope equal that of a typical employer plan is not absolute. In any event, the Obama administration chose to not specify the scope of benefits in detail. Rather, it allowed each state to select its own benchmark plan from four options: one of the three

largest small group plans in the state, the state employee health benefit plan, any of the three largest national Federal Employee Benefits Program plan options, or the largest commercial HMO in the state. Where the benchmark plan did not include one or more of the essential health benefits, the regulations prescribed alternative benchmarks for those benefits. Plans were allowed to change the scope and specifics of benchmark plan benefits within the ten essential benefit categories, but only if the resulting benefit was at least actuarially equivalent to the benchmark plan for that category. As discussed in the section on employer plans, the U.S. Department of Labor found that service coverage in both small and large employer plans was quite extensive.

The largest and most obvious gap in the essential benefits category is adult dental care. While large employers almost all offer some dental coverage to employees, in 2010, three times as many Americans lacked dental insurance as lacked health insurance.[38] One in four nonelderly adults have untreated tooth decay.[39] Poor dental health can lead to major impairments of physical health and can be a marker of lower class status that disadvantages people afflicted by it in a number of ways.[40]

Health services under the Medicaid program are divided into two categories: mandatory and optional. Any state participating in the Medicaid program must provide coverage for the mandatory categories. Federal matching funds are available for the optional coverage categories at the same level as for the mandatory services, but coverage is optional with the states.[41] The optional category includes some key services, such as prescription drugs; key habilitative and rehabilitative services such as physical therapy; occupational therapy, and speech therapy; and adult dental care.[42] While most states cover the important optional benefits, coverage is not universal. For example, thirteen states do not cover adult dental care, and ten of those that do put significant restrictions on coverage, such as only covering emergency dental care. Two states do not cover physical therapy, and four more put on significant limitations. Three states do not cover occupational therapy. Four states do not cover speech therapy.

Recommendations for Eliminating Gaps in Essential Benefits:

- *Make adult dental care an essential benefit.* The list of ten essential benefits is a good one, although a very general one, but the omission of adult dental care was a mistake, and this benefit should be added to the list.

- *Empower the secretary of health and human services to expand essential benefit requirements, as needed.* The authors of the ACA and the Obama administration made a wise choice, in my view, in allowing some flexibility in the way the general categories of the essential benefit package are interpreted. A full federal enumeration of the scope of each general category would inevitably both become dated over time and overly prescriptive with regard to medical practice and specific services, with the potential to limit access to technologies and procedures that may be evolving. But as our understanding of patient's needs grows, more specific requirements within categories may be necessary. For example, some states prescribe certain services for autistic children which are not generally offered in private insurance; it may be that this requirement should become universal.In addition to adding adult dental coverage to the list of mandatory benefits, it makes sense for reform legislation to add authority for the secretary to require specific additional benefits be covered if those benefits are necessary to treat illness or improve or maintain health, regardless of their inclusion in a benchmark program or a typical employer plan. The secretary should not, however, be allowed to exclude benefits from coverage, and the legislation should specify that a secretary's decision not to include a benefit as mandatory should not be viewed as a judgment on its medical necessity or lack thereof.

- *Require all employer plans to cover essential benefits.* The other gap in essential benefits is the failure to require coverage of them by employer plans.

As noted elsewhere, the scope of coverage in employer plans is generally quite good, and required coverage of essential benefits would not affect most employer plans. However, it makes sense to ensure that workers in all plans receive this minimum standard of coverage. Employers should have flexibility to define benefits within each category, but each category must at least be equal in actuarial value to benchmark plans. (This is covered in greater detail in the next section.)

- *Require state Medicaid programs to cover all essential benefits.* The current optional Medicaid benefits should be made mandatory, without the artificial limitations established by some states.

3. Eliminating Problems in Employer-Provided Coverage

Coverage provided by employers—when they do provide it—is generally pretty good in terms of both actuarial value and comprehensiveness of benefits. However, the legal standards for large employers are looser than for exchange plans, and workers are not well protected against outlier employers. Moreover, low-income workers lack the additional protections provided under exchange plans.

Issue Areas in Employer-Provided Coverage

The ACA required large employers—defined as employers with fifty or more full-time-equivalent workers—to provide health insurance for their employees or face a penalty.[43] Requirements that large employers have to meet include no lifetime or annual limits, establishment of annual out-of-pocket maximums using the same standard as exchange plans, allowing dependents under the age of 26 to participate in an employee parent's plan, first-dollar coverage of preventive services, not requiring a referral for obstetrician-gynecologist's services or emergency out-of-network care, and, if they cover mental health benefits, providing parity with physical health benefits. Employers may not put dollar limits on services covered, but may put day or visit limits.[44] Employer plans must provide at least a minimum actuarial value. They are not required to cover the ten essential benefits. There is no provision for subsidies for low-income workers. They are required to meet a minimum affordability standard for premiums.

Small employers have no requirement to provide coverage for their employees. When they do provide coverage, however, the coverage they purchase from insurers must meet the same standards as insurance sold in the individual market. Employees of small employers providing coverage, however, do not have access to exchange plans and the associated premium and cost-sharing subsidies unless the small employer plan fails to meet the same affordability test that applies to large employers, so the same issues of actuarial value and protection for low-income workers that apply to large employers also apply to employees of small employers.

ACTUARIAL VALUE

The insurance offered by employers must cover at least 60 percent of the actuarial value of the plan (equivalent to the requirements for a bronze plan on the exchange). In practice, few large employer plans fall to that level. A study by the Actuarial Research Corporation for the Department of Labor found that there was little difference in the actuarial value of plans offered by small and large employers. Using two different measures, they found that the average actuarial value of employer plans was between 82 percent and 84 percent, somewhat better than the required level for a gold plan.[45]

Employer plans with an actuarial value as low as 60 percent (the same level as a bronze plan) were rare. The average value for the lowest 5 percent of employer-provided plans was between 67 percent and 71 percent, close the actuarial value of a silver plan. Thirty percent of employers offered coverage that was close to or above the value for a platinum plan (90 percent of the actuarial value of the plan).[46]

OUT-OF-POCKET MAXIMUMS

Out-of-pocket maximums for employer plans are also generally much lower than the statutory standard of $7,900—the same limit as for exchange plans. In 2017, among employers with more than 100 workers, the median out-of-pocket maximum for individuals was $2,250; at the high end (ninetieth percentile), the average was $5,100. Family out-of-pocket maximums for employer plans averaged about twice the average maximum for individuals with employer coverage.[47] Even at the high end, the employer out-of-pocket maximum was well below the average silver plan for individuals above 250 percent of the FPL.

