ISSUE BRIEF

SEPTEMBER 2016

The COMMONWEALTH FUND

Hillary Clinton's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit

Christine Eibner, Sarah Nowak, and Jodi Liu

ABSTRACT

Issue: Presidential candidate Hillary Clinton has proposed modifications to the Affordable Care Act to limit consumers' out-of-pocket health spending. **Goal:** We analyzed four of these policies–cost-sharing tax credits to offset spending above 5 percent of income; reduced premium contributions for marketplace enrollees; a fix to the ACA's "family glitch," which leaves some families with expensive employer coverage; and the introduction of a public option on the marketplaces. **Methods:** RAND's COMPARE microsimulation model. **Key findings and conclusions:** These policies would increase the number of insured individuals by 400,000 to 9.6 million, and decrease consumers' health spending relative to current law. Cost-sharing tax credits have the biggest effect–increasing coverage by 9.6 million and decreasing average spending by up to 33 percent for those with moderately low incomes. However, the policies with the largest coverage gains also increase the federal deficit, with impacts ranging from –$0.7 billion to $90 billion.

OVERVIEW OF POLICY OPTIONS AND APPROACH

While the Affordable Care Act (ACA) has insured approximately 20 million people and extended subsidized coverage to millions of individuals,[1] health care costs remain a significant concern for many Americans. As part of her presidential campaign, former Secretary of State Hillary Clinton has proposed several modifications to the ACA to make health care more affordable for consumers. In this analysis, we estimate the impact of four of Clinton's proposed policies on families' health care spending, health insurance enrollment, and the federal deficit. The policies we consider are:

1. **Cost-sharing tax credit** of up to $2,500 per individual or $5,000 per family to offset the cost of out-of-pocket spending that exceeds 5 percent of income. This would be available to all individuals enrolled in private coverage.[2] In this scenario, out-of-pocket spending includes employee premium contributions for employer-sponsored coverage, premium payments for marketplace coverage after taking into account existing credits, and patient cost-sharing at the point of service. The tax credit is refundable and applied against the sum of premium contributions and out-of-pocket cost-sharing.
2. **Reduction in the maximum premium contribution** individuals must make to enroll in a benchmark plan on the ACA's marketplaces. Under current law,

For more information about this brief, please contact:

Christine Eibner
Senior Economist
RAND Corporation
eibner@rand.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1904
Vol. 32

HOW ARE MARKETPLACE PREMIUM CONTRIBUTIONS DETERMINED?

Under current law, people with incomes between 100 percent and 400 percent of the federal poverty level and no other affordable source of health insurance are eligible to receive advance premium tax credits (APTCs) on the ACA's marketplaces. APTC-eligible individuals and families must contribute a percentage of their income toward coverage; the federal government then provides a tax credit to subsidize the additional cost of insurance, up to the cost of the second-lowest-cost silver plan available in the enrollee's community. Enrollees' required contributions vary with income, and increase slightly each year to account for health care cost inflation. In 2016, required contributions ranged from 2.01 percent of income for people with incomes between 100 percent and 138 percent of poverty to 9.66 percent of income for those with incomes between 300 percent and 400 percent of poverty.

Clinton's plan would reduce the maximum amount of the required contribution from 9.66 percent of income to 8.5 percent of income, a factor of roughly 12 percent. Because the required premium contribution scales with income, we assume that the 12-percent reduction would be applied at all income levels. The required percentage contribution under Clinton's plan would therefore range from 1.77 percent of income for those with incomes between 100 percent and 138 percent of poverty to 8.5 percent of income for those with incomes between 300 percent and 400 percent of poverty.

For example, under current law, a single individual with income at 350 percent of the federal poverty level ($41,580) would be required to contribute $4,017 (i.e., $41,580 x 0.0966) toward marketplace coverage. If the second-lowest-cost silver plan available to this individual cost $4,500, the individual's APTC would be $483 (i.e., $4,500 – $4,017). Under Clinton's plan, the individual's contribution would be reduced to $3,534 (i.e., $41,580 x 0.085), and the APTC amount would increase to $966 (i.e., $4,500 – $3,534).

eligible marketplace enrollees receive an advance premium tax credit (APTC) equal to the premium of a benchmark health plan in their geographic area, minus a maximum premium contribution that currently ranges from 2.01 percent to 9.66 percent of income. The APTC will grow over time at the rate by which health care spending growth exceeds inflation (see the "How Are Marketplace Premium Contributions Determined?" text box). The APTCs effectively limit premium contributions to between 2.01 percent and 9.66 percent of income for those who qualify, if they choose a benchmark plan. APTCs are available to those with incomes between 100 percent and 400 percent of the federal poverty level (i.e., $24,300 to $97,200 for a family of four) and no other source of affordable coverage. The maximum premium contribution scales with income; those at the lower end of the income eligibility range contribute the lowest percentage. Clinton's plan would reduce the maximum premium contribution from 9.66 percent to 8.5 percent of income for those with incomes at 400 percent of poverty, with proportional reductions for those at lower income levels.[3]

3. **Elimination of the so-called "family glitch"** and reduction in maximum premium contribution.[4] Under current law, families with access to employer coverage are eligible for APTCs only if the worker's premium contribution for single enrollee coverage exceeds an affordability threshold of 9.66 percent of income. Because family contributions often exceed single contributions, many families with unaffordable employer coverage are precluded from receiving APTCs (see the "What Is the Family Glitch?" text box). Clinton's proposal would "fix" this issue by giving families access to APTCs if the enrollee contribution for family employer coverage exceeded 8.5 percent of income. Because the affordability threshold that triggers APTC eligibility for those with employer coverage is tied to the maximum

WHAT IS THE FAMILY GLITCH?

The Affordable Care Act permits individuals and families to receive APTCs if they have income between 100 percent and 400 percent of the federal poverty level and no other affordable source of health insurance coverage. Employer coverage is considered affordable if the worker's premium contribution for self-only coverage is less than 9.66 percent of income. However, employers typically require workers to contribute more for family coverage than for individual coverage. For example, a worker's annual premium contribution for individual coverage might be $1,000, while the premium contribution for family coverage is $4,000. In this situation, coverage for a worker with income at 150 percent of poverty ($36,450 for a family of four) would be considered affordable because the $1,000 premium contribution for individual coverage is less than 9.66 percent of income. However, the worker would need to spend 11 percent of income on health insurance to enroll in a family plan. Because of the "family glitch," the worker and her family are ineligible for marketplace tax credits, even though they cannot obtain employer coverage without spending more than 9.66 percent of income on health insurance.

premium contribution on the marketplaces (9.66 percent of income under current law versus 8.5 percent of income under Clinton's plan), we modeled the elimination of the family glitch in combination with the reduction in the maximum premium contribution.

4. **Introduction of a public health insurance option** into the ACA's marketplaces. This idea was frequently discussed before the ACA was passed.[5] We assume that the public plan would reimburse hospitals and physicians at Medicare rates and could achieve administrative savings relative to private plans. Although these cost-saving strategies would make the public option cheaper than a comparable private plan, we assume the option would be slightly less popular, depending on its price, because of potential access constraints introduced by lower reimbursement. It is possible people could prefer the public plan if, for example, it has larger networks or fewer restrictions on service use. However, we have limited basis to assume that the public plan would be preferred to the private option; prior research has found that doctors are less likely to accept new Medicare patients than patients with private insurance.[6] We further assume that the public option would put downward pressure on private plan premiums, as a result of increased competition.

We modeled the cost-sharing tax credit, the reduction in the maximum premium contribution, and the public option as separate policies. For reasons described above, we modeled the elimination of the family glitch in combination with the reduction in the maximum premium contribution. In prior work, we estimated the impact of eliminating the family glitch given the maximum premium contributions specified by the ACA.[7] Our analysis focuses on several critical policy options that the Clinton campaign announced as of May 2016. The campaign offered several additional policy options in July 2016; we added the public option scenario in response to these changes. We plan to model Clinton's proposed Medicare buy-in, which was also announced in July, at a later date.

We do not present a combined policy scenario in this brief because, even if we combined all of the options considered, this would still not represent the entirety of Clinton's health reform proposals. For example, Clinton would also impose spending limits for those with high pharmaceutical costs, change negotiation strategies with drug companies, extend 100 percent federal matching rates

to encourage additional states to expand Medicaid, and allow people ages 55 and over to buy into the Medicare program. Some of her proposals that would affect health care in the United States are not directly linked to insurance expansions; for example she would invest in research and development to improve treatments for Alzheimer's disease, make public health investments to reduce exposure to lead and other environmental toxins, and increase funding for primary care services at community health centers.[8]

In our technical appendix, we report the effects of combining all four policies addressed in this brief, recognizing that this is still just a subset of Clinton's proposals.

We conducted the analysis using the RAND COMPARE microsimulation model,[9] an analytic tool that uses economic theory and data to estimate the effect of health reform proposals. For this issue brief, we updated the model to ensure consistency with the most recent estimates of the ACA's impact on coverage. We provide an overview of the model, along with a discussion of the updates, in the technical appendix.

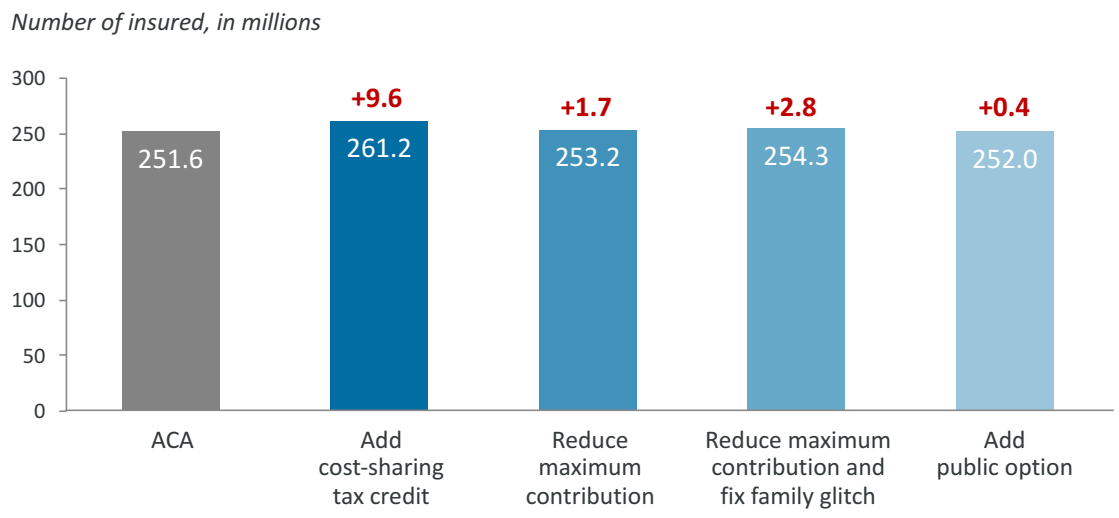
RESEARCH FINDINGS

Insurance Coverage

We estimate that each of the policies under consideration would lead to an increase in the number of people with insurance. We estimate that 251.6 million people would be insured in 2018 under the ACA as currently enacted (Exhibit 1). Adding a cost-sharing tax credit would increase the number insured by approximately 9.6 million. We estimate that approximately 25 million people would be uninsured in 2018 under the ACA (see Appendix Table A.2), so a 9.6 million person increase in insurance represents a 39 percent decline in the share of people without coverage. Reducing premium contributions for marketplace coverage would lead to a 1.7 million person increase in insurance

Exhibit 1

Impact of Clinton's Proposed Reforms on the Number of People with Insurance Coverage, U.S. Population Under Age 65, 2018



Notes: Changes in coverage relative to the ACA scenario are shown on the top of each bar in red and may not sum to subtotals because of rounding. Details reported in Appendix Table A.2.
Data: RAND COMPARE microsimulation model.

enrollment relative to the ACA; addressing the family glitch in combination with this policy insures an additional 1.1 million people. Adding a public option insures an additional 400,000 people relative to the ACA alone.

Our analysis suggests that—of the four policies considered—the cost-sharing tax credit would have the largest effect on coverage. This is in part because the cost-sharing tax credit applies to all individuals who enroll in private coverage, regardless of income or program eligibility. The other policies are more narrowly targeted. For example, the reduction in maximum premium contribution applies only to individuals with incomes between 100 percent and 400 percent of poverty and no access to affordable employer coverage or public insurance. Further, many of the policies are designed to reduce out-of-pocket costs for those who already have insurance; expanding coverage may not be the primary goal of the policy.

Exhibit 2 shows the population of individuals who could potentially benefit from each of the policies considered. Roughly 178 million people are targeted by the cost-sharing tax credits, compared to only 20 million people who would be eligible for reduced marketplace premium contributions. The family glitch fix affects only 5 million, a very small segment of the population. While most people would be eligible to enroll in the public option, the plan is of greatest value to those who do not have access to employer coverage or Medicaid, an estimated total of 42.7 million people, including 22.6 million who would enroll in private nongroup coverage or marketplace plans under the ACA. For all policies, a large segment of the eligible population is estimated to be already insured under the ACA, but would gain access to new or enhanced tax credits or additional insurance options with the Clinton plan.

Exhibit 2. Size of the Eligible Population (in Millions) Under Clinton's Proposed Reforms, 2018

		Size of the eligible population		
Policy	Eligible population	Total	Uninsured with the ACA	Insured with the ACA
Cost-sharing tax credit*	Everyone with access to a private health plan regardless of income (excludes those eligible for Medicaid or other public coverage)	177.5	18.6	158.9
Reduction in maximum premium contribution	Individuals with incomes between 100% and 400% of poverty and no affordable source of coverage other than the marketplaces	19.9	6.0	13.9
Family glitch fix**	Families with access to employer coverage who have incomes in the APTC-eligible range and would pay more than 8.5 percent of income to enroll in family employer coverage	5.3	1.6	3.7
Public option	People with marketplace coverage and those uninsured and ineligible for Medicaid or employer insurance	42.7	20.1	22.6

* Anyone who would qualify for the tax credit if health spending exceeded 5 percent of income is counted as eligible, even if actual health spending is not high enough to trigger the credit. ** Numbers in this row show the marginal population that is affected by the family glitch fix. Those affected only by the reduction in premium contributions are shown in the previous row.
Data: Estimates from RAND COMPARE microsimulation model.

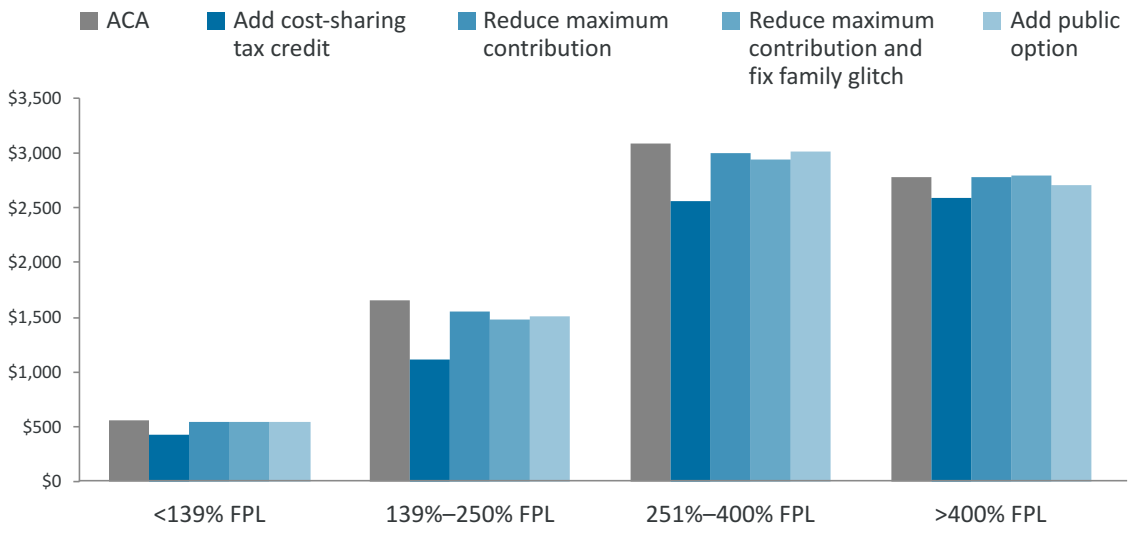
Consumer Out-of-Pocket Spending

In Exhibit 3, we show the effect on total out-of-pocket health care spending (i.e., premium contributions plus out-of-pocket cost-sharing) for everyone with insurance, by family income. We excluded the uninsured from these analyses; uninsured individuals tend to have very low health spending, reduced access to health care, and higher risk of forgoing necessary care or experiencing catastrophic health expenses.