DEDUCTIBLES

As is the case for individual plans, there are no statutory restrictions on deductibles among employer plans other than those that may grow out of the actuarial value standard. High deductible plans are growing rapidly in the large employer market. In 2017, approximately 14 percent of workers in firms with one hundred workers or more were in plans with no deductibles. Slightly more than one-third of the workers were in high deductible health plans (38 percent) and the remainder were in plans with a deductible not classified as high deductible (less than $1,300). Among large employer plans with a deductible, according to the Bureau of Labor Statistics data for 2017, the median individual deductible was $1,250 and the median at the ninetieth percentile was $3,000. Even at the high end, these levels are substantially below the unsubsidized deductibles for silver exchange plans ($4,034).[48]

The Kaiser Family Foundation analyzed data for 2018 and presented results for workers with a deductible of $1,000 or more, somewhat less than the Bureau of Labor Statistics threshold for high deductible plans. Fifty-four percent of workers in large employer plans (defined as plans employers with 200 workers or more) had deductibles this high or higher. Twenty percent had deductibles of $2,000 or more.[49]

Twenty-nine percent of workers in these firms were enrolled in an attached savings option, either a Health Savings Account or a Health Reimbursement Account. Both of these types of accounts are tax favored employer contributions to an account which workers can use to pay health costs, including deductible amounts, not paid by their health plans. Less than half of these workers, however, receive an employer contribution to the account large enough to reduce their deductible to $1,000 or less.[50]

PREMIUMS

As noted above, to meet the standards of the ACA, care must be "affordable," with an employee-paid portion of the premium not exceeding 9.5 percent of family income for single coverage for any full-time employee.

ESSENTIAL BENEFITS

Unlike individual insurance plans or plans purchased by small employers, large employers are not required to provide the ten essential benefits specified in the law. In determining whether or not large employers meet the 60 percent standard, however, the value of the benefits is compared to the value of the essential health benefits provided under a state benchmark plan. Whatever the benefits that the large employer provides, they must be at least equal in actuarial value to the benchmark plan. Some employers attempted to manipulate the actuarial value calculation in such a way that they did not cover—or only minimally covered—inpatient hospital care. IRS regulations outlawed that practice.[51]

In developing the essential benefits guidance, the U.S. Department of Health and Human Services (HHS) looked at a number of sources, which gave information on existing employer coverage.[52] In addition to a U.S. Department of Labor analysis of survey data from large and small employers,[53] HHS also looked at an Institute of Medicine survey of three small group issuers, and did its own analysis of State employee benefit plans, Federal employee plans, and information submitted to healthcare.gov by small group health insurance issuers. HHS concluded that these groups of plans do not differ significantly in the range of services they covered, although there were substantial differences in cost-sharing. HHS found:

TABLE 5

Percent of Family Income Going to Premiums and Out-of-Pocket Expenses, by Percentage of the Federal Poverty Level, 2017		
Income (% of the FPL)	*All Workers*	*Workers with a Family Member in Poor Health*
< 200%	14%	18.5%
200–399%	7.9%	12.0%
≥ 400%	4.5%	7.4%
Source: Gary Claxton, Bradley Sawyer, and Cynthia Cox, "How affordability of health care varies by income among people with employer coverage," Peterson-Kaiser Health System Tracker, April 14, 2019, https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/.		

It appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. . . .

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States. However, in some cases, small group products cover some benefits that are not included in the FEHBP plans examined and may not be included in State employee plans, especially in States for which benefits such as in-vitro fertilization or applied behavior analysis (ABA) for children with autism are mandated by State law. Finally, there is a subset of benefits including mental health and substance use disorder services, pediatric oral and vision services, and habilitative services—where there is variation in coverage among plans, products, and markets.[54]

AFFORDABILITY FOR LOW-INCOME WORKERS

As discussed earlier, the standard for the affordability of coverage offered by large and small employers is less generous than the subsidy schedule provided for families and individuals purchasing coverage through an exchange plan. When both premiums and cost-sharing are taken into account, low-income workers do significantly better under subsidized exchange plans than they do if they get their coverage through an employer. Indeed, low- and moderate-income workers face very substantial burdens in paying for employer-sponsored health care, even where the premiums they pay meet the ACA affordability standard. As shown by Table 5, below, workers with incomes below 200 percent of the FPL must pay, on average, 14 percent of their income for premiums and out-of-pocket payments; for families with at

least one member in poor health, the figure rises to almost 19 percent of family income; and even workers with incomes of 200–399 percent of the FPL pay an average of 12 percent of their income under these circumstances.

More than one-quarter of all workers with insurance through their employer reported problems in paying or inability to pay medical bills.[55]

Recommendations for Eliminating Problems in Employer-Provided Coverage:

While most large employer plans provide fairly good coverage, additional regulation is needed to ensure the goals of universal coverage are met:

- *Cover the essential benefits.* Employers should be required to cover the same essential benefits as exchange plans.

- *Eliminate the family glitch.* As mentioned earlier, applying the premium affordability standard to family coverage under employment-based insurance would eliminate the family glitch.

- *Change the affordability standard.* The affordability standard should be altered to conform to the new exchange cap on premiums for those above 400 percent of the federal poverty level (8.5 percent).

- *Raise the minimum actuarial standard.* The minimum actuarial value of employer plans should be raised to the new level established for cost-sharing subsidy-eligible exchange plans.

- *Prohibit high deductible plans.* High deductibles should be prohibited unless brought down to the level allowed for exchange plans (a maximum of $1,000) by a health savings account or a health reimbursement account.

- *Make coverage and use affordable for low-income workers.* Employee costs in employer plans, including premiums, deductibles, actuarial value, and out-of-pocket limits should be subject to the same reductions for low income workers as would be provided in an exchange plan.

This last point deserves further discussion. To be workable, it would require employers to gather information on their employee's income. Since they are already required to do this in order to determine whether or not they have met the affordability standard for premiums, this would not seem to pose a major burden.

There are two ways in which the required premium and cost-sharing reductions could be implemented. First, employers could simply be required to alter their plans to establish different premium and cost-sharing levels based on a worker's income. Alternatively, the tax system could be used to "buy down" the costs of coverage and services to low-wage workers. For premiums this could be done either by direct payments to workers through an EITC-type structure, or a pass-through to employers. To encourage enrollment and reduce the ongoing burden of premium costs, it should be done in such a way that the tax benefit is available at the time the premium is paid, rather than as a lump sum at the end of the year.

The tax system could also be used to buy down the cost of cost-sharing subsidies for low-wage workers. In this case, the payment would need to go to the employer, as the revised cost-sharing would have to be built into the individual's policy. Since employers design plans to be attractive to the majority of their workers, the availability of the subsidy would be unlikely to encourage employers to raise cost-sharing for workers who were not subsidy-eligible.

4. Continuing Medicaid Expansion

The ACA expanded Medicaid eligibility in two ways. First, it established non-aged, non-disabled childless adults as a beneficiary category. Second, it also expanded coverage of low-income parents. The architects of the ACA assumed

that all states would choose to cover these adults as well as parents at an income level up to 133 percent of the federal poverty level. Prior to the ACA, no federal matching was available for childless adults in these categories, and where states covered parents, they typically did so only at a very low income level.

To ensure that states did expand coverage as envisioned, the ACA did two things. First, it paid 100 percent of the cost of the expansion population for three years, 95 percent for the fourth year, 94 percent for the fifth year, 93 percent for the sixth year, and 90 percent afterwards in perpetuity, so that the federal government rather than the states picked up the vast majority of the costs of the expansion. Second, states that did not expand their coverage to the levels established by the law would lose their federal funds for their existing Medicaid population. When the constitutional challenge to the ACA was heard by the U.S. Supreme Court, however, the Court decided that the requirement that states expand Medicaid or lose their existing funding violated the Tenth Amendment, because it was an unconstitutional "coercion" of states (the colorful epithet "dragooning" was also used).[56] In view of many legal scholars, this was a bizarre finding, but whatever its correctness, it made expansion a state option rather than effectively a state requirement.[57]

As noted earlier, fourteen states—all controlled by Republicans—decided not to expand their Medicaid programs. Of the states that did expand the program, three only did so because popular referenda were passed compelling the expansion. At least two of these three states—Utah and Idaho—are seeking waivers to provide less than the full expansion anticipated under the ACA and approved by voters in the state.

The failure of these states to expand Medicaid left their residents who were below 100 percent of the FPL and not previously eligible without a source of subsidized insurance coverage. The authors of the ACA assumed that all states would expand Medicaid as provided in the statute, and that Medicaid should be the primary source of coverage for the lowest income people without access to employment-based insurance. Accordingly, people in that income group are not eligible for subsidized exchange coverage.

It is difficult to overemphasize how limited Medicaid coverage is in the states that did not expand Medicaid. The median income level that parents must fall below in order to be eligible for Medicaid in the non-expansion states is just 43 percent of the FPL, and nonelderly, non-disabled adults without dependent children are generally not eligible at all, no matter how poor they are.[58]

The adults in the 100–133 percent of the FPL group in are a somewhat different class, however (because of standardized disregards for certain household expenses in computing income established by the ACA, the 133 percent of the federal poverty level included in the legislation actually works out to 138 percent of the FPL). As the result of some glitches in the legislative process, adults in this group are potentially eligible for Medicaid coverage and for exchange coverage, although they are placed in Medicaid in states that have chosen to expand Medicaid. For the expansion population, the benefits required to be covered under Medicaid are defined as an "alternative benefit plan," which is similar to an exchange plan. While states are only required to offer the alternative benefit plan, most expansion plans (20 out of 28) have chosen to provide their traditional Medicaid benefits to this group (excluding nursing home and home and community based coverage).[59] Of those that chose the alternative benefit plan approach, some provide greater benefits than are available under the state Medicaid plan.[60]

Although exchange coverage is available to this group in states that have failed to expand Medicaid, Medicaid coverage is generally preferable, for several reasons. First, except when states have been granted a waiver, no premiums are allowed under the Medicaid plan. Second, cost-sharing is restricted to "nominal" amounts by federal law, and most states do not impose any copayments in Medicaid. Since no premiums are generally allowed, there is no issue of people enrolling only when they get sick, so individuals can enroll at any time. The ACA also provided for accelerated enrollment procedures, so that people can be enrolled or renew their

enrollment by phone or online.[61] When someone eligible but uncovered enters the health care system, through an emergency room visit, for example, providers will typically enroll them. The ACA required presumptive eligibility and immediate coverage for the expansion population. For other Medicaid beneficiaries, retroactive coverage is generally available, so it is in the interest of the provider to enroll the beneficiary in order to receive payment for services.

One possible negative with Medicaid versus private insurance coverage is that low Medicaid reimbursement rates (for physicians, an average of 72 percent of Medicare rates) may mean that more providers are available through the exchanges, although data show that Medicaid enrollees are as likely to have a regular source of care as privately insured enrollees.[62]

Medicaid is clearly an important part of the expansion of coverage created by the ACA. Insurance gains occurred not only among the income group newly eligible for Medicaid, but also among people already eligible but not participating, probably because the efforts to sign up people for the ACA reached this group as well. Overall, the Congressional Budget Office estimates that 12 million people gained coverage because they were made eligible for Medicaid by the ACA. Of those who meet the new eligibility criteria, 65 percent live in states that expanded Medicaid, while 35 percent do not.[63] This suggests that an additional 6 million uninsured would gain coverage if all states expanded eligibility as envisioned when the ACA was passed. Additional people currently eligible would also be likely to enroll in those states.