There are three striking findings. First, all the policies reduce the insured populations' out-of-pocket spending on health care relative to the ACA. However, the magnitude of the effect varies depending on the policy and the result of differences in the size of the population eligible for the policy. For example, the cost-sharing tax credits affect people with employer coverage and low-income individuals in states that did not expand Medicaid. In contrast, the reduction in premium contributions affects only those who are eligible for APTCs on the ACA's marketplaces. Fixing the family glitch, which we modeled in combination with the reduction in marketplace premium contributions, affects an even smaller segment of the population—those with access to employer coverage where a family contribution is in excess of 8.5 percent of income. While the public plan introduces a relatively low-cost option on the marketplaces, this policy generally has a modest effect on consumer spending because many people who would enroll in the public plan already receive APTCs. However, in the public-option scenario, spending declines by approximately 9 percent for those with incomes between 139 percent and 250 percent of poverty ($33,534 to $60,750 for a family of four). In some cases, individuals in this income range can enroll in the public option at no cost. This occurs when the APTC amount, which can be based on the price of a private plan, is large enough to cover the full cost of the public plan.[10]

Exhibit 3

Impact of Clinton's Proposed Reforms on Total Out-of-Pocket Health Care Spending of Insured People, by Income, 2018



Notes: Out-of-pocket spending = premium contributions + out-of-pocket cost-sharing. Dollar values are reported in Appendix Table A.3.
Data: RAND COMPARE microsimulation model.

Second, in all scenarios, total out-of-pocket health spending increases as income moves up to 400 percent of poverty, but then falls or remains in a close range for individuals with incomes above 400 percent of the federal poverty level. The decline in spending for individuals above 400 percent of poverty reflects the fact that most people in this income range are insured through employer coverage and typically face relatively low out-of-pocket premium contributions. Insured individuals with incomes between 250 percent and 400 percent of poverty ($60,750 to $97,200 for a family of four) have the highest health spending of any income group; they may be enrolled in marketplace plans with low actuarial values[11] and they are also eligible for fewer subsides than lower-income individuals.[12] Even when enrolled in employer coverage, individuals in this income range may receive a less-generous employer policy than higher-income workers.

Third, relative to the ACA, the cost-sharing tax credit leads to significant reductions in out-of-pocket spending particularly for low- and moderate-income individuals. Lower-income individuals who are not otherwise enrolled in public coverage are more likely than higher-income individuals to be eligible for the tax credit, because even a small health expense can lead to health spending in excess of 5 percent of their income. On a proportional basis, the effect is particularly large among insured people with incomes between 139 percent and 250 percent of poverty. With the tax credit, these people experience a 33 percent reduction in spending. The estimated spending reduction is lower (23%) for those with incomes under 139 percent of poverty, partly because many are enrolled in Medicaid and therefore unlikely to spend more than 5 percent of their incomes on health care.

Government Spending

In Exhibit 4, we consider the effect of each policy on the deficit. The cost-sharing tax-credit scenario has the largest effect on the deficit, increasing the estimated impact by $90.4 billion, relative to the ACA. This larger impact reflects the fact that this policy targets a larger share of the population than other reforms. The tax credits extend to everyone with private insurance (including employer-sponsored coverage) and people with incomes above 400 percent of poverty. But despite the large estimated increase in the deficit, the effect is mitigated to some extent by a reduction in Medicaid enrollment. In some cases, Medicaid-eligible individuals would enroll in employer-sponsored or other private coverage to take advantage of the cost-sharing credits, thereby reducing Medicaid spending while increasing outlays related to the credit.

Reducing the maximum premium contribution alone leads to a $3.5 billion dollar increase in the deficit, primarily because the government would spend more money on APTCs. Adopting this policy in combination with the family glitch fix increases the deficit more because additional people become eligible for tax credits. The public option marginally reduces the deficit, despite slightly higher insurance enrollment under this policy relative to the ACA. When a public option is introduced, the federal government reaps two forms of savings. First, we assume that private premiums fall slightly because of competitive pressures, reducing APTC outlays. Second, we assume that in some areas APTCs will be tied to the public option, which is less expensive than a private plan and less costly to the federal government. (A full discussion of how we model the public option and its effects on government spending can be found in the technical appendix.)

Exhibit 4. Net Deficit Impact (in Billions) Under Clinton's Proposed Reforms Relative to the Affordable Care Act, 2018

	ACA	Add cost-sharing credit	Reduce maximum premium contribution	Fix family glitch and reduce premium contribution	Add public option
Additional federal outlays (negative values *reduce* the federal deficit)					
Medicaid and CHIP spending	$0.0	–$25.0	$0.0	$0.3	–$0.2
Premium tax credits*	$0.0	$3.5	$3.7	$9.1	–$0.8
Cost-sharing reductions (CSRs)	$0.0	$1.0	$0.2	$0.5	$0.3
Cost-sharing tax credits	$0.0	$110.8	$0.0	$0.0	$0.0
Total change in outlays	$0.0	$90.3	$3.9	$10.0	–$0.6
Additional federal revenues (negative values *increase* the federal deficit)					
Individual mandate	$0.0	–$3.4	$0.3	-$0.5	$0.1
Employer mandate	$0.0	$3.3	$0.1	$0.5	$0.0
Total change in revenue	$0.0	–$0.1	$0.4	$0.0	$0.1
Net change to federal deficit	**$0.0**	$90.4	$3.5	$10.0	**–$0.7**

Notes: Impacts that increase the federal deficit are shown in red, while those that decrease or have no effect on the federal deficit are shown in black. Changes in outlays and revenues are estimated relative to the ACA. We do not show the ACA's changes to Medicare payment or revenues generated through new taxes and fees. These revenue-generating provisions remain roughly constant across scenarios and thus have no marginal impact on the deficit relative to the ACA. * Congressional Budget Office models premium tax credits as a reduction in revenue if they reduce taxes owed and an increase in outlays if the credit exceeds tax liabilities. For simplicity, we count the entirety of the premium tax credit as increase in outlays.
Data: Estimates from RAND COMPARE microsimulation model.

DISCUSSION

All of the policies considered increase the number of insured people and reduce consumers' out-of-pocket spending on health care. The cost-sharing tax credit, which affects the largest segment of the population, increases insurance coverage by nearly 10 million, decreases average consumer spending by as much as 33 percent, and increases the federal deficit by $90 billion in 2018.

For the currently uninsured population, the cost-sharing tax credit acts as an alternative to the APTCs, potentially reaching low-income uninsured people in states that did not expand Medicaid. Specifically, for people ineligible for APTCs, the cost-sharing tax credit subsidizes insurance premium contributions that exceed 5 percent of income, up to a maximum of $2,500 annually for an individual or $5,000 for a family. Similarly, APTCs subsidize premiums in excess of a required percentage contribution, which ranges from 2.01 percent to 9.66 percent of income, up to the cost of the second-lowest-cost silver plan in an individual's community.

The cost-sharing tax credits reduce consumer out-of-pocket spending for all groups; people with incomes above 400 percent of poverty will see a 7 percent reduction in spending. The reduction in spending even for those with high incomes suggests an opportunity for targeting the tax credit. For example, it would be possible to reduce or eliminate the credit for higher-income individuals, either to reduce the impact on the deficit or to increase the credit amount for people with very low incomes.

Relative to the cost-sharing tax credits, the other policies have more modest effects on coverage, out-of-pocket-spending, and the federal deficit, primarily because these policies are more narrowly targeted than the cost-sharing tax credits. However, these policies have a greater effect on the small subset

of people to whom they are targeted.[13] For example, marketplace enrollees who switch from private coverage to the public plan experience an average 17 percent decline in out-of-pocket spending.

Three of the four policies considered here increase the federal deficit. The cost-sharing tax credits, which have the biggest impact on coverage and spending, have the largest impact on federal outlays. We have not modeled how these credits would be financed, but this policy would likely require new taxes or offsetting savings from other proposals, like reductions in Medicare drug spending. If new taxes are required to finance the cost of the proposed options, the net impact to individuals' pocketbooks might change. For some, the savings generated by the tax credit could be reduced or even outweighed by additional spending in the form of tax payments.

It is also unclear how the proposed policies would affect long-term growth in health care spending or how this growth would affect the federal deficit. Because new tax credits shield consumers from the effects of higher costs, consumers may opt to use more care, providers may increase prices, or insurers may relax utilization management processes. Such changes may ultimately cause national health spending and the federal deficit to increase. At the same time, competitive pressures created by the public plan and other Clinton policies, such as leveraging Medicare's bargaining power to lower prescription drug costs, may reduce the rate of health care cost growth and the deficit. Our analysis does not consider how Clinton's proposals may affect the long-term trajectory of health spending in the United States.

Clinton's plan includes numerous additional policies, such as new protections for prescription drug users, extending 100 percent federal matching for the first three years to states that newly expand their Medicaid programs, offering a Medicare buy-in for individuals ages 55 to 64, and allowing undocumented immigrants to buy into the marketplaces without federal subsidies. Because we did not consider all these policies, we cannot estimate the full effect of Clinton's health reform proposals in combination. We present the combined effect of the four policies considered in this brief in the technical appendix. The effects on coverage and the federal deficit under the combined scenario are similar to the effects of the cost-sharing tax credits implemented individually. However, combining the four options adds additional cost-sharing protections for low- and moderate-income individuals with insurance.

NOTES

[1] N. Uberoi, K. Finegold, and E. Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016,* ASPE Issue Brief (Office of the Assistant Secretary for Planning and Evaluation, March 2016).

[2] See Hillary Clinton's factsheet, "Hillary Clinton's Plan for Lowering Out-of-Pocket Costs."

[3] See Hillary Clinton's factsheet, "Clinton Will Build on the Affordable Care Act While Sanders Would Start Over and Reopen a Contentious Debate."

[4] Ibid.

[5] See Hillary Clinton's factsheet, "Hillary Clinton's Commitment: Universal, Quality, Affordable Health Care for Everyone in America."

[6] C. Boccuti, C. Fields, G. Casillas et al., *Primary Care Physicians Accepting Medicare: A Snapshot* (Henry J. Kaiser Family Foundation, Oct. 30, 2015).

[7] S. A. Nowak, E. Saltzman, and A. Cordova, *Alternatives to the ACA's Affordability Firewall* (RAND, 2015).

[8] See Hillary Clinton's factsheet, "Hillary Clinton's Commitment: Universal, Quality, Affordable Health Care for Everyone in America."

[9] A. Cordova, F. Girosi, S. A. Nowak et al., "The COMPARE Microsimulation Model and the U.S. Affordable Care Act," *International Journal of Microsimulation,* 2013 6(3):78–117.

[10] APTCs reflect the cost of the second-lowest-cost silver plan available to the individual, minus a fixed percentage of the individual's (or family's) income. The percentage contribution, R, increases from 2.01 to 9.66 percent as income increases from 138 percent to 400 percent of the federal poverty level. The public option can be free to the individual if $\text{Premium}_{\text{public}} < \{\text{Premium}_{\text{private}} - (R^{*}\text{income})\}$.

[11] For example, the average employer plan has an actuarial value of approximately 83 percent, which is more generous than gold, silver, or bronze coverage on the marketplaces. See J. R. Gabel, R. Lore, R. D. McDevitt et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs,* June 2012 31(6):1339–48.

[12] For example, individuals with incomes above 250 percent of FPL are ineligible for cost-sharing reductions.

[13] For example, Nowak, Saltzman, and Cordova (see note 7 above) found that eliminating the family glitch caused average total health spending to fall by 32 percent, from $6,564 to $4,484, among the 2.3 million people directly affected by the policy.

About the Authors

Christine Eibner, Ph.D., is a senior economist at the RAND Corporation and associate director for RAND's Health Services and Delivery Systems Research Program. Dr. Eibner's recent studies have considered changes in health insurance enrollment since 2013, use of pharmaceuticals among marketplace enrollees compared to employer-insured individuals, and geographic variation in marketplace premiums and cost-sharing. In addition, she has led a series of analyses using the RAND COMPARE microsimulation model to assess how changes to the ACA could affect key outcomes, including federal spending, Medicaid enrollment, and individual market coverage. Dr. Eibner's research has been published in journals such as Health Affairs, Health Services Research, and the New England Journal of Medicine. She earned her Ph.D. in economics from the University of Maryland, and her bachelor's degree from the College of William and Mary.

Sarah Nowak, Ph.D., is a physical scientist at the RAND Corporation, specializing in mathematical modeling. Much of Dr. Nowak's recent work has focused on using the RAND COMPARE microsimulation model to evaluate health insurance reforms including assessing the impact of the ACA on individual and family spending, and how alternatives to current ACA provisions would impact health insurance coverage and enrollment, government spending, and families' health care spending. Dr. Nowak also led a recent study that used a survey of patients and agent-based modeling to examine the role of social networks on women's breast cancer screening decisions. Dr. Nowak holds a Ph.D. in biomathematics from the University of California, Los Angeles and a bachelor's degree in physics from the Massachusetts Institute of Technology.

Jodi Liu, Ph.D., is an associate policy researcher at the RAND Corporation. Dr. Liu's work has involved using the RAND COMPARE microsimulation model to analyze the effects of health care reform on insurance coverage and health care spending. For her dissertation, she estimated health care spending under national single-payer alternatives. Her other work has included an analysis of changes in Medicare's physician payment system and an evaluation of policy alternatives at the intersection of long-term care and dementia. She holds a Ph.D. in policy analysis from the Pardee RAND Graduate School, a master's degree in global disease epidemiology and control from the Johns Hopkins Bloomberg School of Public Health, and degrees in biomedical and chemical engineering from the University of Michigan.

Editorial support was provided by Deborah Lorber.

The
COMMONWEALTH
FUND

www.commonwealthfund.org

ISSUE BRIEF
SEPTEMBER 2016

The COMMONWEALTH FUND

Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit

Evan Saltzman and Christine Eibner

ABSTRACT

Issue: Republican presidential candidate Donald Trump has proposed to repeal the Affordable Care Act (ACA) and replace it with a proposal titled "Healthcare Reform to Make America Great Again." Proposed reforms include allowing individuals to deduct the full amount of premiums for individual health plans from their federal tax returns, providing block grants to finance state Medicaid programs, and allowing insurers to sell insurance across state lines. **Goal:** To assess how each of these reforms, when implemented individually, would affect insurance coverage, consumer out-of-pocket spending on health care, and the federal deficit in 2018. **Methods:** RAND's COMPARE microsimulation model. **Key findings and conclusions:** The policies would increase the number of uninsured individuals by 16 million to 25 million relative to the ACA. Coverage losses disproportionately affect low-income individuals and those in poor health. Enrollees with individual market insurance would face higher out-of-pocket spending than under current law. Because the proposed reforms do not replace the ACA's financing mechanisms, they would increase the federal deficit by $0.5 billion to $41 billion.

OVERVIEW OF POLICY OPTIONS AND APPROACH

Since the Affordable Care Act (ACA) was enacted in 2010, critics have advocated that the law be repealed and replaced with an alternative set of reforms. Republican presidential candidate Donald J. Trump has offered a "repeal-and-replace" proposal titled "Healthcare Reform to Make America Great Again."[1] In this brief, we consider the impact of repealing the ACA and enacting three of the key policies proposed by Trump. The policies considered are only elements of Trump's overall health care reform proposal, which includes several features we did not model, including increasing price transparency and removing barriers to entry in the prescription drug market.[2] We analyzed each policy in conjunction with repeal of the ACA, rather than as a combined package. By considering each policy on its own, we can more easily understand each option's effect on coverage, consumer out-of-pocket costs, and the federal deficit. The policies we consider include:

1. **Fully repeal the ACA.**
   In this scenario, all provisions of the ACA are repealed, including Medicaid expansion and means-tested tax credits for coverage in the health insurance marketplaces. All market reforms in the individual market are eliminated,

For more information about this brief, please contact:

Christine Eibner
Senior Economist
RAND Corporation
eibner@rand.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1903
Vol. 31

including community rating and prohibiting insurers from denying coverage to people with preexisting conditions. Also includes the repeal of ACA measures designed to offset the cost of Medicaid expansion and subsidies for marketplace insurance, such as revenue generated through the individual and employer mandates, reductions in the rate of Medicare spending growth, and the implementation of new taxes and fees.[3]

2. **Repeal, plus allow individuals to fully deduct health insurance premium payments from their tax returns.**
   Current laws and provisions outside the ACA exclude employer spending on health insurance from income and payroll taxes. However, prior to the ACA, the significant tax advantages available to those with employer-sponsored coverage did not extend to those enrolled in private, individual-market policies obtained outside of an employer.[4] The ACA began to bridge this gap by providing means-tested advance premium tax credits (APTCs) for purchasing individual market insurance. Trump's proposal would eliminate APTCs, and allow individuals to use pretax dollars to purchase individual market insurance.

3. **Repeal, plus block grants for Medicaid and the Children's Health Insurance Program to the states.**
   Medicaid and the Children's Health Insurance Program (CHIP) are jointly funded by states and the federal government. The federal government currently contributes 50 percent to 75 percent of total costs for Medicaid enrollees who were eligible prior to the ACA, higher amounts for CHIP enrollees, and higher amounts for those made eligible for Medicaid because of the ACA. Under a block-grant system, the federal government would instead give states a fixed amount to fund their programs. We assume that, under Trump's plan, this amount would be based on pre-ACA Medicaid and CHIP spending levels, including spending on expansions that occurred prior to the ACA.[5] In addition, we interpret Trump's block-grant program as including CHIP, although Trump's plan does not specifically mention this program.