Where the Medicaid expansion has occurred, research shows that it has improved access to care, utilization of services, affordability of care, and financial security. A number of studies have also shown a positive effect on health outcomes.[64]

Recommendations for Continuing Medicaid Expansion:

The biggest issue in Medicaid is making the expanded coverage provided by the ACA universal. There are different theories has to how to accomplish this in light of the Supreme Court decision that mandating the expansion by conditioning receipt of federal matching for the entire program on expansion is "coercive." Possible approaches include:

- *Fully fund Medicaid expansion.* One approach would be to restore 100 percent matching for the expansion on a permanent basis, on the theory that the lack of any state cost sharing would make expansion irresistible. A group of health policy experts at the Urban Institute has proposed a broad program that has many similarities with the recommendation in this paper. They estimate the annual federal cost for instituting such a Medicaid policy at $95.5 billion annually.[65]

- *Provide carrots and sticks through the general federal match rate.* Another approach was advanced in an article in the *New England Journal of Medicine*. The authors propose a policy of slightly lowering the overall program match rate for states that do not expand their Medicaid population and slightly raising it for those that do. This combination of carrots and sticks would likely have about the same fiscal impact on both the federal government and participating states as raising the match to 100 percent for the expansion population, but the authors feel it would pass muster with the Supreme Court while making failure to expand even less attractive for the states that have not done so to date.[66]

- *Restart the clock on federal matching for "second chance" states.* One possible way to provide an additional carrot for states that have thus far chosen not to participate would be to reset the clock on 100 percent matching for those states and allow them to receive 100 percent matching for three years from the date they chose to reenter the program and 95 percent matching for the succeeding three years if they did so within four years of the enactment date of this second chance. This would not have the large

fiscal impact of the two proposals described above, and would be similar to the original provisions of the ACA, which provided for federal payment of 100 percent of the cost of expansion for the first three years and 95 percent in the second three years. This was proposed by President Obama in his 2017 budget.

- *Federalize coverage in non-expansion states.* An ingenious final approach, suggested by Jean Lambrew and Jen Mishory, would bypass Medicaid altogether and transfer responsibility for care for all non-disabled, non-aged single adults and parents from Medicaid to the federal government in states that have chosen not to expand their coverage. The proposal would include a "claw-back," as was done for drug costs transferred from Medicaid to Medicare when Medicare Part D was enacted, so that states that have not chosen expansion would still be responsible for the costs that they would have incurred under the state Medicaid program existing at the time of transition. This approach might achieve the coverage goals of Medicaid expansion without running afoul of the Supreme Court's decision, since the state would suffer no financial penalty from its implementation—although the Court might still decide that taking away control of an existing part of its Medicaid population from a state that failed to expand coverage was also coercive. This approach might also be perceived as unfair, as it would have the effect of providing greater federal funding for populations within the non-expansion states than in the expansion states, since the federal government would be picking up 100 percent rather than 90 percent of the costs.[67]

A variant on this proposal that would avoid both problems would be to provide federal coverage only to the expansion population in these fourteen states. In order to provide equity with the states that voluntarily chose expansion, the match rate for the expansion population in these states would be lifted from 90 to 100 percent. States that have not expanded their coverage might choose to do so if the alternative is federal administration of benefits for this population and the match is 100 percent—and if they chose not to, coverage would still be provided. The cost of this proposal would be similar to providing a 100 percent match rate for the entire expansion population and would provide immediate coverage for this group in the states that chose not to expand.

My own view is that the opposition to Medicaid expansion is essentially ideological and partisan, rather than based on a calculation of costs. Indeed, studies have shown that Medicaid expansion actually either improves state budgets by reducing costs they would otherwise incur enough to more than offset the costs of their match or produces minimal additional costs. Moreover, states get the benefit of improved health for their residents and greater tax revenues from greater participation in the workforce and the multiplier effect of additional funds flowing into hospitals and other providers in the state.[68]

Interest groups, primarily health care providers, will continue to push for expansion, as will broad popular support—as shown by the success of referenda held on the issue in conservative states. It took a number of years before all states elected to participate in the original Medicaid program (fifteen years for Arizona, the last state to join the program). In the long run, all states will likely participate in Medicaid expansion, and increasing the match rate is a significantly increased federal cost that will likely have a marginal impact on this decision.

Mechanisms for Increasing Enrollment

While making coverage affordable for all is the most important step that can be taken for universal coverage, it will likely not ensure that everyone enrolls in insurance coverage. One way to address this problem is to expand methods for encouraging enrollment.

There already has been some discussion of measures to increase enrollment of eligible individuals and families. Experts at The Urban Institute suggest automatic

enrollment of Medicaid-eligible families based on data from the food stamp and TANF programs.[69] Increased investment in the navigator or other sources of assistance for potential enrollees could also make a significant difference. A Commonwealth Fund survey, cited earlier, found that 75 percent of those who had received personal assistance ultimately enrolled, versus 56 percent of those who had not received such assistance.[70] Another possibility would be automatic enrollment of eligible but unenrolled individuals through the tax system. Individuals would be required, as they were when the individual mandate was in effect, to include proof of insurance with their tax submissions. Those who did not do so would be automatically assigned to an insurance program in their area. Individuals could opt out, but a substantial body of research indicates that opt-out programs have much higher participation rates than opt-in programs. Employers could also be required to verify insurance status of all workers, including part-time workers and temporary and contract workers. They could then be required to automatically enroll those eligible for coverage under the employer plan, unless the employee opted out, and refer others for automatic enrollment to government.

Restoring the individual mandate would certainly increase enrollment and would likely reduce premium costs by enrolling, on a relative basis, more healthy people in the exchanges. Over the long run, it would probably bring enrollment closest to universality. On the other hand, it is the only part of the law that is clearly unpopular. Whether restoring the individual mandate is truly necessary, given the other proposed changes that would substantially increase the affordability of coverage and encourage enrollment, is an open question. Medicare Part B has no mandate associated with it, but it is highly subsidized and enrollment is practically universal. If the mandate is restored, perhaps acceptability could be increased by relabeling it as a compensatory payment for potential uncompensated care, rather than as a requirement to buy insurance.

One issue that has not been discussed in this proposal is the politically fraught question of enrollment of undocumented residents. If comprehensive immigration reform were to pass, this would become a non-issue, since there should be no argument in favor of excluding those on path to citizenship from the benefits of assistance in obtaining health insurance or the right to enroll in subsidized or unsubsidized insurance programs. Failing that, it should be noted that an estimated 16 percent of the currently uninsured—4.9 million people—are undocumented residents. On the other hand, although they have no access to public programs, 58 percent of the undocumented are insured. They have obtained coverage through an employment-based policy, or bought an individual policy out of their own resources.[71]

Conclusion

This proposal described in this report builds on the impressive achievements of the ACA and will, if implemented, largely achieve the historic goals of universal health: affordable, quality care for all as a matter of right—the same goals that inspired the architects of the ACA.