4. **Repeal, plus promote the sale of health insurance across state lines.**
   Health insurance has historically been regulated by the states. Therefore, insurers seeking to offer policies in multiple states must comply with each state's insurance regulations. Prior to the ACA, state insurance regulations varied widely, particularly with respect to underwriting, guaranteed issue, and coverage denials. The ACA established minimum standards, but if the law were repealed, the significant regulatory variation across states would likely return. Although details have not been fully specified, this policy would allow insurers in one state to sell plans in state without complying with the other state's regulations.

Because we analyzed only some of Trump's proposed policies, we cannot conclude that a scenario that combined the effects of these reforms would be an accurate representation of the full impact of Trump's health plan. As a result, we do not report a scenario combining these reforms in the main text of this brief, although it is available in the technical appendix.

We used the RAND COMPARE microsimulation model, which estimates the impact of health policy changes. Specifically, we analyzed how the proposed reforms would affect the

distribution of health insurance coverage by income and health status, the federal deficit, and the level of out-of-pocket spending in the individual market. To quantify the impact on out-of-pocket spending, we focused on the individual market because many of the policies enacted by the ACA and proposed by Trump are targeted to this market. In particular, the Trump proposals would eliminate key ACA individual market reforms, including:

- premium tax credits and cost-sharing reductions for individual market enrollees
- prohibitions on rescinding and denying coverage to those with preexisting conditions
- community-rating regulations that allow insurers to set premiums only based on age, smoking, and geography, without considering sex or health status[6]
- minimum standards for plan generosity and covered benefits
- annual and lifetime caps on health benefits.

Trump's plan would remove these requirements and subsidies and introduce new policies that affect the individual market, including tax deductions and the ability to sell plans across state lines.

Modeling health reform proposals that have not yet been turned into legislation can be challenging because of lack of specificity. Further, Trump would implement several other proposals that could interact with the health policies, such as changes in tax rates. Consequently, we make several modeling assumptions, which we discuss briefly in the How This Study Was Conducted section at the end of this brief. A detailed description of the model and assumptions is provided in the technical appendix. In the technical appendix, we also compare our results to two previous studies that have estimated the impact of Trump's proposals.[7]

RESEARCH FINDINGS

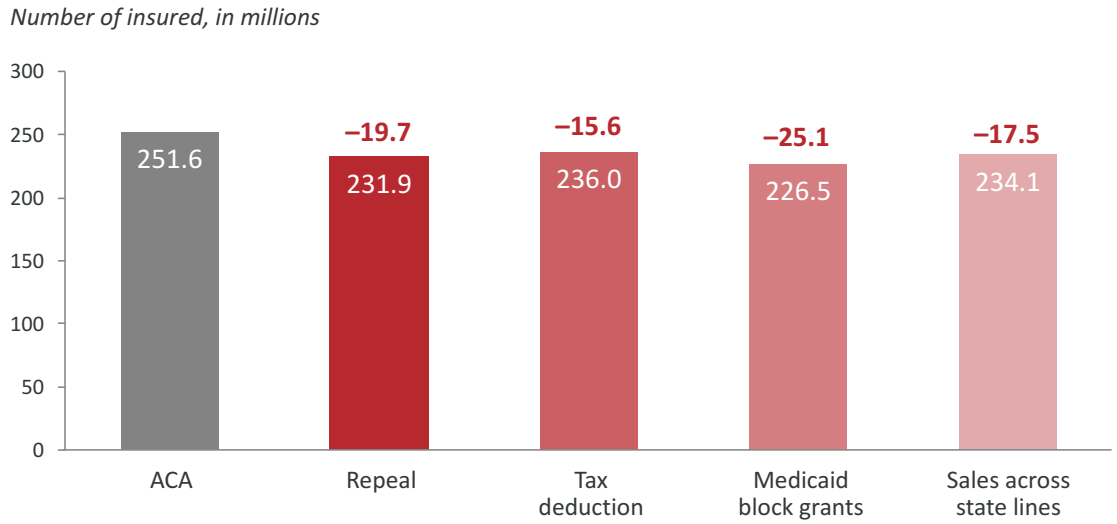
Insurance Coverage

Repealing the ACA would result in 19.7 million fewer people with health insurance in 2018 (Exhibit 1). This estimate assumes that individuals who newly enrolled in Medicaid under the ACA, but who were eligible under prior law,[8] would remain enrolled even if the law were repealed.[9] Repealing the ACA and adding a tax deduction for health insurance would result in 15.6 million fewer people with health insurance. The Medicaid block-grant program results in 25.1 million fewer people with health insurance, including approximately 5.5 million people who were eligible for Medicaid under pre-ACA rules who lose coverage because states may lack the funds to sustain enrollment among this population. Allowing insurers to sell across states lines reduces coverage by 17.5 million people.

Exhibit 2 illustrates each policy's effect on the number of people without insurance, by income level. All three policies would increase the ranks of the uninsured among those with incomes under 250 percent of the federal poverty level (i.e., $60,750 for a family of four). For those with incomes above 250 percent of poverty, the policies have mixed effects. Repealing the ACA would have little impact on insurance enrollment for people with higher incomes; the same is true of repealing the ACA in combination with the Medicaid block-grant program. However, repealing the ACA in combination with the tax deduction or allowing insurers to sell across state lines would increase the number of higher-income people with insurance. We estimate that 2.7 million more people with incomes over 250 percent of poverty would be insured with the tax deduction, and 1.4 million more higher-income people would be insured if insurers were allowed to sell across state lines.

Exhibit 1

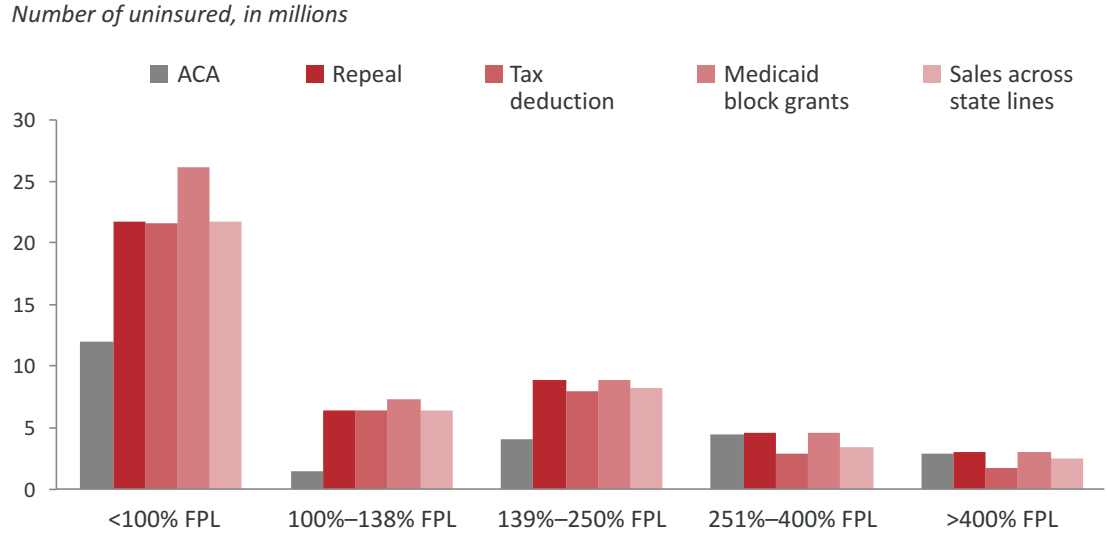
Impact of Trump's Proposed Reforms on the Number of People with Insurance Coverage, 2018



Notes: Changes in coverage relative to the ACA scenario are shown above each bar, in red.
The estimated distribution of enrollment by source of coverage is available in Appendix Table A.2.
Data: RAND COMPARE microsimulation model.

Exhibit 2

Impact of Trump's Proposed Reforms on Income Distribution of the Uninsured, 2018



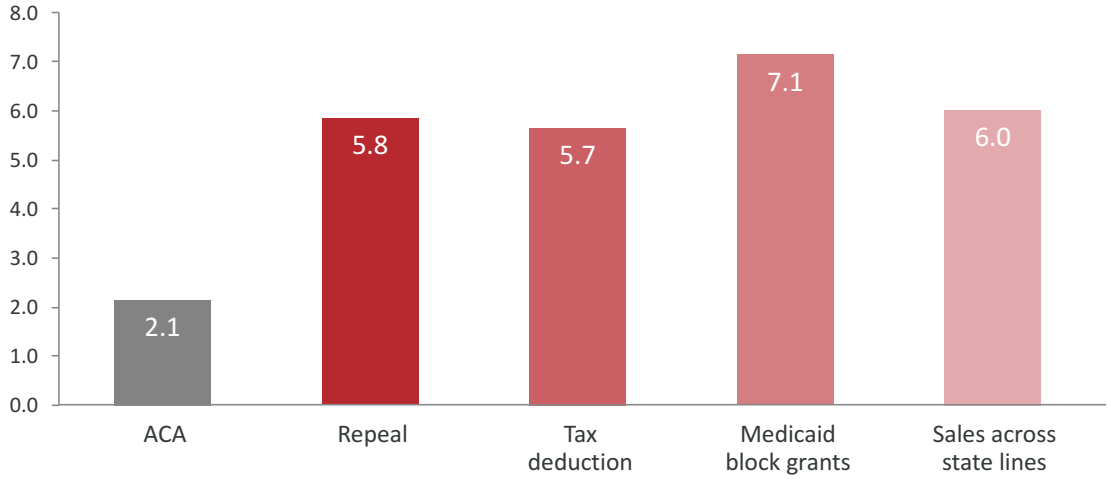
Notes: FPL = federal poverty level. Specific numbers are available in Appendix Table A.3.
Data: RAND COMPARE microsimulation model.

We estimate that repealing the ACA would cause the number of uninsured individuals in fair or poor health to increase from 2.1 million to 5.8 million (Exhibit 3). Implementing Medicaid block grants or allowing insurance sales across states lines would further increase the number of uninsured in fair or poor health. Looking at the Medicaid block-grants option, the increase in the number of uninsured people in fair or poor health reflects the general decline in insurance, from 231.9 million to 226.5 million (Exhibit 1). However, in the sales-across-state-lines scenario, the number of uninsured individuals in fair or poor health increases relative to full repeal, despite the fact that more people are insured overall. This is because—as modeled—the sales-across-state-lines scenario leads to regulatory liberalization, making it easier for insurers to deny coverage to older and sicker people.

Exhibit 3

Impact of Trump's Proposed Reforms on the Number of Uninsured Individuals in Fair or Poor Health, 2018

Number of uninsured in fair or poor health, in millions



Data: RAND COMPARE microsimulation model.

Out-of-Pocket Spending

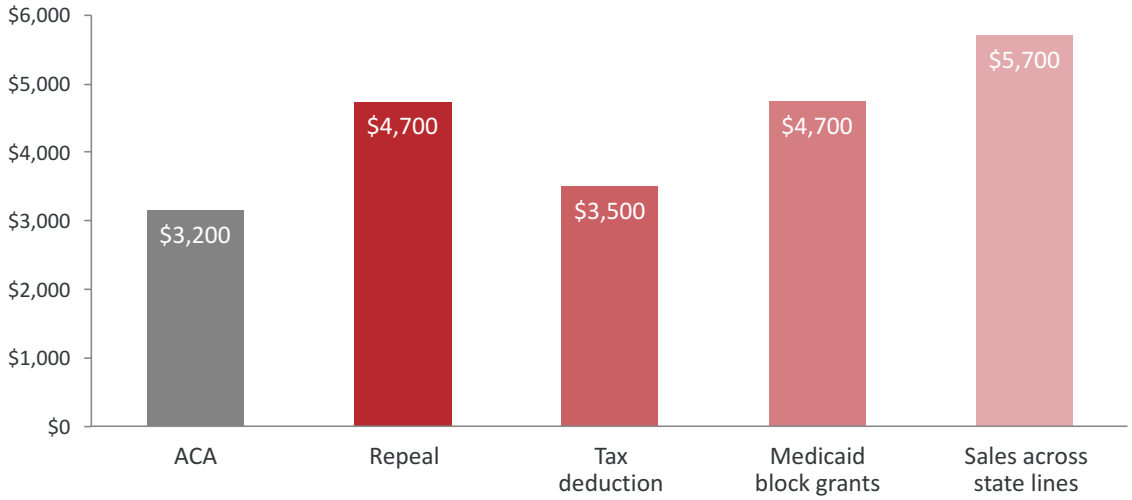
In Exhibit 4, we analyze how Trump's plan would affect consumer spending for individuals who would have enrolled in individual market coverage (i.e., private coverage not obtained through an employer) under the ACA. We estimate that total out-of-pocket spending for individual market enrollees, including enrollee premium contributions and cost-sharing at the point of service, averages about $3,200 per year in the ACA scenario. Fully repealing the ACA would cause total out-of-pocket expenses to increase to $4,700. Repealing the ACA and replacing it with a tax deduction would result in average out-of-pocket spending of about $3,500 per year because the tax deduction is less generous on average than the ACA's Advanced Premium Tax Credits (APTCs) and cost-sharing subsidies, particularly for the lower- and middle-income people who benefit from these policies. If insurers were allowed to sell insurance coverage across state lines, we estimate that average out-of-pocket spending

would be approximately $5,700 annually. The large increase in out-of-pocket spending in the last scenario reflects several factors. First, it provides no premium or cost-sharing support for enrollees, leading to an increase in the proportion of health care costs they pay for. Second, it would lead to a proliferation of "bare-bones" plans, which have low premiums but high out-of-pocket cost-sharing at the point of service. Our analysis estimates effects for a standardized population of individuals who enrolled in individual market coverage under the ACA. Average out-of-pocket spending would be lower for the population that actually enroll in the sales-across-state-lines scenario because these enrollees are disproportionately young and healthy.[10]

Exhibit 4 shows that Trump's proposed tax deduction would increase out-of-pocket spending for individuals enrolled in the individual market. In part, this is because the tax deduction tends to be less generous than the ACA's APTCs for individuals with low and moderate incomes. Exhibit 5 shows how tax-related subsidies (e.g., deductions and APTCs) to individual market enrollees would differ between the ACA and Trump's plan, by enrollees' income and family size. While the results vary depending on enrollees' age and family composition, individuals with incomes below 300 percent of poverty (approximately $35,640 for a single individual) tend to benefit more from the ACA's means-tested tax credit structure, while individuals with incomes above that level benefit more from the Trump plan's tax deduction.

Exhibit 4

Impact of Trump's Proposed Reforms on Average Annual Out-of-Pocket Expenses for Individual Market Enrollees, 2018



Notes: The exhibit shows average annual out-of-pocket expenses, including premium and cost-sharing, for a standardized population consisting of individuals projected to be enrolled in the individual market under current law.
Data: RAND COMPARE microsimulation model.

Exhibit 5. Estimated Subsidies Under Trump's Proposed Reforms for Individual Market Insurance, by Income and Household Composition, 2018

Household	ACA advance premium tax credit	Proposed Trump tax deduction
27-year-old adult	Benchmark plan premium = $3,100	
Income: $17,500 (150% FPL)	$2,400	$500
Income: $35,000 (300% FPL)	$0	$500
Income: $46,500 (400% FPL)	$0	$800
Income: $70,000 (600% FPL)	$0	$800
60-year-old adult	Benchmark plan premium = $8,000	
Income: $17,500 (150% FPL)	$7,300	$1,200
Income: $35,000 (300% FPL)	$4,700	$1,200
Income: $46,500 (400% FPL)	$0	$2,000
Income: $70,000 (600% FPL)	$0	$2,000
60-year-old married couple	Benchmark plan premium = $16,000	
Income: $23,500 (150% FPL)	$15,100	$1,600
Income: $47,000 (300% FPL)	$11,300	$2,400
Income: $63,000 (400% FPL)	$0	$2,400
Income: $94,500 (600% FPL)	$0	$4,000
40-year-old parent and three children*	Benchmark plan premium = $9,400	
Income: $36,000 (150% FPL)	$8,000	$1,400
Income: $71,500 (300% FPL)	$2,800	$1,400
Income: $95,500 (400% FPL)	$0	$2,400
Income: $143,000 (600% FPL)	$0	$2,400
Two 40-year-old parents and two children*	Benchmark plan premium = $11,300	
Income: $36,000 (150% FPL)	$9,900	$1,700
Income: $71,500 (300% FPL)	$4,700	$1,700
Income: $95,500 (400% FPL)	$0	$2,800
Income: $143,000 (600% FPL)	$0	$2,800

Notes: FPL = federal poverty level. The exhibit compares the tax credit that various household types would receive for purchasing the benchmark plan (i.e., the second-lowest cost silver plan) under the ACA's advance premium tax credit (APTC) formula and under a tax deduction. In both cases, the subsidy depends on premiums. Specifically, the ACA's APTC is calculated using the benchmark plan, while the value of the tax deduction is the product of the premium and the individual's marginal tax rate. We compute a nationally weighted average premium for the benchmark plan for 2016 and inflate to 2018. Estimates are presented in 2018 dollars.
Data: Estimates from RAND COMPARE microsimulation model.

Federal Deficit

Finally, we estimated the effect of the proposed reforms on the federal deficit (Exhibit 6). According to our analysis, repealing the ACA would increase the deficit by a net $33.1 billion in 2018. Although repealing the law would reduce federal outlays on Medicaid and tax credits, repeal would also eliminate the ACA's revenue-generating provisions, such as changes to Medicare payment and taxes on health plans, medical devices, and other goods and services. For example, in the full repeal scenario, federal outlays are reduced by $35.9 billion relative to the ACA, while revenue is reduced by $69 billion, for a net increase to the federal deficit of $33.1 billion.

Exhibit 6. Impact of Trump's Proposed Reforms on the Federal Deficit (in Billions) Relative to the Affordable Care Act, 2018

Changes to federal outlays and revenues, relative to ACA	ACA	Repeal	Tax deduction	Medicaid block grants	Sales across state lines
Additional federal outlays (negative values *reduce* the federal deficit)					
Premium tax credits and deductions	$0.0	–$46.0	–$39.3	–$46.0	–$46.0
Cost-sharing reductions	$0.0	–$4.1	–$4.1	–$4.1	–$4.1
Medicaid/CHIP spending	$0.0	–$31.7	–$30.6	–$64.4	–$31.2
Medicare and other spending*	$0.0	$46.0	$46.0	$46.0	$46.0
Total change in outlays	$0.0	–$35.9	–$28.0	–$68.5	–$35.3
Additional federal revenue (negative values *increase* the federal deficit)					
Individual mandate revenue	$0.0	–$7.1	–$7.1	–$7.1	–$7.1
Employer mandate revenue	$0.0	–$12.9	–$12.9	–$12.9	–$12.9
ACA taxes and fees	$0.0	–$49.0	–$49.0	–$49.0	–$49.0
Total change in revenue	$0.0	–$69.0	–$69.0	–$69.0	–$69.0
Net change to federal deficit	**$0.0**	**$33.1**	**$41.0**	**$0.5**	**$33.7**

Notes: The exhibit considers the effect of the reforms relative to current law. Impacts that increase the federal deficit are shown in red, while those that decrease or have no effect on the federal deficit are shown in black. * We do not model the ACA's effect on taxes (including taxes on the medical device, insurance, and pharmaceutical industries, limits on health savings accounts, and surtaxes on high-income individuals) and Medicare spending, and instead take these numbers from the Congressional Budget Office.[11] We exclude revenues that may result from the possibility that firms drop coverage as a result of health reforms and pass savings back to workers in the form of taxable wages. Prior research has shown that, to date, employers do not appear to have dropped health insurance in response to the ACA.[12] Estimates are presented in 2018 dollars.
Data: Estimates from RAND COMPARE microsimulation model.

Repealing the ACA and replacing it with a tax deduction would increase the deficit by $41.0 billion relative to the ACA, mostly because of the federal cost of the tax deduction. Assuming the Medicaid block-grant amount is set to pre-ACA levels adjusted for inflation, we project that the block-grant program would increase the deficit by $0.5 billion. The block-grant scenario is less expensive than full repeal because, under full repeal, we assume that the federal government would continue to fund Medicaid costs for previously eligible individuals enrolled after the ACA was enacted. As modeled, the block-grant amounts are based on pre-ACA Medicaid spending, and do not account for this "woodwork" population (i.e., previously eligible individuals who enrolled in Medicaid following the ACA).

Assuming that Medicaid block grants are based on pre-ACA funding levels, they would be costless to the federal government relative to full repeal. However, states would face a conundrum regarding how to finance the population that is currently enrolled in Medicaid. We assume that states would eliminate eligibility for the ACA's Medicaid expansion population if offered block grants based on pre-ACA funding levels. But more than half of those who newly enrolled in Medicaid in 2014 were eligible under previous rules.[13] Unless the block grants covered this woodwork population, states would have to find alternative means to finance this group or would need to reduce enrollment to break even. In our analysis, we assumed that states would find ways to reduce enrollment, such as by cutting eligibility levels or reducing enrollment assistance and outreach. However, if states pursued a policy of financing the woodwork population, then both Medicaid enrollment and state budgetary costs would increase relative to our estimates.

Allowing insurers to sell across state lines would increase the deficit by $33.7 billion relative to the ACA. Like the other proposals considered, the sales-across-state-lines scenario reduces federal spending relative to the ACA, because of the elimination of ATPCs and cost-sharing reductions and reduced spending on Medicaid and CHIP. However, these savings are more than offset by the reductions in revenue caused by repealing the ACA, including the loss of revenue from individual and employer mandates and the elimination of ACA-related taxes and fees.

DISCUSSION

In this analysis, we considered three health policies proposed by Republican presidential candidate Donald Trump. Relative to the ACA, we found that all three policies would reduce health insurance enrollment and increase the federal deficit. While all of Trump's policies reduce spending on health insurance programs and subsidies (e.g., Medicaid, tax credits) relative to the ACA, they also reduce federal revenue by repealing the ACA's financing mechanisms, including changes to Medicare payment and taxes on medical devices, health plans, and branded prescription drugs. On net, the proposed reforms increase the deficit by $0.5 billion to $41 billion. We estimate that the tax deduction scenario would lead to the largest deficit increase, as a result of losses in tax revenue collected.

Because there were few details available about these policies, we made several key modeling assumptions regarding implementation. For example, we assumed that Medicaid block-grant funding would be based on pre-ACA spending. While different assumptions could lead to different results, it is generally true that features of Trump's reform proposals are likely to lead to reduced insurance coverage for those with lower incomes and those with preexisting health conditions. First, the program does not replace the ACA's subsidies to low- and middle-income individuals who were not eligible for Medicaid prior to the ACA and who lack affordable insurance offers through an employer. While Trump's health insurance tax deduction acts as an implicit subsidy for health insurance, its effects disproportionately benefit those with higher incomes and higher marginal tax rates.

Second, none of Trump's proposals guarantee that insurance will be available for individuals in poor or fair health who may have been denied coverage or charged higher premiums in the individual market under pre-ACA law. As a result, we estimate that the scenarios would increase the ranks of the uninsured in fair or poor health by 3.6 million to 5.0 million, with the highest numbers occurring in the Medicaid-block-grants scenario. The sales-across-state-lines scenario would lead to lower premiums on the individual market and result in about 2 million additional people being insured relative to the full-repeal scenario. However, because the policy does not require that insurers

offer coverage to individuals with preexisting conditions, an additional 200,000 in fair or poor health would be uninsured relative to full repeal alone.

In addition to the three policies considered here, Trump also proposes to expand the use of health savings accounts, increase price transparency in health care, and remove barriers to entry in the pharmaceutical industry. Because we did not model these additional policies, we cannot comment on the full effect of Trump's health reform proposals. However, in our technical appendix, we consider the combined effect of the three policies modeled in this brief. We estimate that the number of individuals with insurance under all three policies combined is similar to the number if the ACA were repealed without any replacement. Although enacting Medicaid block grants leads to a reduction in coverage relative to full repeal, adding the tax deduction and allowing sales across state lines brings enrollment back to the full-repeal level. However, relative to full repeal, the combined scenario has a lower impact on the federal deficit, and leads to reduced insurance coverage among the lowest-income groups. Both of these effects reflect the impact of the Medicaid block grants, which reduce insurance coverage for lower-income populations while also reducing federal spending.

We have not modeled how Trump's plan would be financed but, if implemented, these policies would likely require new taxes or offsetting savings from other proposals to maintain deficit neutrality. Further, modifications or additions to Trump's plan would be required if policymakers wish to avoid coverage losses, particularly for lower-income and less-healthy individuals. For example, refundable tax credits indexed by income instead of a regressive tax deduction could target subsidies to low-income individuals. High-risk pools also could provide a mechanism for those with preexisting conditions to obtain coverage. These reforms likely would expand coverage compared to the reforms considered in this brief; however, they also would increase the federal deficit relative to full repeal.

HOW THIS STUDY WAS CONDUCTED

The RAND COMPARE model creates a synthetic population of individuals, families, and firms using national survey data. After calibrating the modeled behavior of people and firms to match actual outcomes, COMPARE introduces proposed reforms to assess how the choices of individuals and firms are affected. To evaluate the reforms proposed by Trump, we first eliminated all reforms introduced by the ACA, including the individual and employer mandates, premium tax credits and cost-sharing subsidies, and market rating reforms, such as community rating and guaranteed issue. We then added each of Trump's reforms one by one to the full-repeal scenario using the following approach:

Tax deduction

We allowed individuals in the model to deduct the full cost of employer coverage and individual market coverage from their tax returns in determining their federal adjusted gross income. We assumed that households could apply the deduction against their federal income tax obligation, but not against their state income or payroll tax obligations.

Medicaid block grants

To determine the amount of the federal grant, we estimated the level of Medicaid enrollment that would have existed in 2018 if the ACA had not been implemented, and calculated the federal contribution for this coverage. Because funding amounts would likely be based on pre-2014 rules, we assumed that states would first roll back their Medicaid eligibility limits to pre-ACA levels. However, the ACA increased enrollment among both those newly eligible and those previously eligible for

Medicaid (i.e., the "woodwork effect"). We assumed that states would further reduce eligibility limits or otherwise discourage enrollment so that spending would not exceed the amount of the block grant.

Sales across state lines

We assumed that allowing insurers to sell across state lines would lead to regulatory liberalization relative to the rules in effect prior to the ACA. To model this effect, we adjusted the individual market to reflect insurance dynamics in the states with the least restrictive regulations prior to the ACA. In particular, we assumed that the premium difference between older and sicker individuals relative to younger and healthier individuals would widen. Further, we assumed that insurance denial rates (e.g., for preexisting conditions) would approach 30 percent—similar to what occurred in states with the highest denials prior to the ACA. Finally, we assumed that the elimination of benefit mandates and other consumer protections, such as risk adjustment, would exacerbate adverse selection and result in less generous, catastrophic-type plans becoming prevalent. As we discuss in detail in the technical appendix, there are several reasons why this degree of regulatory liberalization may not be realized. In addition, final legislation could include regulatory floors that seek to avert widespread insurer location in states with the least restrictive regulatory practices prior to the ACA. For example, Trump has publicly voiced support for protections to ensure that people with preexisting conditions have access to health insurance, although these protections are not discussed in his proposal. If the sales-across-state-lines policy were accompanied by restrictions on insurers' ability to deny policies to those with preexisting conditions, and if other protections were put in place such as minimum benefit generosity levels, we would expect different results. Minimum benefit generosity requirements would likely cause insurers to offer more generous plans with higher premiums than we have estimated and lower out-of-pocket costs. If the individual market population has high price sensitivity, then it is likely that higher premiums would reduce enrollment relative to the predictions we make in our analysis. This reduction in enrollment could occur even if restrictions on denial rates allowed a larger share of the population to purchase individual insurance than we assume.

We report all results for the calendar year 2018.

NOTES

[1] See: https://www.donaldjtrump.com/positions/healthcare-reform.

[2] Trump proposes three other reforms that we cannot model and, therefore, do not include in our analysis. First, Trump proposes allowing individuals to use health savings accounts (HSAs). HSAs exist under current law and it is unclear if and how Trump would modify HSAs. Second, Trump's plan requires "price transparency from all healthcare providers." As discussed in detail by Cutler and Dafny (2011), the impact of price transparency is theoretically ambiguous. Empirical evidence for price transparency is limited, but evidence from recent initiatives in California and New Hampshire suggests that price transparency had little impact on prices (Cutler and Dafny, 2011). Finally, the plan advocates removing "barriers to entry into free markets for drug providers that offer safe, reliable, and cheaper products." Two key barriers to entry in the pharmaceutical industry include patent protection and Food and Drug Administration (FDA) regulation. Trump's plan provides no detail on how these barriers would be modified, and very little evidence exists to evaluate the impact of such modifications. (Notably, an analysis of Trump's proposed reforms by the Center for Health and Economy also omits consideration of these three reforms.)

[3] Examples of new taxes include the section 9010 tax, the Patient-Centered Outcomes Research Institute tax, taxes on medical devices and branded prescription drugs, the tanning tax, and an increase in the hospital insurance tax for high-income individuals.

[4] In addition to the tax exclusion for ESI, under current law, self-employed individuals can deduct individual-market health insurance premiums, taxpayers can deduct medical expenses exceeding 10 percent of adjusted gross income if itemizing, and qualified individuals can claim the Health Coverage Tax Credit (HCTC) under the Trade Preferences Extension Act of 2015.

[5] Many states expanded Medicaid beyond categorical eligibility limits prior to the ACA. We assume the block grant would be sufficient to fund these expansions at pre-ACA enrollment levels, but would not cover early state Medicaid expansions (prior to 2014) that occurred under the ACA.

[6] Age rating is limited to a 3-to-1 ratio (i.e., 64-year-olds cannot be charged more than three times as much as what 21-year-olds are charged), smoking rating is limited to a 1.5-to-1 ratio, and geographic rating areas must be based on counties, MSAs, or three-digit zip codes with limited exceptions.

[7] Center for Health and Economy, *Healthcare Reform to Make America Great Again* (H&E, July 7, 2016); and Committee for a Responsible Federal Budget, "Analysis of Donald Trump's Health Care Plan" (CRFB, May 9, 2016).

[8] "Previously eligible" in this context refers to people who were eligible for Medicaid prior to the ACA's coverage expansion.

[9] The woodwork effect leads to increased Medicaid enrollment under repeal compared to the pre-ACA environment. Without the woodwork effect, we estimate that 25 million fewer people would have health insurance if the ACA were repealed.

[10] Actual enrollees are younger and healthier because older and sicker people are more likely to be denied coverage in the sales-across-state-lines scenario.

[11] Congressional Budge Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (CBO, June 2015).

[12] G. Claxton, M. Rae, N. Panchal et al., "Health Benefits in 2015: Stable Trends in the Employer Market," *Health Affairs,* Oct. 2015 34(10):1779–88.

[13] M. Frean, J. Gruber, and B. D. Sommers, *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act,* NBER Working Paper #22213 (National Bureau of Economic Research, April 2016).

About the Authors

Evan Saltzman, M.S., is a doctoral student in health care management at The Wharton School of the University of Pennsylvania and an adjunct project associate at the RAND Corporation. He is interested in studying health reform under the Affordable Care Act and its impact on health insurance markets. Mr. Saltzman is a modeler on the RAND COMPARE microsimulation modeling team and has played key roles on numerous studies assessing the impact of the Affordable Care Act. His research has been cited by the U.S. Supreme Court and numerous media outlets, including the *Washington Post* and the *New York Times*. Mr. Saltzman received his master's degree in operations research from Georgia Tech and his bachelor's degree in mathematics and economics from the College of William and Mary.

Christine Eibner, Ph.D., is a senior economist at the RAND Corporation and associate director for RAND's Health Delivery Systems Program. Dr. Eibner's recent studies have considered changes in health insurance enrollment since 2013, use of pharmaceuticals among marketplace enrollees compared with employer-insured individuals, and geographic variation in marketplace premiums and cost-sharing. In addition, she has led a series of analyses using the RAND COMPARE microsimulation model to assess how changes to the ACA could affect key outcomes, including federal spending, Medicaid enrollment, and individual market coverage. Dr. Eibner's research has been published in journals such as *Health Affairs*, *Health Services Research*, and the *New England Journal of Medicine*. She earned her Ph.D. in economics from the University of Maryland and her bachelor's degree from the College of William and Mary.