Ensuring universality and affordability of coverage. The recommended changes to the premium responsibilities of individuals at different income levels will go a long way toward ensuring that no individual or family will be deterred from enrolling in coverage because of cost. While no system that does not provide for automatic enrollment will ever achieve fully universal coverage, the steps described above will substantially expand actual coverage—perhaps to a degree approximating universality—and are designed to make coverage affordable and accessible for all.

Ensuring access to services is not limited by ability to pay. The recommended changes to the cost-sharing obligations of people at different income levels and the proposed new limits on deductibles and out-of-pocket costs will ensure that care for those who are insured is fully affordable and will constitute a right, not a privilege. Further work may be needed to define the scope of cost-sharing for individuals at different income levels that will truly assure that cost is never a barrier to care.

Ensuring that needed services are covered. With regard to the services required to be covered, the essential benefit package under the ACA requirements and the services

provided under the Medicaid program may require further adjustment as new knowledge is gained as to needed therapies and as experience reveals gaps in either the essential benefit package or the way the scope of services within the essential benefit package is defined. At this point, the one clear gap that needs to be filled is the addition of adult dental care to the package. Most Medicaid optional services, including adult dental care, should be converted to mandatory services.

There are three major political barriers—beyond predictable partisan and ideological opposition—that will need to be overcome to enact this program. First, it will entail significant federal costs. The key cost concept that affects the ability to enact the program is scorable costs; that is, the amount the Congressional Budget Office estimates the legislative changes made by the program will change spending as compared to current law.

The main change in scorable costs generated by this program come from increasing premium and cost-sharing subsidies. To the extent that employer costs are increased by the new requirements for family affordability, limitations on deductibles, dental coverage, and reduced premiums and cost-sharing for low income workers, there would also be a decrease in federal tax revenues. Alternatively, if some of these improvements in employer coverage are financed through the tax credits to individuals or employers, there would be an increase in direct federal costs.

While a detailed estimate of the scorable costs of enacting this proposal is beyond the scope of this report, experts at the Urban Institute estimated the increased federal cost of a somewhat similar proposal at $131 billion annually in 2020.[72] Of this amount, $95 billion was for raising the federal Medicaid match for the expansion population to 100 percent, with assumed participation by all states. Assuming that these states will eventually expand coverage without changes in the law would not incur these costs as scorable, since current law regarding the Medicaid match would either not be changed or would only be marginally changed. The alternative proposal discussed here of federalization of the expansion population would incur these costs. On the other hand, the proposal advanced here would be more expensive than the Urban Institute plan in other respects, since it would provide a somewhat greater reduction in cost-sharing as the result of lower deductibles and out-of-pocket limits and mandated coverage of adult dental care. In addition, the Urban Institute plans does not include this plan's costs for greater employer responsibility and assistance to low-wage workers gaining coverage through an employer plan.

The second major political barrier is the recommendations regarding expanded responsibilities for coverage by businesses. These recommendations will likely encounter significant political resistance from the business community, which typically resists federal establishment of standards for the health insurance they offer as a matter of principle.

An additional barrier is that moving many Medicaid optional coverage categories into mandatory categories may result in some resistance from states. Although most of the optional categories are already covered by most states, the cost of expanded adult dental coverage will be significant. Moreover, many states tend to oppose federal mandates as a matter of principle.

Overcoming these barriers will be challenging, but substantively, the changes they would bring about are more in the nature of incremental improvements than major alterations in the current system. Surely, the political challenges associated with these improvements to the ACA are less daunting than was the original enactment of the ACA. And while ambitious legislation incorporating the full scope of these changes would be the ideal, the proposal can also be enacted in incremental steps.[73]

Whether the program is adopted incrementally, or by a single legislative action, the goal that would be achieved is clear. Finish the job that the ACA started. Complete the work of Medicare and Medicaid and CHIP. Guarantee every American access to affordable, quality health care. Assure that, once and for all, health care is a right, not a privilege.

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David Nexon was Senator Edward M. Kennedy's senior health policy advisor and director of the Democratic health staff of the Senate Health, Education, Labor and Pension Committee from 1983 to 2005.

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THE CENTURY FOUNDATION

Appendix: A Pathway to Universal Health Care: Building on the Affordable Care Act

OCTOBER 8TH, 2019 — DAVID NEXON

Appendix A: Undoing the Trump Administration's Assault on the Affordable Care Act

The Trump Administration has taken a number of steps that have undermined the ACA. The first step in any program to improve the ACA will require nullifying the Trump administration's attempts to undermine the ACA by administrative action.

The attempt by the Trump administration and by congressional Republicans to repeal the Affordable Care Act failed in the U.S. Senate by one vote. Democratic control of the House, as well as the severe losses Republicans suffered in the 2018 congressional election—in large measure driven by the unpopularity the repeal attempt—makes a successful legislative assault on the program unlikely. But the Trump administration has used its regulatory authority to attempt to weaken the Act in a variety of ways. Indeed, the very first executive order that Trump issued after his inauguration declared that it was his goal to repeal the ACA, and directed all federal agencies to "exercise all authority and discretion available to them to waive, defer, grant exemptions for, or delay implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty or regulatory burden, families, health care providers, health insurers, patients, recipients or health care services . . . ," and so on.[1]

Some of the Trump administration's steps to undermine the law may fail as the result of court challenges, but others will likely survive, and even those that are ultimately struck down will act as a drag on the program. In addition, as part of their overall tax reform package, Republicans succeeded in including a repeal of the tax penalties used to enforce the ACA's individual mandate to purchase health insurance. The administration has also joined a number of Republican state attorneys-general in a suit that attempts to have the entire law struck down as unconstitutional.

The Trump program of sabotage has two broad prongs. One prong is a wide variety of measures designed to undermine the system of private insurance created by the ACA. That system was to ensure that everyone not eligible for public coverage or affordable employment-based insurance has access to affordable, comprehensive private insurance. The second prong is the assault on the Medicaid program—and especially the Medicaid expansion established by the ACA.