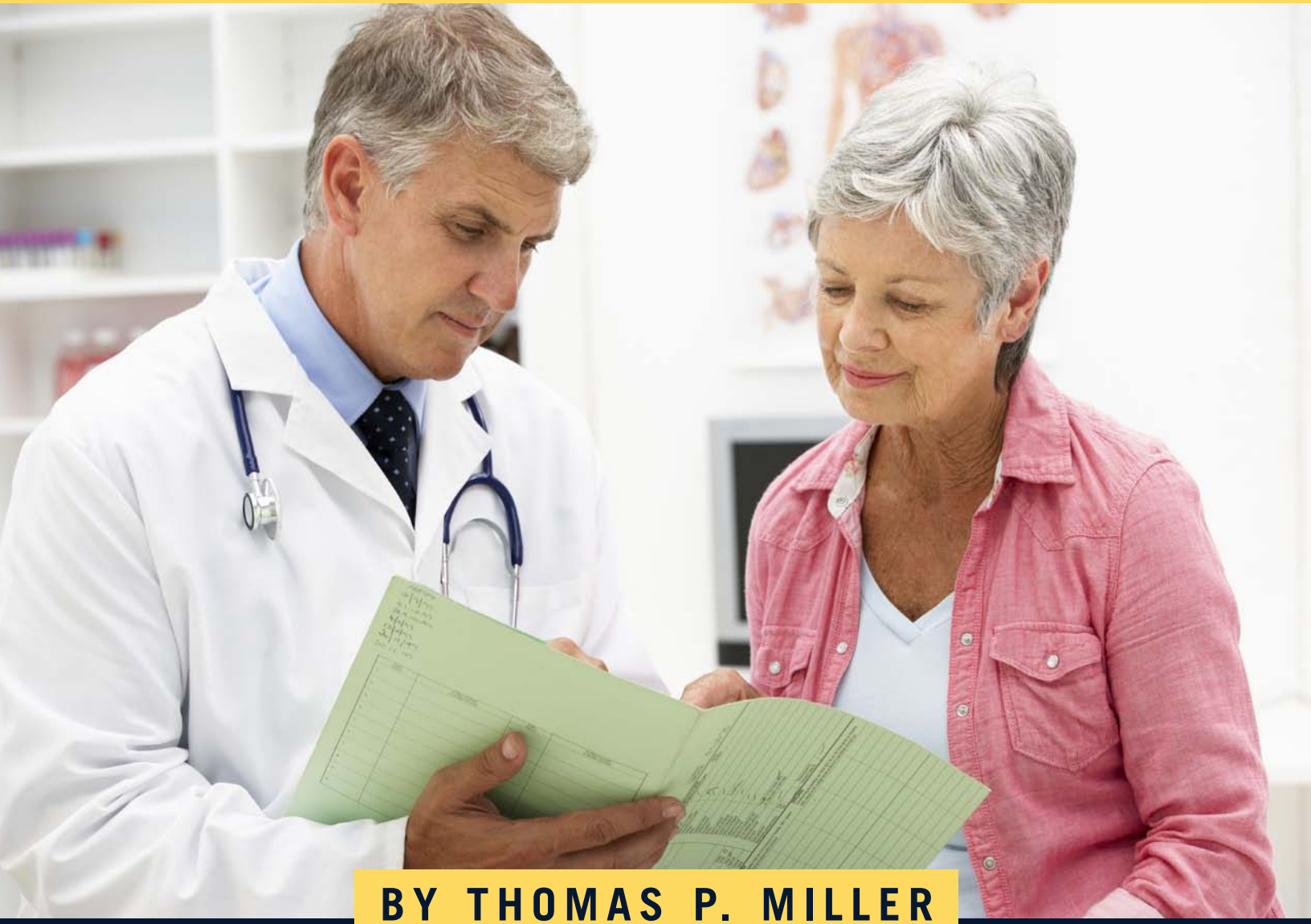
Editorial support was provided by Deborah Lorber.

The COMMONWEALTH FUND

www.commonwealthfund.org

WHEN OBAMACARE FAILS

The Playbook for Market-Based Reform



BY THOMAS P. MILLER

AEI

AMERICAN ENTERPRISE INSTITUTE

WHEN OBAMACARE FAILS

The Playbook for Market-Based Reform

BY THOMAS P. MILLER

DECEMBER 2012

AMERICAN ENTERPRISE INSTITUTE

Contents

Acknowledgments

I would like to thank Henry Olsen for steady editorial guidance, Grace-Marie Turner for unflagging encouragement and support, and Catherine Griffin for superb research assistance. Important elements of the policy analysis and recommendations for the chapters on defined-contribution financing and protection against preexisting conditions reflect previously coauthored work with James Capretta. The Pioneer Institute supported earlier published versions of my work on state-based health policy reform. John Stephen contributed greatly to my understanding of Medicaid reform.

President Obama and the 111th Congress made this work necessary. Future policymakers may find it more useful.

Executive Summary

The Affordable Care Act (ACA) is too misguided to succeed, too dangerous to maintain, and far too flawed to fix piecemeal.

Repealing most, if not all, of the ACA is necessary to clear the way for the lasting health care reforms we need. Ending the acute pain caused by what is more commonly called "Obamacare" is the beginning, not the end, of providing a safe, effective, and more sustainable cure. To make this happen, we need a clearer vision for the policy changes necessary to fix our health care system and improve the health of Americans.

Although the Supreme Court narrowly upheld the main components of the ACA, including its individual mandate, last June, the law still may not be fully implemented. But it will not simply fall from its own dead weight and quietly leave the scene. Repealing as much of the ACA as possible remains a necessary part of fixing the fundamental ailments of our health care system that Obamacare has failed to solve, and in many ways has worsened.

However, offering only a simple return to the pre-ACA status quo would be a woefully inadequate and unappealing alternative. Americans need principled and effective solutions to the problems of high health care costs, inconsistent health care quality, and gaps in access to affordable care. A replacement plan that works and lasts should provide better rules, tools, and incentives to help patients, purchasers, and providers improve their health at costs they are willing and able to pay, within more secure but steadily improving arrangements.

The policy challenges for the post-Obamacare landscape include:

- Retargeting taxpayer subsidies for health coverage;
- Protecting vulnerable Americans;
- Improving the performance of a consumer-based health system;
- Making Medicare and Medicaid more accountable, effective, and sustainable; and
- Managing the complex transition to a health system truly based on choice and competition.

This study aims to fill in the blanks for many ACA opponents who promise to replace it but do not take the next step: telling Americans how they would do so in a credible and convincing manner. The key policy prescriptions are neither unprecedented nor illusory. They reinforce the core principles and values held by a clear majority of Americans in their roles as voters, consumers, patients, and taxpayers.

A replacement and renewal program for better health care and health:

- Starts with defined-contribution financing of all forms of taxpayer-subsidized health insurance coverage;
- Retargets subsidies to strengthen the health care safety net for the most vulnerable Americans;
- Stimulates responsible competition among the states in information-based regulation of health insurance and health care delivery; and
- Builds better connections between more diverse coverage options and insurance consumers.

The many structural details, tradeoffs, and transition timetables in carrying out these objectives require careful attention, but the guiding principles must involve reliance on incentives, information, choices, competition, personal responsibility, and trust in individuals.

By redirecting personal health care decisions away from dysfunctional politics and back into the hands of patients and physicians, we can and we will do better. We can no longer afford not to change course, turn the policy page, and move ahead.

1

Examining the Stakes and Prescribing a Cure

The Patient Protection and Affordable Care Act of 2010 (also known as Obamacare or simply the ACA) was unpopular, unwise, and unsustainable when first enacted in March 2010. It was followed by another two and a half years of stumbling implementation and fierce battles in the courts, on Capitol Hill, and throughout the states. The real-world evidence keeps mounting that the new health law is too costly to finance, too difficult to administer, too burdensome on health care practitioners, and too disruptive of existing health care arrangements that many Americans prefer.[1]

The ACA is not just too misguided to succeed. It is too dangerous to maintain and far too flawed to fix on a piecemeal basis. The law will stifle future economic growth, distort health care delivery, and limit access to quality care. It doubles down on our already unsustainable entitlement spending for health care by transferring dedicated funds from one overcommitted program (Medicare) to establish a new one (government-exchange-based coverage subsidies) and expand another old one (Medicaid).

Obamacare is also on course to erode meaningful limits on the powers of the federal government. Its maze of current and future mandates, regulatory edicts, and arbitrary bureaucracy undermines political accountability and the rule of law. The ACA was built on faulty premises, disguised with accounting fictions, and narrowly pushed through Congress via cynical deal making. It cannot work, and will not stand.

The mounting battle over the future course of the ACA and our health care system is fundamentally about power, control, and freedom. Who will be in charge of our health care decisions? Responsible patients, providers, and private payers guided by their personal preferences, priorities, and principles in choosing those who compete to serve them best? Or political brokers who aim to extend the chains of dependency on the modern welfare state even further up the income and risk ladders and across a much larger share of the economy?[2] Will health care treatment be determined by decentralized, patient-centered choice and competition? Or will it be dispensed through the government-centric channels of political expediency, one-size-fits-none bureaucratic commands, and special-interest deal making?

The answers that voters, consumers, and policymakers provide to those crucial questions over the next two years, as the ACA begins its fuller-scale implementation, will determine how we resolve the challenging health policy issues of today and the future. The stakes could not be higher. They involve the future growth and sustainability of the US economy, the health of all Americans, the relationship between citizens and government, and the preservation of the values that define our civil society.

Filling the "Replace" Vacuum

Repealing the ACA in whole remains necessary to clear the way for the lasting reforms of health care we so desperately need. Ending the acute pain caused by Obamacare is the beginning, not the end, of providing a safe, effective, and more sustainable cure. But neither step will happen without a clearer vision and playbook for the policy changes needed to fix our health care system and improve the health of Americans.

Unfortunately, most serious political debate among Obamacare's critics over the substance, scope, and scale of what should "replace" the ACA has been frozen since the health law's enactment. Even throughout the long 2012 election cycle, many may have understood the urgent case for preventing the

implementation and institutionalization of Obamacare but focused too little on what to do instead.

First, grassroots activists concentrated narrowly on outright repeal as a common unifying goal. Then, elected Republican officials and other GOP candidates for office (who, together, constituted the overwhelming majority of political players resisting ACA implementation) mostly scrambled to stay in front of the energetic parade of their constituents opposing Obamacare. With only a few exceptions, the former found it much easier to hope that the Supreme Court would do most of their work by ruling the entire health law unconstitutional and invalid. Developing a more coherent yet popular replacement plan is a heavy lift. Moving beyond the empty rhetoric of past proposals that dodge the difficult policy complexities and political tradeoffs of sustainable health reform is key.

The mounting battle over the future course of the ACA and our health care system is fundamentally about power, control, and freedom.

The Supreme Court Will Not Save the Day

On June 28, the Supreme Court finished the main round of constitutional law challenges to the ACA. In a splintered set of opinions tied together with some contorted reasoning by Chief Justice John Roberts, the court ruled that the health care law's mandate that individuals purchase federally approved health insurance is unconstitutional under the power of Congress to regulate interstate commerce. But the court declared the individual mandate constitutional as a tax.

Critics countered that this interpretation flew in the face of the ACA's legislative history and language. President Obama himself once insisted the law did not impose a tax. But no matter how controversial and contradictory the ruling is, it represents a major legal victory for the Obama administration and other supporters of the health law. The ACA had survived a legal challenge that could have entirely invalidated it.

Another part of the opinion struck down as unconstitutionally coercive was the ACA's attempt to require all states to expand their Medicaid programs. The court ruled that individual states can decide whether they will comply with the new ACA Medicaid rules without risking loss of federal funds for their existing programs.

The overall ruling underscores the dangers of relying too heavily on the Supreme Court to solve policy problems. Opponents of the law should have used the time while the court was deliberating to formulate attractive legislative proposals to both repeal and replace it. But they did not.

Did the 2012 Election Settle the Issue?

The Republican-controlled House of Representatives voted to repeal the entire law last year, but Republicans still lack control of the Senate after the November 2012 election. Moreover, President Obama was reelected, making the issue of passing another full-repeal bill moot for at least the next four years.

Nevertheless, how aggressively the ACA is implemented, interpreted, and enforced, and whether it is reconsidered and revised in part, remain to be determined. Although the individual mandate is the law's most unpopular feature, a consistent plurality (and sometimes a majority) of Americans has opposed the ACA since its enactment into law on March 23, 2010.[3] Of course, measuring the degree and depth of this opposition depends on when and how opinion survey questions are asked.[4] It appears likely that public support for full repeal has softened since the Supreme Court ruled last June that the ACA was constitutional and former Massachusetts governor Mitt Romney failed to make ACA repeal one of the top issues in his unsuccessful campaign for president.[5]

Despite those factors, support for either partial or full repeal and replacement of portions of the ACA remained strong as of early November 2012. National

exit polls conducted on Election Day found 24 percent of voters wanted to repeal some of the law and 25 percent wanted to repeal all of it (a combined near-majority of 49 percent), whereas 26 percent of voters wanted the law expanded and 18 percent wanted it left as is.[6]

Other Battle Fronts Ahead

Obamacare remains in more imminent jeopardy in the administrative and economic arenas. Converting the complex, contorted, and at times contradictory text of the ACA into workable form presents a daunting challenge to its successful implementation. In many cases, Congress failed to finish its job in refining and cleaning up the final language it rushed through the Senate in December 2009. It often delegated the most difficult administrative tasks to the secretary of Health and Human Services for further rulemaking, left its intentions deliberately ambiguous, or even outright failed to reconcile conflicting directives.[7]

Many states have resisted the ACA's presumptive demands on their own administrative resources to take care of the dirty work and shoulder potential political blame for problems in trying to implement new mechanisms and carry out unprecedented tasks. Despite two years of feverish rulemaking and interim "guidance" from the Obama administration, the most crucial administrative tasks—particularly, creation of state-run health benefits exchanges and definition of the essential benefits they will offer—are still largely unresolved and behind schedule as remaining time on the ACA implementation clock runs down.

Finally, the ACA offers overly generous subsidies for coverage through health exchanges and an expanded Medicaid program. This adds another underfunded entitlement on top of the existing fiscally unsustainable ones for Medicare and Medicaid. The economic stress resulting from financing these subsidies will extend beyond the deficit-ridden federal budget.

By commanding even more of the economic resources of young and future generations to pay for publicly funded health care coverage, the ACA will preempt vital investments in human capital (like education, job skills, and family formation), innovative research, and infrastructure replacement needed to restore economic growth and job creation. Channeling a higher share of health spending through the inefficient political filters of Washington increases the additional burdens and costs (so-called "deadweight losses") that reduce our overall well-being. These include higher tax rates, greater work disincentives, increased regulatory uncertainty, further price distortion, new rent-seeking behavior, and more inefficient allocation of resources.[8]

How aggressively the ACA is implemented, interpreted, and enforced, and whether it is reconsidered and revised in part, remains to be determined.

The lull in the larger health policy storm while interested parties awaited first the Supreme Court's decision on the constitutionality of the ACA, and then the results of the presidential election, is over. Current members of Congress and future candidates who seek to replace them, as well as other ACA critics, need to determine and articulate their own basic visions of health policy that go beyond the simple nostrums of "none of the above" or "back to the future." Repealing most, if not all, of the ACA is necessary, but that alone is not sufficient to fix the fundamental ailments of our health care system that Obamacare has failed to solve and will only worsen.

Even if a simple return to the pre-ACA status quo was possible, it would be woefully inadequate. Longstanding health policy mistakes are behind many of the chronic conditions that handicap the performance and potential of US health care. Americans need principled and effective solutions to the problems of rising health care costs that threaten to outrun the ability of families, employers, and taxpayers to pay them. Real solutions involve more than just doing less

damage by somewhat limiting the full effects of past and present mistakes in health policy.

Despite the many remarkable peaks of excellence and cutting-edge innovation demonstrated by US medical institutions and health care practitioners, the quality of care delivered remains too uneven and unpredictable. Whether various components of the health care system provide sufficient value for their high price tags, particularly for more resource-constrained consumers, often is difficult to determine. Transparent and robust measures of all-in costs, health outcomes, customer service, and patient experiences remain too limited to ensure sufficient consumer empowerment and provider accountability. Incumbent interests often combine with political gatekeepers to resist new entrants and disruptive innovations in health care delivery. Finally, decades of applying multiple layers of complex regulation, hidden cross-subsidies, and unfunded liabilities on top of a mostly mid-20th century health policy structure that assumes comprehensive employer-based private insurance coverage have left our health care system unprepared to deal with more substantial demographic and economic shifts in society.

Americans need principled and effective solutions to the problems of rising health care costs that threaten to outrun the ability of families, employers, and taxpayers to pay them.

Of course, not even a credible and comprehensive "replace" proposal can guarantee that everyone will achieve and maintain good health throughout their lifetimes at minimal cost. But it should make it more likely that they will do so by strengthening and supporting private health care markets and public health systems that are value maximizing, accountable, dynamic, consumer-centered, consensual, equitable, and sustainable. Each consumer should have the opportunity to improve the overall value of his or her health care decisions by making better choices that reflect their needs and preferences. Health care providers should be rewarded for their success in managing risks, improving health outcomes, and serving consumer demands. Health care choices are improved, revitalized, and expanded through vigorous competition, accountability, information transparency, and continuous rounds of entrepreneurial innovation.

The decision ahead is not *whether* to reform health care policy. This study will not belabor the many reasons already on the record for changing direction from where the ACA plans to take us.[9] Instead, it focuses on how we do so, and why choosing certain clear, principled policies will succeed in replacing the ACA when Obamacare fails. Yes, the ACA is destined to waste resources, create scarcity, and then ration it by displacing competitive markets with welfare state politics. But broader support for repealing and replacing it, sooner rather than later, will become stronger if such a move goes beyond either a leap into the unknown or grudging acceptance of more familiar disappointments.