The steps taken by the Trump administration to undermine the system of private insurance created by the ACA form a veritable murderer's row of anti-patient regulations and

guidances. The administration slashed programs to help people navigate the exchanges and made other adjustments that made it more difficult to enroll.

It took a number of steps to raise premium, make the marketplace unsustainable, and water down the quality of coverage. These steps included allowing less-valuable silver plans to be offered, adjusting indexing in a way that would reduce the value of the premium subsidies provided by the ACA, suspending cost-sharing subsidy payments to insurance companies, and allowing "junk plans" not meeting the standards of the ACA to siphon off younger and healthier enrollees from the insurance exchanges, exposing these enrollees to substandard insurance. The administration broadened the definition of Association Health Plans (AHPs) in a way that would remove patients from ACA protections and open up greater opportunities for fraud and risk selection. It redefined section 1332 waivers, intended to allow states to experiment with ways to improve coverage, so that they could become an engine for making coverage worse rather than better. It relaxed the standards for the essential health benefits insurance was supposed to offer.

Beyond the attempts to undermine the private insurance program established by the ACA, the Trump administration also took aim at Medicaid. The Republican bill to repeal the Affordable Care Act not only proposed eliminating the provisions of the ACA to expand Medicaid, but it also took sought to weaken the underlying program by converting it to a block grant. Absent legislative action, the administration is using the demonstration authority under section 1115 of the Medicaid statute to encourage states to modify their programs, especially for the expansion population, in ways that would reduce rather than increase coverage and access to essential services.

Private Insurance

The key elements of the Trump administration's attempt to use its real or asserted regulatory authority to weaken the structure of comprehensive, affordable private insurance established by the ACA include:

- *Making it more difficult for potential beneficiaries to enroll in marketplace plans.* Immediately after taking office, the administration canceled ads informing potential beneficiaries about enrollment in the program. It actually used public funds to attack the ACA, with the U.S. Department of Health and Human Services (HHS) releasing videos featuring people who said they were harmed by the ACA, as well as using its Twitter account to disseminate anti-ACA messages. Later in the year, the administration ended contracts to provide information and assistance to people who might wish to enroll in exchange plans, and subsequently cut funding for marketplace outreach by 90 percent and funding for navigator assistance by 40 percent. HHS staff were forbidden to participate in marketplace enrollment events. A subsequent cut reduced navigator funding to just 20 percent of its 2016 level. HHS reduced email outreach for the marketplace open enrollment period by cutting all the names from the list of people who were not currently enrolled.[2]

In addition to reducing information and assistance for enrollment in exchange plans, the Trump administration also cut the open enrollment period in half, from twelve weeks to six weeks, and shut down the system for enrolling except for one Sunday morning during the enrollment period, Sundays being a popular time for enrollment events sponsored by outside groups.[3] It also made it more difficult for people to sign up during special enrollment periods.[4]

In its most recent proposed rule, issued in January 2019, the administration suggested it might eliminate automatic re-enrollment for beneficiaries who fail to choose a plan during the open enrollment period. This rule would not only reduce total enrollment, it would also be most likely to disproportionately disenroll people in good health who likely have less commitment to ensuring that they have insurance coverage. This, in turn, would raise premiums for those who remained. While this proposal was not included in the final rule, the administration noted that it had not ruled out implementing it in the future.

- *Raising premiums, making the marketplace unsustainable, and watering down the quality of coverage.* As noted above, the administration included repeal of the enforcement provisions of the individual mandate in their omnibus tax bill. The key regulatory steps they initiated in order to raise premiums and make the marketplace unsustainable included:

    - o allowing less valuable silver plans to be offered;
    - o adjusting indexing in a way that would reduce the value of the premium subsidies;
    - o suspending cost-sharing subsidy (CSR) payments;
    - o allowing "junk plans" not meeting the standards of the ACA to siphon younger and healthier enrollees from the health exchanges, potentially raising premiums for those remaining in the exchanges (as well as creating a group of individuals who have insurance that does not provide them adequate protection);
    - o allowing association health plans;
    - o opening up section 1332 waivers; and
    - o relaxing essential health benefit standards

- Repealing the enforcement provisions of the individual mandate. The provision was included in the Republican omnibus tax bill passed in December of 2017. The repeal went into effect in 2019, but the Trump administration had already stopped requiring evidence of insurance to be submitted to the IRS, suggesting that the penalty would not be enforced even without legislation.[5] The Congressional Budget Office (CBO) estimated in November 2017 that repeal of the individual mandate would increase the number of the uninsured by 13 million by 2025 and raise average premiums in the nongroup market by 10 percent, because those people most likely not to enroll if there were no financial penalty for failing to do so would be disproportionately younger and healthier.[6]

- *Allowing less-valuable silver plans to be offered.* In a proposed rule finalized in April 2017, the Trump administration granted silver plans additional flexibility to lower the average value of their offerings. Silver plans are required under the statute to pay at least 70 percent of the cost of the services they cover. This 70 percent is referred to as their actuarial value. Under the regulations established by the Obama administration, plans were allowed a so-called *de minimus* variation from the 70 percent, presumably to allow for some uncertainties in calculation. This *de minimus* variation was set at a maximum of 2 percent. The Trump administration rule expanded this to 4 percent. The cost of premiums for the second-least-expensive silver plans in a region are, under the ACA, used to set the premium subsidies for all plans. This change would allow the lower cost benchmark plan used to determine subsidies to offer less valuable coverage and have the effect of increasing the unsubsidized share of the premium or reducing the value of the benefits for all enrollees, regardless of whether they enrolled in the specific low-cost plan. A calculation by Aviva Aron-Dine and Edwin Park at the Center for Budget and Policy Priorities found an example family of four with an income of $65,000 would see a reduction in its tax credit subsidy for coverage of $327, or more than 4 percent. Alternatively, the family could buy a plan with a lower premium, but be subject to an increase in its per person deductible of $550.[7]

- *Adjusting indexing.* In its 2019 proposed rule, the Trump administration proposed to adjust the indexing of premium subsidies provided in the

ACA in a way that would reduce the value of the subsidies. In order to hold down the twenty-year cost of the ACA and help achieve its passage, the ACA legislation provided that annual subsidy increases would be set at a level that was likely to be somewhat less than actual premium growth. Specifically, the law set a cap on the percent of income that individuals would have to pay for coverage (the cap varied by income level and phased out 400 percent of the FPL for premium subsidies). Under the limit, if premiums grew faster than GDP, the maximum percent of income individuals would have to pay would rise at a rate equal to the average premium increase divided by the GDP increase.