We must replace not just the ACA, but also the pre-ACA health policy mix, with better rules, tools, and incentives. The new health policy remedies should allow patients, purchasers, and providers to improve their health at costs they are willing and able to afford, within secure but steadily improving arrangements.

The Policy Prescription for a Safe, Effective, and Sustainable Cure

A safe, effective, and sustainable cure for the after-effects of Obamacare must deal with a number of key issues. They boil down to providing better incentives and information resources to help us live within our financial means while improving our health. Well-functioning markets and private choices can handle these tasks effectively and nimbly. But our slow-responding and risk-averse public health coverage

programs cannot without significant reform. A successful cure has six key treatments.

1. Retarget taxpayer subsidies for health care coverage. We need to limit and redirect the current open-ended subsidies for private health insurance, Medicare, and Medicaid. They cost too much, distort health care decisions, and hide the real prices we pay. The current subsidy menu rewards more volume instead of encouraging better value and higher-quality care. While trying to reallocate and spend other people's money so generously across the board, our policies squander the resources needed to most help those Americans with the greatest needs and fewest resources.

2. Protect vulnerable Americans. The current health care safety net is overstretched, underfunded, and bursting at the seams. By trying to do too much, it performs badly. We must restructure it to protect more effectively individuals and families facing the greatest burden of serious preexisting health conditions, while providing shorter-term help to those coping with sudden misfortune. Such assistance should bolster, not weaken, personal responsibility and encourage smarter health care decisions instead of subsidizing poor health habits.

3. Improve the performance of a consumer-based health system. Health care policy should help patients, providers, and other purchasers to seek and find better value in health care options, without trying to micromanage how medicine is practiced or dictate personal health care choices. Government policies can enhance the production and aggregation of the basic data and related measures needed to develop usable, accessible, and relevant health information. But government officials should suggest and inform, rather than dictate, what constitutes the "best" or "better" health care. Public policy for private health insurance regulation should rely more on assisting consumer and provider decisions than on prescribing or prohibiting them. Shining a brighter spotlight on what works better and makes sense, through such informed competition, will drive buyers and sellers to seek and achieve better outcomes. However, a vibrant and innovative health system will not spring to life until we do a better job connecting consumers to real health care markets and better health care products (particularly in the individual and small-group sectors of health insurance). This involves opening new doors to market-driven choices, rather than trying to restrict access to only politically favored types of coverage.

4. Reform Medicare and Medicaid to become more accountable, effective, and sustainable. Reforming these two dominant public health coverage programs is more than just a budgetary exercise that rebalances spending commitments with revenue. The effects of Medicare and Medicaid are so significant that the rest of the health care system cannot begin to function more effectively and efficiently until both programs change how they do business with medical providers, beneficiaries, and taxpayers. We must end the long-standing problems of trillions of dollars in unfunded liabilities, quality-blind and uncoordinated care, bureaucratic price fixing, cost shifting to private-sector payers and providers, intergenerational inequity, and broken promises. We need a better mix of private-sector innovation and performance-based incentives with public-sector subsidies, safeguards, and supervision.

5. Facilitate the evolution from a dominant employer-based private insurance market toward one based on choice and competition across a more level playing field. Employer-sponsored insurance (ESI) will continue to be the foundation of private health coverage, but it is slowly eroding at the margins, particularly in the small-group market. Individuals who are self-employed, moving between different parts of the labor market, or simply dissatisfied with what their employer offers them need better choices. They deserve an insurance market that serves a more mobile and dynamic working-age population. The days of tax and regulatory policies that disproportionately favor traditional employer coverage are numbered.

6. Timing and transition considerations temper the immediacy and impact of health reform theory. Translating attractive reform theories into workable policies will require careful attention to timing, transparency, and fairness. Reform efforts that rely on expanded options, phased-in incentives, and clear communications can avoid the whiplash of too-sweeping health policy transformation. Necessary midcourse corrections in interrelated reform measures should be anticipated and welcomed.

We must move personal health care decisions out of the hands of politicians and back to patients and physicians.

Getting from here to there in a politically, as well as economically, sustainable manner entails a lengthy and complex process that must be clear and realistic. Sudden surprises, unworkable administrative demands, arbitrary disruptions in current practices, and "assume a miracle" implementation can undermine the path to progress.

Such a health policy replacement and renewal program does not have to invent new ideas and find imaginary friends. It can build on many thoughtful policy proposals, either waiting on the shelf or needing only some modest refinements, that would

- Transition from open-ended "defined benefits" to "defined contribution" financing of various taxpayer subsidies for health care across all insurance platforms (primarily Medicare, Medicaid, and employer-sponsored coverage);

- Retarget public subsidies for coverage to base them more on an individual's relative income and health status;

- Provide a sustainable safety net for individuals facing serious health risks who experience difficulty finding affordable insurance coverage;

- Tie expanded protections against preexisting health conditions and enhanced portability of insurance in the individual market to incentives to maintain "continuous" insurance coverage;

- Foster responsible competition in insurance regulation among the states and move toward an information-based approach to such regulation;

- Limit any benefit standards to the most flexible and minimal levels possible;

- Assign state governments the task of ensuring that their reformed insurance markets credibly guarantee that willing buyers can find willing sellers (that is, through other mechanisms that rely more on competition, consumer choice, and information assistance than on proscriptive regulatory coercion);

- Aggregate and enhance the best data available to expand consumer access to useful information about health care cost, quality, and value but encourage more decentralized competition in measurement of provider performance.

- Institute premium-support and competitive-bidding mechanisms as structural building blocks for Medicare reform before determining what level of assistance future taxpayers can and will support;

- Take Medicaid off ACA-injected budgetary steroids and delegate most of its operational policies to the states (with negotiated standards of accountability for outcomes);

- Mainstream more Medicare and Medicaid beneficiaries into affordable, competitive private health plan options; and

- Avoid policy bias between employer-sponsored insurance and individual insurance, without dictating the speed or direction of changes in the mix of private coverage.

Most of all, to ensure sustainable health care improvement, better incentives, information, choices, competition, personal responsibilities, and trust in individuals will work much more effectively than top-down mandates, arbitrary budgetary formulas, and bureaucratic buck-passing. We must move personal health care decisions out of the hands of politicians and back to patients and physicians.

Reform measures should encourage a dynamic cycle of innovative improvement in health care delivery and reward those who succeed in lowering projected costs and improving health outcomes. And all of the resulting health care options in the post-reform world must face a reality check to ensure that they are workable, accountable, and sustainable. Health policy reform should also acknowledge its limits and reinforce the important roles of other public policies, civic institutions, private decision makers, and personal responsibilities.

Notes

1. Tom Miller, James C. Capretta, and Grace-Marie Turner, "Why the (Un)Affordable Care Act Should Be Repealed and Replaced," *The American Journal of Medicine* 125, no. 5 (2012): e1–e4, http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934312000095.pdf.

2. George Will, "A Battle Won, but a Victory?" *Washington Post*, March 23, 2010.

3. In an average of all 202 public opinion polls compiled by RealClearPolitics.com conducted after March 23, 2010 (when President Obama signed the ACA into law) through November 4, 2012, 52.4 percent of Americans surveyed were against/opposed to the ACA while 39.7 percent were for/favored the ACA. For many of those months, a majority of Americans were opposed. See Real Clear Politics, "Obama and Democrats' Health Care Plan," (Polling Data), www.realclearpolitics.com/epolls/other/obama_and_democrats_health_care_plan-1130.html#polls.

4. For example, opposition to ACA was not quite as strong before the law was enacted. The Real Clear Politics average of 139 public opinion polls conducted between April 23, 2009, and March 23, 2010, indicates that 48.7 percent of Americans were against/opposed the proposed health law, while 40.6 percent were for/favored earlier versions of the ACA. The RCP average of polls conducted *after* the Supreme Court's decision on June 26, 2012, indicates a return to those preenactment levels of opposition versus support regarding the health law, with 50.6 percent against the ACA and 42.1 percent for the law. See Real Clear Politics, "Obama and Democrats' Health Care Plan."

5. For example, the November 2012 Kaiser Health Tracking Poll emphasized that the proportion of Americans that report wanting to see the ACA repealed had dropped to a new low of 33 percent after the November election. See Henry J. Kaiser Family Foundation Health Tracking Poll, "Health Care Factored in 2012 Election, but Far from a Starring Role," November 2012, www.kff.org/kaiserpolls/upload/8382-F.pdf. However, the poll used some language in framing its survey question that could have biased the findings to some degree, presenting a choice between "EXPAND law or KEEP law as is" versus "REPLACE with Republican alternative or REPEAL law and NOT REPLACE it." Earlier Kaiser Health Tracking Polls have tended to be outliers compared to other opinion surveys, in usually finding stronger public support for the ACA.

6. Karlyn Bowman and Andrew Rugg, "What You May Have Missed in the Polls: More Results from the Exit Polls," AEIdeas.org, November 16, 2012, www.aei-ideas.org/2012/11/what-you-may-have-missed-in-the-polls-more-results-from-the-exit-polls. See also ABC News, "Poll: Fewer Support Obamacare Repeal," November 13, 2012, http://abcnews.go.com/politics/t/blogEntry?id=17708968.

7. See Tevi Troy, *"The Secretary Shall": How the Implementation of the Affordable Care Act Will Affect Doctors* (Washington, DC: Hudson Institute, May 2012), www.hudson.org/files/publications/SecShallTroy--052212web.pdf; and Robert E. Moffit, *Why Congress Must*

Confront the Administrative State (Washington, DC: Heritage Foundation Center for Policy Innovation, April 2, 2012), www.heritage.org/research/reports/2012/04/why-congress-must-confront-the-administrative-state.

8. See, for example, Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," *Policy Analysis*, no. 669 (Washington, DC: Cato Institute, October 13, 2010), www.cato.org/pubs/pas/PA669.pdf.

9. Grace-Marie Turner et al., *Why ObamaCare Is Wrong for America* (New York: HarperCollins, 2011).

2

Rethinking Subsidies for Employer-Sponsored Insurance, Medicare, and Medicaid

Defined-Contribution Financing for Taxpayer Subsidies

A reform agenda that will both replace Obamacare and fix the flaws of previous health policy begins (but does not end) with a fundamental change in how we publicly finance and subsidize health care. Under current law, whether one's health coverage is provided through employers, Medicare, or Medicaid, taxpayer subsidies to help finance it are essentially open-ended. They largely insulate insured Americans from the full costs of insurance and health care. The defined-benefit promises under such insurance plans encourage greater use of and higher costs for care. Converting those public subsidies into defined-contribution payments is the first step toward providing beneficiaries with strong incentives to obtain the most value for them.

For almost 70 years, federal tax treatment has favored employer-sponsored group health insurance through a tax exclusion that does not count employer-paid premiums as taxable compensation for workers.[1] This provides employees with a strong incentive to take larger shares of their compensation in the form of more costly and comprehensive health coverage instead of as taxable cash wages.

In Medicare coverage for the elderly and disabled, most beneficiaries participate in the program's traditional fee-for-service (FFS) insurance arrangement. This allows enrollees to see any licensed health service provider, with few (if any) questions asked, so long as the patient is willing to incur the relatively modest cost-sharing charges intended to limit unnecessary use. Moreover, this initial layer of cost sharing is largely muted because almost 90 percent of Medicare beneficiaries also have supplemental insurance coverage that pays for whatever costs of covered services

Overall Policy Prescriptions:

- Convert taxpayer subsidies for insurance coverage (Medicare, Medicaid, and employer-sponsored insurance) into defined-contribution payments.
- Ensure that private health care consumers and public health program beneficiaries have more direct control over how taxpayer dollars are spent for their health care.
- Provide an enhanced infrastructure of health information and connections to intermediary agents to assist consumers in making their choices more actionable and effective.
- Base more-refined adjustments in levels of support within particular categories of beneficiaries primarily on such factors as income and health risk (and perhaps geography).

Policy Prescriptions for Employer-Sponsored Insurance:

- Clarify and prioritize multiple objectives for private health insurance subsidies.
- As a starting point, switch to flatter, refundable tax credits whose average value is fixed (but subject to some degree of risk adjustment).

(continued on the next page)

Policy Prescriptions for Medicare:

- Determine the competitive price for core Medicare benefits in a relevant market for the average Medicare beneficiary.
- Allow the results of annual health plan bids alone to determine the benchmarks for taxpayer subsidies, rather than relying on average costs for traditional FFS Medicare in a given market area as the default setting.
- Apply premium support to earlier cohorts of newly eligible enrollees, and perhaps even current enrollees so that the benefits of competitive cost pressures make a difference before fiscal pressures overwhelm the program another 10 years from now.

Policy Prescriptions for Medicaid:

- Develop a defined-contribution alternative for Medicaid coverage that holds taxpayer costs and program eligibility rules relatively more constant but allows the nature, level, and quality of Medicaid's health benefits to become more variable.
- Adopt a block-grant or capped-allotment approach to Medicaid reform.
- Develop a clear integration plan with the employer market so that eligible Medicaid beneficiaries with defined contributions can retain their choices even as they move out of pure Medicaid financing into other private coverage financed in part with tax credits.
- Target initially the portion of the Medicaid population below age 65, nondisabled, and looking for a qualitative upgrade from traditional Medicaid coverage.

that Medicare FFS does not.[2] Hence, the generous taxpayer subsidies for basic Medicare coverage are leveraged even further by supplemental insurance, which encourages use of more services and more intensive treatment—at little or no additional costs to beneficiaries beyond their supplemental insurance premiums. Federal taxpayers pick up most of the extra costs.[3]

How can this work? Current and past Medicare beneficiaries have had a substantial share of their post–age-65 health care costs heavily subsidized by younger taxpayers. For example, Steuerle and Rennane estimate that a two-earner couple earning average wages and retiring in 2011 will receive three times as much in lifetime Medicare benefits ($357,000) as they pay in lifetime Medicare taxes ($119,000), in constant 2011 dollars.[4] (This taxpayer subsidy is at about the same proportionate share of Medicare spending for single Medicare beneficiaries, but somewhat greater for lower-earning ones). Not surprisingly, annual growth in the volume and cost of Medicare spending reflects the fact that, at the point of care, Medicare beneficiaries remain cushioned against the true costs of what they demand and receive.

The Medicaid program's taxpayer subsidies operate in a somewhat different, but still open-ended, manner. The program is financed with a flawed system of federal-state matching payments, with no limit on the amount that states can decide to draw down from the US Treasury each year. For every dollar of Medicaid costs, federal taxpayers pay, on average, 57 percent, and state taxpayers pick up the rest. This open-ended matching grant formula encourages more, rather than less, Medicaid spending. If state officials want to cut their state's share of Medicaid costs, they have to cut the overall program's spending by $2.30 to save $1.00 in state funds, because the other $1.30 is returned to the federal government. States are much more likely to devise ways to maximize how much they can get from Washington for Medicaid services while looking for creative ways to contribute the required state portion of the funding without really doing so.

The ACA will expand Medicaid even further, beginning in 2014, to all Americans, except undocumented aliens, earning less than 138 percent of the

federal poverty level. (See the "Defined Contributions and State-Level Accountability for Medicaid" section for more on its rules for the federal share of Medicaid financing for those newly eligible for Medicaid under the health law.) In any case, the older federal-state financing share rules will remain in place for the populations eligible for Medicaid before the ACA was adopted in March 2010.

Defined-Benefit Subsidies Encourage Higher-Cost, but Lower-Value, Health Spending. The common characteristic within Medicare, Medicaid, and employer-sponsored insurance—the three dominant defined-benefit insurance arrangements for the vast majority of Americans—is that a large portion of every extra dollar spent on premiums or services is paid by a third party and heavily subsidized by Uncle Sam. Those public subsidy arrangements also mean that the real customers in our health system are not the patients but the big payers of insurance claims filed by doctors and hospitals—namely, the federal government, the states, and the country's employers. The result is more maddening bureaucracy, redundant paperwork, unaccountable service delivery, and uneven quality.

Defined-benefit financing reinforces the nature of Medicare FFS to encourage fragmented, volume-driven care and rely on across-the-board reimbursement reductions for all health care providers to reduce fiscal pressures. Medicaid's defined-benefit structure overpromises guaranteed services that it cannot deliver or afford, resulting in overstretched state budgets, below-cost reimbursement to providers, reduced access to care, and isolation from the types of coverage available to other working-age Americans. The open-ended defined-benefit nature of the tax exclusion for employer-sponsored private health insurance has skewed the distribution of tax benefits to higher-income workers, disadvantaged individual (non-ESI) purchasers of health care, and produced disruptions in insurance coverage for workers changing or losing jobs.

Most of all, open-ended financing of taxpayer subsidies for defined-benefit health coverage has produced high levels of health spending. These levels could be lowered if private health care consumers and public health program beneficiaries had more direct control over how taxpayer dollars are spent for their health care and recognized the full costs and consequences of their health care choices instead of assuming they are paid largely with other people's money. The ACA does little, if anything, to solve this problem. Indeed, its primary objective is to ensure that the uninsured are also enrolled in expansive and heavily subsidized third-party coverage arrangements, which remain at the heart of today's cost-escalation problem.

The common characteristic within Medicare, Medicaid, and employer-sponsored insurance is that a large portion of every extra dollar spent on premiums or services is paid by a third party and heavily subsidized by Uncle Sam.

The plan to put about 16 million low-income Americans into the Medicaid program starting in 2014 does not include any significant structural changes in how the program operates. Even though Medicaid already is stressing the limited resources of most state governments and failing to compensate physicians and hospitals for their basic costs of care, the proposed expansion will distort future spending levels even more. The new law temporarily increases the federal match for all states to 100 percent for the population of *new* program participants (also beginning in 2014),[5] which will only encourage state officials to look for additional ways to push even more Medicaid costs off their books and onto the federal budget while they can.[6]

The other major component of the ACA's coverage expansion involves benefits provided through the law's state-based insurance exchanges and federally mandated insurance regulations. If the ACA's individual

mandate and related insurance requirements survive future congressional attempts to repeal or revise them, the concept of defined-benefits health care will be cemented even further into federal law. They will be accompanied by sweeping rules for what must be covered by most insurance plans sold in the United States and what kind of cost sharing insurers and health plans sponsors can impose on enrollees. The upcoming ACA regime for "private" health insurance would elevate the importance of political lobbying far above that of contractual negotiation by health care providers, consumers, and other private payers.

Everyone needs to start seeing more of the real price tags in more competitive and accountable health care markets again, instead of the fake ones at the government discount store.

The ACA does not directly challenge the defined-benefit nature of current Medicare FFS coverage as an open-ended legal entitlement for beneficiaries. Instead, it reduces the future rate of growth in Medicare spending as a way to finance the ACA's expansion of other kinds of subsidized defined-benefit coverage for the below-65 population (in the state exchanges and in Medicaid).

Despite a handful of limited demonstration projects and rhetorical lip service regarding health delivery system reform in Medicare, the ACA achieves its Medicare spending cuts the old-fashioned way—through across-the-board reimbursement reductions in the level of its formula-driven administered prices for thousands of health services and products in FFS Medicare, plus related reductions in payments to private Medicare plans. Of course, such deep reductions in payments for services will only exacerbate already-strong incentives in FFS Medicare for providers to make up for low payments by increasing the volume of defined-benefit services that they deliver to beneficiaries and charge primarily to taxpayers.

As long as defined health benefits are treated as open-ended legal entitlements whose costs seemingly are paid with other people's money, they will continue to place mounting pressure on federal and state government budgets while distorting the nature and structure of health care decisions. How would a more sustainable, market-based, and patient-oriented version of health reform avoid the chronic conditions of taxpayer support of health coverage through a defined-benefits structure?

Defined-Contribution Financing Realigns Incentives to Lower Costs and Improve Quality. Currently, various mechanisms launder, hide, and redirect the amount and nature of defined-benefit promises through third-party intermediaries. Switching to defined- contribution financing for health coverage will ensure that beneficiaries receive their taxpayer subsidies more directly.

Why? Direct payment in the form of defined-contribution subsidies would empower and encourage consumers and patients to make better health care choices. The subsidies would stimulate more innovative and accountable competition among health care providers. And they would encourage us all to save and invest so that we are able to pay more for health care when it delivers more value but redirect our resources elsewhere when it delivers less.

This integrated transition to defined-contribution payments should apply to Medicare, Medicaid, and ESI. Switching taxpayer support for them to defined contributions would help make the limits of public financing more transparent, renegotiable, and fairly allocated. Levels of defined-contribution support from taxpayers should vary, depending primarily on the needs and nature of the population in question. For example, Medicaid and Medicare beneficiaries are likely to present more costly health-risk challenges and need more extensive health services than will most working-age beneficiaries of the current tax exclusion. Other, more-refined adjustments in levels of support within particular categories of beneficiaries

should be based primarily on such factors as income and health risk (and perhaps geography).

Limiting taxpayer support through defined contributions would not restrict spending of additional *private* (or personal) dollars to enhance or expand coverage. The better version of defined-contribution health benefits would place initial control and choice of how to spend those taxpayer subsidies in the hands of beneficiaries. Then, it would follow through by providing an enhanced infrastructure of health information and connections to intermediary agents to assist them in making their choices more actionable and effective.

In short, federal government budgeting would be more manageable and rational with a cap on taxpayer liabilities, but the biggest payoff will come in better health care, better health, and more sustainable support for insured Americans.

Defined-Contribution Reform of Open-Ended Tax Subsidies for Private Health Insurance

The tax exclusion for employer-sponsored health insurance has operated since 1943 as an open-ended, uncapped defined-benefit entitlement of the tax code. It selectively favors certain purchasers of health insurance (higher-income workers in larger firms offering comprehensive insurance) over others. It only appears to make health care seem less expensive, while raising its real overall costs. How do we change the distorted price signals it produces throughout the health system?

"Cadillac" Tax: Too Weak, with New Distortions. The ACA introduced a very limited and flawed first step toward solving the price signal problem. It adopted a so-called Cadillac tax on more costly employer-provided health benefits plans, but it will not take effect until 2018. The premium thresholds at which it would first apply are set at relatively high levels compared to today's average premium costs, and they include various special adjustments and exceptions (for age, gender, early retirees, and certain high-risk professions).

The future levy also is structured as a 40 percent excise tax on insurers and self-insured employer plan sponsors and administrators on the amount by which their plan's premiums exceed the future thresholds. This tax was designed to raise revenue only in later years but still make the ACA look more budget-deficit neutral on paper than it would be in practice.

The Cadillac tax also tried to maintain the illusion that someone else—private insurers or employer plan sponsors—would pay it, rather than insured employees. But this politically driven camouflage found a new way to distort incentives, by disconnecting the levy's uniform "wholesale" rate from insured workers' different marginal income tax rates at the "retail" level. The latter rate actually determines the amount of tax subsidy that any individual with an employer-paid plan premium receives through the tax exclusion.[7] Moreover, the Cadillac tax applies only to employer-provided group insurance. (The ACA provides different types of tax treatment for other kinds of health insurance purchased by individuals outside their workplace.[8])

Clarifying and Prioritizing Multiple Objectives. The case for changing insurance tax subsidies so that they operate much more as defined contributions than as open-ended defined benefit subsidies first requires clarifying our policy priorities. Multiple goals for reforming the tax treatment of private health insurance often are in partial, if not complete, conflict. They might include some mixture of making tax subsidies more progressive, providing more financial assistance directly to low-income insurance purchasers, maintaining the pre-ACA level of health insurance tax subsidies for everyone else, eliminating distortions and inefficiencies in health spending versus improving health risk pooling, or even favoring particular types of insurance coverage.[9]

In the real world, we simply cannot craft tax policy that runs in so many different directions without stumbling and short-circuiting. We also encounter practical barriers to carrying out at full strength most of these objectives, even in isolation. For example, equalizing the tax subsidy discount rate for all health

insurance purchasers would increase taxes on upper-income taxpayers (unless rough offsets to marginal income tax rates are made). It also would likely forgo any capping of maximum tax expenditures for individuals and families.

Providing more generous financial assistance directly to lower-income households is difficult to do with appropriated funds outside the delivery and income information infrastructure of the Internal Revenue Service. Tying more narrow policy reform goals to tax subsidies for health insurance would require complicated political and administrative distinctions or even an optional, parallel-track tax system.[10]

The general starting point for more balanced, defined-contribution tax subsidies involves a switch to flatter, refundable tax credits whose average value is fixed.

The Case for Full Repeal (of Insurance Tax Subsidies). Let's pause and take a deep breath. There is a pure, market-based case for eliminating *all* tax subsidies for health insurance (and health care), except in cases of great need (based on relatively low income or predictably persistent high health risk). The current excessive levels of tax expenditures, as well as public program health subsidies in Medicare and Medicaid, try to foster the illusion that we can pay most, or at least a substantial share, of everyone's health insurance premiums with other people's money. But there simply is not a sustainable line of credit or enough projected tax revenue to keep financing these efforts at the same current-law levels far into the future.

The federal tax system should not, and actually does not, need to bribe upper-middle-class and wealthier Americans to purchase and maintain insurance coverage. Policymakers could instead lower their other taxes to offset the net effects of reducing or even eliminating their access to current tax subsidies for health care spending (particularly, the tax exclusion for the cost of health insurance paid by their employers). This policy reform would help make the full unsubsidized costs, and the real value, of their current coverage and care more transparent to them. It would encourage more efficient health care choices without raising overall federal taxes on workers covered by employer health plans.[11]

However, that does not mean that additional subsidies (offset by other spending reductions in health care in the federal budget) will not be needed to help other populations targeted on the basis of their unusual income and health-risk needs. Those dollars can pay for some, and sometimes all, of the insurance costs of their basic care. But almost everyone needs to start seeing more of the real price tags in more competitive and accountable health care markets again, instead of the fake ones at the government discount store.

Starting Point: Need-Adjusted Tax Credits. So much for health reform daydreaming. Such a cold-turkey approach to substantial withdrawal from the dulling narcotic of taxpayer subsidies for health coverage would be too much of a short-term shock to embedded expectations, long-standing arrangements, and the demonstrated inability of Congress to make serious decisions on such fundamental policy changes before the last minute. Other configurations for changes in the tax treatment of health insurance could achieve at least some of the aforementioned policy goals to various degrees, but they become too complicated to withstand 30-second analyses and attract sufficient political support.[12]

Barring the onset of the oft-promised but rarely seen debate over fundamental tax reform, the defined-contribution approach should focus primarily on restoring a more level playing field for all purchasers. This is difficult to accomplish simply through changes in the deductibility of health insurance premium costs under the federal income tax.[13] Hence, the general starting point for more balanced, defined-contribution tax subsidies involves a switch to flatter, refundable tax credits whose average value is fixed (but subject to some degree of risk adjustment). This type of tax subsidy better maintains neutral incentives on the margin

for health spending at higher levels than the capped amount of tax credits for health insurance premiums will subsidize.

Converting today's tax preference for employer-paid premiums into a refundable, universal credit for the under-65 population would mean that every American household could use the credit when they purchase health insurance. The likely average value of the credit might approximate the current average tax subsidy for job-based coverage—in the range of about $5,000 to $6,000 per family.[14] Any household that chose to forgo purchasing at least some basic level of insurance would lose the entire value of the credit, which is much greater than the dollar amount of the penalties imposed under the ACA's individual mandate, beginning in 2014.[15] Insurers also would be highly motivated to offer new lower-cost insurance options to meet the needs of millions of cost-conscious consumers.

In their initial fixed-dollar form, refundable tax credits necessarily fail to adjust for a beneficiary's risk status or income level. An imperfect policy tradeoff here involves the feasibility of making such fine-tuned adjustments and the administrative ability to do so given the limits of current risk-adjustment and income-reporting mechanisms. Another tradeoff involves balancing the desire to unleash the potential of millions of new cost-conscious individual consumers within a more competitive insurance marketplace against concerns that policy change that is too rapid and drastic might lead to undue disruption of current coverage and insufficient capacity to provide viable choices and options. In any case, this key component of fundamental health reform needs to be addressed as soon as possible, although its pace and scope remain subject to prudential considerations and practical limits.

Defined Contributions for Medicare Subsidies

Applying a defined-contribution approach to taxpayer subsidies for Medicare benefits aims primarily at encouraging private plans and traditional FFS Medicare to compete for market share and determine the most economical price for a given set of health care benefits for the elderly. The taxpayer contribution to beneficiaries to help purchase Medicare coverage can be either determined by market means (competitive bidding) or fixed at a politically determined amount. The latter approach is difficult to sustain and requires periodic arbitrary, delayed, and backward-looking adjustments. It is time for a more market-based method to determine the real cost of more efficient and effective ways to deliver a package of basic Medicare benefits to beneficiaries.

The primary role of competitive-bidding mechanisms for Medicare premium support is to discover what it actually costs to deliver core Medicare benefits in a better manner.

Premium Support. Competitive bidding among all Medicare-based health plans could tell the federal government whether its defined-contribution levels are too high, too low, or getting close to being about right. It would provide the foundation for a premium support model for Medicare financing that was first developed in greater detail by the 1999 National Bipartisan Commission on the Future of Medicare.[16] Premium support operates through a defined-contribution subsidy structure to stimulate greater price competition among private Medicare plans and the traditional FFS program and to make beneficiaries more value-conscious when they choose plans.

A well-designed premium-support approach to Medicare financing must move beyond broad rhetorical brushstrokes and fill in the structural details needed to ensure effective choice and competition for seniors. This includes

- Defining in broad terms the statutory health benefits package on which private plans and the traditional FFS Medicare program

would bid. Using a less rigorous standard of actuarial equivalence in comparing variations in different plans' health benefits packages would help maintain incentives for innovation, dynamic competition, and preference-sensitive variation in plan benefits.

- Defining the relevant market areas for competitive bidding. They should reflect actual health care market patterns (local and sub-regional) rather than politically constructed ones (national and regional) designed to maximize cross-subsidies and hide the real costs of care.

- Allowing the results of the annual plan bids alone to determine the benchmarks for taxpayer subsidies, rather than relying on average costs for traditional FFS Medicare in a given market area as the default setting. This would increase competitive pressure on bidders to offer their best prices.

- Determining first the competitive price for core Medicare benefits in a relevant market for the average Medicare beneficiary. Subsidies then could be adjusted at the health-plan level to deal with the peaks and valleys in income levels and health-risk profiles of particular collections of beneficiaries. Additional premium assistance for lower-income beneficiaries, and risk adjustment for plans that attract unusually large collections of high-risk or low-risk beneficiaries, may be appropriate, but it should not hide information about the basic competitive price of care and coverage.

- Deciding on how great a share of those actual costs of more efficiently delivered Medicare benefits should be subsidized by taxpayers. (Hint: the correct answer is not 100 percent!) For example, the Bipartisan Commission plan in 1999 started with a very generous initial level: roughly 88 percent of the enrollment-weighted average price of all competing bids for standard-option Medicare plans.[17]

- Providing full rebates to beneficiaries choosing plans whose bids set premiums at levels below the level of the resulting (taxpayer-subsidized) benchmarks. But they should still be required to pay the full marginal amount out of pocket in supplemental premiums if they choose plans more expensive than the benchmarks.

Clarifying the Primary Goal? Most of these decisions require first determining the primary policy goal of premium support and defined-contribution financing of Medicare. Is it to achieve more efficient and higher-value health care? Or is it simply to lower the future rate of growth of Medicare spending? Or, even more cravenly, just to keep currently happy beneficiaries reassured of little if any disruption to their existing health care arrangements? If we pretend that none of those goals conflict with one another, the resulting prescription for solving these several simultaneous equations remains likely to be contradictory, unaffordable, and unsustainable.

Clearer resolution of the tradeoffs between those major policy goals and their relative order of priority will go a long way in determining settings for the various elements of premium support. For example, too many promises to beneficiaries of generous benefits, limited cost sharing, protective regulation, and standardized coverage will negate other policy objectives. They will conflict with efforts to slow Medicare spending growth, reduce tax burdens on younger workers, shrink massive budget deficits, and increase choice and competition through better private plan alternatives. The political balance struck between limiting taxpayer costs, reducing Medicare spending growth, insulating beneficiaries from market-based price tags, and maintaining relative stability on the supply side of health care also will shape how policies are designed. Moreover, the actual level at which

future taxpayer subsidies under premium support might increase, phase out, or be rebated to beneficiaries will remain subject to future reconsideration and political negotiation.

Special protection must be maintained for the most vulnerable low-income or high-risk Medicare beneficiaries using separate policy tools: supplemental income-based subsidies and risk adjustment of aggregate premium-support payments made to competing plans. But just how "low-income" will low-income Medicare beneficiaries needing greater premium support turn out to be? Subsidies that creep up the income ladder above the current special-assistance ceilings for dual-eligible (Medicaid plus Medicare) seniors will hit younger taxpayers harder and reduce beneficiary incentives to make more cost-conscious care and coverage choices on the margin.

Structural Reform First, Savings Later. Because future supplies of Medicare subsidies are not unlimited, they should be allocated more efficiently and equitably, in a manner that no longer obscures the true cost of promised benefits. At the same time, their level and structure should provide beneficiaries with incentives to obtain the most value and opportunities to augment subsidies with their own private resources. Getting this basic reform structure right and in place soon is more important than the magnitude of the initial budget savings it produces.

Hence, the primary role of competitive-bidding mechanisms for Medicare premium support is to discover what it actually costs to deliver core Medicare benefits in a better manner. Resetting the level at which taxpayers' funds subsidize most, but not all, of those costs is an important, but secondary, policy decision that cannot be made persuasively until we know what all the costs really are or could be (not just those assigned through FFS Medicare's labyrinth of administered prices and treatment codes).