The existing rules based this calculation on the increase on premiums for employment-based plans, on the grounds that premiums in the individual market would be much more unstable, based on uncertainties from implementation of the ACA and the associated expansion of individual coverage to a much wider population. As described, the actions of the Trump administration have increased uncertainties in this market. But the Trump proposal would adjust the percent of income individuals would have to pay before subsidies kicked in based on increases in premiums in the entire market, including both individual and employer increases, effectively reducing the subsidies individuals would receive.[8]

- *Suspending CSR subsidy payments.* Following a lower court ruling (currently stayed, and pending appeal), Trump threatened to suspend the payments under the ACA that subsidized cost-sharing for individuals and families with incomes under 400 percent of the FPL. Even the threat of this action had the effect of creating uncertainties for insurers and prompting some to leave the exchange market.[9] The policy was made final on October 12, 2017.

Because insurers are still required to provide the cost-sharing reductions mandated under the ACA, even without the federal payments, the effect of removing the federal payments is to require premium increases to cover the cost of the subsidies. The Congressional Budget Office (CBO) and the Joint Tax Committee (JCT) jointly estimated that the effect of this change would raise silver plan premiums (the most popular offering in the exchanges) by 10 percent in 2018, and 20 percent in subsequent years.[10] In fact, average premiums for all plans jumped significantly between the 2017 and 2018 plan years—from $341 per month in 2017 to $621 per month in 2018.[11]

This jump in premiums had little effect on people eligible to receive subsidies under the ACA. Premium subsidies are tied to a cap on the percentage of income spent for premiums, so for people who are eligible, premium costs do not go up as actual premiums rise. Cost-sharing subsidies, which are available only to individuals with incomes below 250 percent of the FPL, are based on raising the actuarial value of the plan—the amount paid by the insurance company for covered services—from the 70 percent required for silver plans generally to a higher level. Since the actuarial value of the plan is based on the proportion of covered costs paid by the insurer and has nothing to do with premiums, the increase in premiums does not affect cost-sharing subsidies, either. Ironically, because the premium subsidies were pegged to the cost of silver plans, the jump in silver plan premiums allowed some subsidy-eligible individuals to buy more valuable gold plans more cheaply than the silver plans to which the subsidies were pegged. But people not eligible for premium subsidies faced substantially higher costs for silver plan coverage as the result of the new policy.[12]

- *Allowing junk plans.* Among the most blatant attempts of the Trump administration to undermine the ACA are the steps they have taken to permit the marketing of lower cost substandard plans that would not meet the minimum requirements of the ACA and are designed to siphon healthy consumers out of the ACA risk pool. The ACA did indeed allow short-term health plans, primarily as a vehicle for consumers in transition between insurance plans—perhaps because they were changing jobs—but who did not necessarily qualify for a special enrollment period under an exchange plan to purchase low-cost short-term health plans. These plans were not required to meet ACA requirements.

But the original regulations limited the duration of such plans to no more than three months. On February 20, 2018, the Trump administration proposed to allow such plans to be offered for one year and to be renewed for up to three years, essentially treating them as regular insurance plans not subject to such central ACA requirements as provision of essential benefits, open enrollment, prohibition on pre-existing condition limitations, and lifetime and annual limits.[13] The proposal was finalized August 3, 2018. The Urban Institute estimated the change would increase the number of people without minimum essential coverage by 2.6 million in 2019 and raise premiums for ACA plans by 18 percent in states that do not limit such plans (only six had such limitations).[14]

- *Relaxing rules on association health plans.* Association health plans (AHPs) are arrangements allowing a group of employers to either offer or purchase a single insurance plan for themselves and their employees. They are a subset of multiemployer welfare arrangements (MEWAs). The rules for such arrangements are quite complicated. In general, the rules have been designed to prevent selection of health risks out of a broader risk pool, fraud, and avoidance of appropriate state regulation. Because these arrangements are treated like a large employer plan, they are exempt from many of the ACA requirements that would be applicable if the members purchased coverage as individuals or as small businesses. Despite the existing rules, MEWAs have had a long history of fraudulent arrangements in which the organization is set up as an insurance plan that avoids state regulation, collects premiums, but defaults without paying the promised benefits.

The ACA modified the rules for AHPs. In general, AHPs did not get special treatment under the ACA. Instead, if an individual or small business obtains coverage through an AHP, they are treated as any other small business or individual insurance plan and subjected to the same rules and regulations. The exception is when an AHP qualifies as a single multiemployer plan under ERISA (The Employment Retirement Income Security Act), which would allow it to be treated as a large group health plan for ACA purposes. Historically, ERISA multiemployer plans were plans set up by employers all working in the same industry, such as trucking or construction, pursuant to a collective bargaining agreement.

In January 2018, the Trump administration's Department of Labor issued a proposed rule that made it much easier for a health plan issued or purchased by an association to be considered a MEWA treated as a group health plan. With some modifications, the rule was finalized on June 19, 2018, but blocked by court action (which is under appeal by the administration). The rule would have relaxed the commonality of interest rules that restricted MEWAs to employer associations that have a strong relationship, not those that were set up largely to sell insurance to members or are a general business group like a Chamber of Commerce. Under the new rules, an AHP's principal purpose can be the provision of benefits, although it must have at least one "substantial business purpose." This can be as limited as holding conferences or promoting common economic interests.

The new rule would undermine the ACA in two ways. First, employees of small businesses that join an AHP could lose benefits that would otherwise be guaranteed by the ACA, including provision of essential benefits. Second, AHPs could be designed to attract healthier groups of small employers, raising the costs for those who remained in the broader risk pool. Three separate estimates of the proposed rule found the result would be substantial increases in premiums in both the individual and small group market.[15]

- Section 1332 waivers. On October 22, 2018, the Trump administration also issued guidance designed to further undermine the ACA marketplace. This guidance encouraged states to use the so-called section 1332 waivers for this purpose. Section 1332

of the ACA allows states to implement a system of guaranteed coverage different from that specified in statute if it is as least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number or residents of the state as would be provided coverage absent the waiver, and does not increase the federal deficit. Prior to the guidance, a number of states used 1332 waivers to set up reinsurance programs designed to reduce premiums in the marketplace.[16]

The Trump administration's modifications to the Obama administration guidance undermines section 1332 in several ways. First, the modified guidance now states that the Trump administration would look favorably on plans that provide increased access to "affordable private market coverage," which is defined to include short-term health plans and association health plans. The Trump administration states that it will also look favorably on plans that promote "consumer driven health care," which is shorthand for high deductible plans. The guidance does not require states to show that as many people would actually be covered under the waiver as under the regular program; rather the plan is evaluated on whether it provides access to such coverage, so the waiver standard could be met if more people enroll in less comprehensive coverage. The previous standard also evaluated the coverage provided to vulnerable subgroups of the population under the waiver; this requirement is now dropped. The requirement that a waiver plan be adopted by state statute has also been weakened, giving a state governor authority to move ahead with a plan that might not be approved by a state legislature.

One expert summarizes the changes to the guidance as showing the Trump administration's willingness to approve proposals that would lead to:

- "An increase in the number of people with less comprehensive coverage relative to the ACA;
- An increase in the number or consumers exposed to higher cost-sharing and out-of-pocket costs relative to the ACA;
- Coverage losses or higher out-of-pocket costs among vulnerable populations, such as older adults or low-income people; and
- Expanded coverage options, such as short-term health plans, that exclude coverage for preexisting conditions and other key benefits using health status underwriting."[17]

- *Watering-down essential health benefits.* The ACA requires coverage of ten categories of essential health benefits in individual and small group plans: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. While these categories cover a broad range, they are also general, and thus do not by themselves indicate the scope of coverage within each category. Moreover, plans are generally allowed to put limits on days of treatment or number of visits for these services, although not dollar limits.

The statute addresses this issue by directing the U.S. secretary of health and human services to "ensure that the scope of essential health benefits is equal to the benefits provided under a typical employer plan." There are also some other directives to the secretary—for example, that the benefits take into account health needs of diverse populations—that suggest that the requirement that the scope equal that of a typical employer plan is not absolute. In any event, the Obama administration chose to not specify the scope of benefits in detail. Rather, it allowed each state to select its own benchmark plan from four options: one of the three largest small group plans in the state; the state employee health benefit plan, any of the three largest national Federal Employee Benefits Program plan options, or the largest commercial HMO in the state. Where the benchmark plan did not include one or more of the essential health benefits, the regulations prescribed alternative benchmarks for those benefits. Plans were allowed to change the scope and specifics of benchmark plan benefits within the ten essential benefit categories, but only if the resulting benefit was at least actuarially equivalent to the benchmark plan for that category.

The Trump administration proposed to weaken the ten essential benefit requirements in several ways. First, it allowed states to select a benchmark for any state, essentially reducing the benchmark requirement to those of the least generous state benchmark. The proposal also allowed the state to pick and choose among benchmark categories from other states. Finally, states could choose a benchmark that is a "typical employer plan," defined in a way that would allow states to choose a benchmark from any plan with more than 5,000 enrollees, substantially expanding the permissible choices for a benchmark plan. An analysis by New York Medical College professor Adam Block and colleagues looked at four states and found that this change would allow these states, if they chose to, to drop anywhere from six to ten currently covered benefits.[18]

Medicaid

On January 11, 2018, the Trump administration issued new guidance for section 1115 of the Social Security Act, which allows demonstration projects that may waive some of the normal federal Medicaid rules. The guidance would encourage states to establish demonstration projects that have the goal of creating incentives for Medicaid beneficiaries to participate in work and community engagement activities.[19] For the first time, the new guidance would allow states to impose this work or community activity requirement on individuals as a condition of their gaining and maintaining Medicaid eligibility.

To date, fifteen states have waivers approved or pending.[20] Work or community activity requirements under the waivers generally apply only to working-age adults and have various exceptions, including such exceptions as young children at home, disability, or medical frailty. Virtually all of the waiver applications project that there will be substantial coverage loss as a result of the new work requirements, further undercutting the goal of universal coverage.

The Kaiser Family Foundation estimates that if work requirements were imposed in all Medicaid programs, between 1.4 million and 4 million of the 23.5 million working age, non-disabled adults currently on Medicaid would lose coverage—between 6 percent and 17 percent of all enrollees in this category. In both cases, large majorities of those who lose coverage would be kicked off the rolls because of reporting or other administrative requirements, rather than because they actually failed to fulfill the work requirement or qualified for an exemption.

The Kaiser Family Foundation survey of adults on Medicaid potentially subject to work requirements found that 62 percent were already working. Among those not working, most (32 percent) were not working because they were caregiving for other family members, not working due to school attendance, or in fair or poor health due to illness or disability. All of these would be potential reasons for exclusions from the requirements under most state waivers, although under the terms of specific waivers a "medical frailty" exclusion might not apply to all those self-reporting not working for health reasons and caregiving might not be allowed for those with older children. Only 6 percent were not working for other reasons, which could include problems beyond the individual's control, such as lack of transportation or lack of available jobs or training.[21]

The Kaiser analysis appears to be borne out by the experience under the Arkansas work and community participation requirements. Over 18,000 individuals lost coverage—more than 25 percent of all beneficiaries subject to the policy. An analysis by the Center for Budget and Policy Priorities suggests that most of those who lost coverage did so because of failure to fulfill reporting or other bureaucratic requirements rather than actual ineligibility.[22]

As with other attempts to undermine the ACA, the 1115 waivers are being challenged in court, and so far the courts have agreed that work requirements are not consistent with the legislative goals of the Medicaid program.

Regardless of the reasons why individuals might not qualify for coverage under a work and community participation requirement or the legal arguments regarding use of 1115 waivers, the existence of such a requirement undercuts a basic premise of universal coverage: that health care is a matter of right, not a privilege.

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