Competitive-bidding mechanisms should determine relative levels of premium support by taxpayers in different health care market areas. But they need clear operating rules, guided by key policy goals.[18] If the foremost goal is lower costs, setting the winning bid price at the least costly one submitted might drive down premiums over time, at the risk of failing to ensure sufficient capacity to serve all beneficiaries. At the opposite end, using competitive bidding to arrive at an enrollment-weighted average price of subsidized coverage based on all bids would keep more competitors in business, more beneficiaries happy, and the traditional Medicare program more insulated from competition. However, that would come at the expense of reduced pressure for greater efficiency gains and resulting higher Medicare costs falling mostly on taxpayers, but also on Medicare premium payers.

The 2011 premium-support proposal by Sen. Ron Wyden (D-OR) and Rep. Paul Ryan (R-WI) suggests that they might favor setting the premium support amount at the lower of either the second-least-expensive private plan bid in a market area, or the cost of traditional Medicare FFS.[19] The 1999 bipartisan Medicare commission's model relied more on an enrollment-weighted average of all competitive bids (based on the previous year's enrollment figures for Medicare beneficiaries among all plans offering competing bids). The bottom line: enrollment-sensitive bidding rules that reward lower, but not just the lowest, premiums will provide the best long-term balance.

Competitive bids need to be "real," with participating plans held to their bid price for core-benefits package premiums until the next year's round of open-season bidding, enrollment, and plan switching. Private plans may not thrive in all markets when competing with the traditional FFS Medicare program. A switch to defined-contribution financing and level-playing-field competition cannot ensure that private plans will be abundant everywhere, while simultaneously rewarding efficiency with larger market share. Competition will show signs of working when FFS Medicare's premiums have to rise or its program benefits packages and care management practices must be revised in markets where private plans can offer better benefits at the same, or lower, premiums.

Fleshing Out Premium Support. Several other secondary issues involving Medicare premium support rules should be resolved.

Could a supplemental tier of separately priced benefits also be offered by private insurers that first must follow bidding rules in selling an initial common core of standard Medicare benefits? Yes.

How could the power of competitive pressure unleashed through a premium-support reform overcome the ingrained inertia of most Medicare beneficiaries to choose one plan and stick with it as long as possible? Initial random assignment of newly eligible Medicare enrollees into both private plans and Medicare FFS—as a default setting subject to informed consent and opt-out guarantees—might reduce the passive bias of the current program toward enrollment in the dominant traditional FFS public program. On the other hand, premium spikes in Medicare FFS in some markets where it is less cost-competitive, or the absence of private plan options in other areas where limited provider options make network contracting by private insurers less viable, could test the limits of political tolerance.

Enrollment-sensitive bidding rules that reward lower, but not just the lowest, premiums will provide the best long-term balance.

Another unaddressed issue in many premium-support-style proposals involves how the administrative managers of Medicare FFS might be empowered (turned loose) to adjust their program configurations to respond to new competitive pressure from private plan alternatives. Political resistance to untying the hands of government bureaucrats to allow them to act like managers seeking to retain or expand market share (if not "profits") is strongest among the many micromanagers of Medicare on Capitol Hill. But it also strikes a chord among risk-averse FFS beneficiaries.

Past constraints on FFS Medicare's flexibility to respond to new market signals by adjusting premiums, cost sharing, and benefits and selectively contracting with providers should be relaxed from congressional shackles to level the playing field with its private competitors. The necessary safeguards include ensuring sufficient disclosure of new policies and practices and breaking up administration of the FFS program into regional, or smaller, units.

The Costs of Delay. Even the best version of premium support with competitive bidding, running at full speed, would be hard-pressed to close the entire fiscal gap between Medicare's political promises and the resources realistically available to fund them in the immediate years and decades ahead.[20] Projected delays in implementation would obviously make this process even slower. Hence, the issue can be addressed more effectively on a separate and faster track, which could reduce the risks of undermining the basic case for greater efficiency, affordability, and value in Medicare health care benefits through premium-support reform based on greater choice and competition.

The recently proposed Seniors' Choice Act by Senators Tom Coburn (R-OK) and Richard Burr (R-NC) offers a number of worthy policy reforms to deliver larger Medicare budget savings sooner and more equitably.[21] They suggest:

- Unified cost sharing across traditional Medicare's alphabet soup (parts A, B, and D) of program and provider silos;
- Income-related maximum stop-loss protection against catastrophic risks;
- Means-tested cost-sharing levels;
- Restrictions on secondary Medigap coverage of FFS Medicare's cost-sharing requirements;
- An early phased-in increase in the share of Medicare Part B costs paid by beneficiary premiums; and
- Gradual increases in the initial age of eligibility for Medicare.

At least some of these provisions will need to be enacted in the near term, despite the political obstacles they face.

In one way or another, American voters and officeholders will need to reconsider the degree to which means testing for access to large taxpayer subsidies for Medicare is both economically necessary and politically tolerable. Another layer of response to imminent fiscal pressures will involve gradually lowering in later years whatever initial levels of premium support are determined purely through competitive-bidding mechanisms. More drastic fiscal pressures will lead to more formulaic budgetary targets for larger cost reductions.[22]

The biggest challenge to defined-contribution-style reform of Medicare may involve the need to deliver Medicare cost savings soon enough and large enough. That would mean applying premium support to earlier cohorts of newly eligible enrollees, and perhaps even current enrollees so that the benefits of competitive cost pressures make a difference before fiscal pressures overwhelm the program another 10 years from now. The Ryan-Wyden plan, like most other reform proposals, dodges this issue by calling a timeout on implementation for another decade, even though this contradicts the purported message that choice and competition should be good for everyone, not just new beneficiaries much further over the next election year's horizon. The ACA roadmap for Medicare cost reductions offers little more than the unsustainable illusion of perpetual annual reimbursement cuts for health care providers,[23] and it then redirects them to help pay for the other new entitlement subsidies it dispenses to younger Americans. All of those "savings," and more (but implemented in a more choice-sensitive and competition-driven manner) will be needed in the decades ahead merely to keep Medicare solvent for its older beneficiaries.

This policy menu for Medicare is particularly complex and politically uncharted. It certainly merits much more discussion, initial experimentation, and careful monitoring, but those uncertainties should not dissuade policymakers from allowing it to unfold sooner rather than later.

Defined Contributions and State-Level Accountability for Medicaid

Medicaid before the ACA Expansion. The ACA plans to add about 16 million more low-income Americans to the Medicaid program without making any important structural changes in how Medicaid operates. Even before this massive expansion (the fiscal equivalent of a steroid injection of federal funding) begins in 2014, Medicaid is already in a near-crisis state, both fiscally and operationally. States are buckling under the weight of its costs. Networks of physicians and hospitals willing to see large numbers of Medicaid patients continue to shrink. The resulting quality of care delivered to many Medicaid beneficiaries remains disappointing.[24]

The biggest challenge to defined-contribution-style reform of Medicare may involve the need to deliver Medicare cost savings soon enough and large enough.

Moreover, the distortions in today's Medicaid program of matching federal financial support for defined-benefits spending, both of which encourage high costs, will be made even worse as the ACA initially increases the federal match for all states to 100 percent for the "Medicaid expansion" population that begins to receive new benefits beginning in 2014. The states will respond to this incentive quite predictably, by dropping any remaining efforts to control Medicaid's costs for newly eligible enrollees and looking for ways to push even more costs off of their books and onto the federal budget for as long as they can.[25]

The existing Medicaid program's many rules at the federal level, and the thousands of pages of regulations defining them, already repeatedly hamstring state-level flexibility, innovation, and cost containment. The process for states to seek a waiver from the federal government is often lengthy and time consuming. As a

result, too many important elements of the current system remain trapped in a one-size-fits-all approach with little meaningful competition for services.[26]

States seeking to implement broader and more coordinated managed-care approaches to particular Medicaid populations first must obtain federal waivers from "unrestricted choice of provider" rules—a process that exhausts precious time and resources and delays unnecessary reforms. ACA advocates say that the new law will support innovative efforts to establish more integrated and customized care for various types of Medicaid beneficiaries and will solve these problems. But wary state officials recall similar previous promises that failed to materialize in practice, as the imperative to maintain federal command and control, or simply bureaucratic caution and inertia, delayed and frustrated many state-based initiatives.

Too many important elements of the current system remain trapped in a one-size-fits-all approach with little meaningful competition for services.

The most recent urgent concern for states already struggling to maneuver through difficult budgetary environments involves the maintenance of effort provision imposed on them in the ACA. This provision keeps states from reducing or restricting eligibility to their Medicaid programs below the level that was in place when the law was enacted on March 23, 2010. The ACA will increase states' Medicaid costs in other ways, particularly when it encourages higher numbers of previously eligible people to enroll in the program (because of both its individual coverage mandate and more unified processes to determine eligibility for federal subsidies through state-based health benefits exchanges). One congressional report, *Medicaid Expansion in the New Health Law: Costs to the States*, issued jointly last year by the Senate Finance Committee (Minority) and the House Energy and Commerce Committee (Majority) estimated that the ACA will cost state taxpayers at least $118.04 billion related to Medicaid through 2023—nearly double the previous Congressional Budget Office estimates of $60 billion through 2021.[27]

Mainstreaming Medicaid Beneficiaries into Private Insurance? Because Medicaid was originally established in 1965 primarily to provide health coverage for nonelderly welfare recipients,[28] it was never integrated into the insurance system for working-age Americans. Lack of coordination between Medicaid coverage and private health insurance for lower-income Americans continues to cause serious problems. When nonelderly Medicaid beneficiaries earn more income, they often lose eligibility for Medicaid even if they face uncertain prospects for insurance in the employer-based market. This creates strong disincentives to gain employment and move up the wage scale. It can also disrupt ongoing relationships with physicians and other regular sources of health care as someone moves back and forth between Medicaid and private employer insurance plans.

Ideally, replacing both traditional Medicaid assistance and the tax preference for ESI with defined-contribution payments for both kinds of coverage would open up new possibilities for explicit and beneficial coordination between them. In most past formulations for restructuring taxpayer financial contributions for health insurance coverage, all working-age Americans and their families would receive a baseline amount of assistance through a fixed, refundable tax credit. But Medicaid beneficiaries with especially low incomes will need greater financial assistance. Medicaid funds could supplement the tax credits to pay for more of their remaining premiums and cost sharing. Phasing out the full amount of those additional Medicaid payments in gradual steps related to household income would avoid large disincentives for the beneficiaries to increase their wage earnings and other income.

One approach might give states an incentive to develop specific insurance-selection structures that allow Medicaid beneficiaries to enroll in the same kinds of plans as workers with higher wages and to

have full choice among competing plans with different models for delivering and accessing health services. Medicaid participants could have a greater share of their premiums subsidized by a combination of a refundable tax credit and a still-substantial portion of the Medicaid payments for which they previously were eligible. The premium assistance would flow directly to the Medicaid beneficiaries, but they still would face some additional costs if they chose to enroll in more expensive coverage options.

However, several lesser versions of this approach have been proposed before, with very limited success at best. For example, most states were already granted authority well before the ACA to use Medicaid funds to provide premium assistance to subsidize the purchase of private health insurance for eligible beneficiaries, such as employer-sponsored coverage. Enrollment in such premium-assistance options has been less than 1 percent of total Medicaid or Children's Health Insurance Program enrollment. The leading impediments to premium assistance include federal and state price controls that shift costs to private payers, complex and costly administrative procedures, lack of affordable (or any) employer-sponsored coverage for many low-income workers, and employers' concern about increasing their own health plan costs.[29]

Beyond Medicaid Block Grants. Another approach to Medicaid reform frequently proposed by Republican members of Congress involves transferring the federal government's financial share of Medicaid financing to state governments as block grants. The main political hurdles facing such proposals involve disagreements over how those funds would be reallocated among the states, how generously they might be adjusted in the future relative to projected health care costs, and what level of current federal guarantees and minimum standards for Medicaid should be maintained. Giving state governments a different aggregate allotment of Medicaid funding and more discretion does not by itself solve the problems of lack of informed choice, insufficiently vigorous competition in benefits design, and poor incentives for improved health care delivery.

Future efforts to develop a defined-contribution alternative for Medicaid coverage should start by holding taxpayer costs and program eligibility rules relatively more constant, while allowing the nature, level, and quality of Medicaid's health benefits to become more variable. New defined-contribution arrangements must have the freedom to include a different mix of benefit, cost sharing, and medical-care management than traditional Medicaid. This approach would reward insurers, health care providers, and state policymakers for raising the quality of health care, the value of health benefits, and the satisfaction of Medicaid patients instead of just struggling to keep the apparent costs of the program lower (or hidden). States pursuing more market-based, consumer-choice reforms also should acknowledge that they may have to decide to cover fewer people, leave more details of health spending decisions to beneficiaries ready and eager to make them, pay participating health care providers for the full costs of care, and measure quality of delivered care more accurately.

Such a defined-contribution version of Medicaid needs a clear integration plan with the employer market so that choices made by eligible Medicaid beneficiaries can be retained even as they move out of pure Medicaid financing into other private coverage financed in part with tax credits. For that reason, this reform should target initially the portion of the Medicaid population below age 65, nondisabled, and looking for a qualitative upgrade from traditional Medicaid coverage that only promises seemingly generous benefits but actually pays providers too little to deliver them. Applying a defined contribution to the costliest and most medically complex Medicaid beneficiaries—the aged, blind, and disabled, many of whom are dually eligible for Medicare coverage—is more problematic and less practical in the near term.

Delinking levels of state and federal spending on this portion of Medicaid is equally important. The open-ended federal reimbursement of at least half, and often more (the average is 57 percent across all states), of state Medicaid program expenditures creates strong incentives for states to spend less carefully. Each state's

Medicaid program ends up larger than it would be if its own taxpayers had to pay the entire cost.

The primary policy options include the politically treacherous overhaul of the Federal Matching Assistance Percentages (FMAP) rules that, in practice as opposed to in original theory, have rewarded richer states at the expense of poorer ones and encouraged additional state Medicaid spending on the margin to maximize matching federal dollars.[30] Rearranging the federal share of Medicaid funding into block grants to the states, with future annual updates indexed somewhat below current Medicaid spending growth rate projections, has traditionally provided a formulaic shortcut. A more aggressive approach might limit federal assistance to funding fully just the upper layers of catastrophic acute care for the below-65, nondisabled portion of Medicaid participants, while states become responsible for financing as much of the coverage and cost sharing below those levels as they decide to handle.

New defined-contribution arrangements must have the freedom to include a different mix of benefit, cost sharing, and medical-care management than traditional Medicaid.

In one form or another, putting Medicaid on a more fixed budget would provide greater budgetary certainty at both levels of government. By knowing the likely amount of federal assistance to expect in future years, state Medicaid programs could be managed more carefully for the long haul. The best working example thus far for doing this involves a capped allotment of federal funds through the current FMAP formula to provide states with upfront funding over a predetermined period of time. Such initially fixed federal funding should come with incentives: if the state spends below the grant, it can use the savings for other areas of need, just like in the Temporary Assistance to Needy Families program. Congress can also provide bonus payments for each state if it achieves appropriate benchmarks.

The federal government should allow states adopting this option to

- Determine their own eligibility categories and income threshold levels for Medicaid;
- Establish rates and service delivery options;
- Design benefit packages that best meet the demographic, public health, and cultural needs of each state or region (whether that involves adding, deleting, or modifying benefits); and
- Use cost sharing as a way to promote individual responsibility for personal health and wellness.

Rhode Island pioneered this Medicaid reform approach after receiving a Medicaid global waiver in 2009 (approved by the outgoing Bush administration) to establish a new state-federal compact. Under the waiver, Rhode Island promised to operate its Medicaid program under an aggregate budget cap (combined federal and state spending) over a five-year period. If the state program spends more than the average historical spending trend rate the state and federal governments agreed on and its total Medicaid spending exceeds the cap, Rhode Island is responsible for 100 percent of those additional costs. This waiver is not a pure block grant because it preserves the FMAP formula for determining the relative federal share of the total level of the state Medicaid program's spending through 2013, but only up to the aggregate spending cap. Within these federal funding limits, the state has much greater freedom to design and redesign its Medicaid program.[31] Rhode Island also gained much more flexibility in administering its program, and federal reporting requirements were streamlined.

Early results in Rhode Island are promising.[32] The state was able to make a number of important changes in the way it administers its Medicaid program,

including rebalancing long-term care, keeping more seniors in community settings rather than expensive nursing homes, incentivizing higher-quality care, designing wellness programs to prevent the need for more expensive care, purchasing reforms to increase competition, and giving beneficiaries more direct control over health care spending. A December 2011 independent evaluation of the waiver by the Lewin Group focused just on the early effects of the state's reforms to rebalance long-term care (LTC) services. It estimated budget savings of $56–61 million for state fiscal year 2008 to state fiscal year 2010 for three of the state's Medicaid waiver and budget initiatives. Lewin noted significant increases in the number of physician visits for LTC Medicaid beneficiaries transitioning from fee-for-service care to a care management program, as well as reductions in their number of emergency room visits and inpatient admissions. The report concluded that the global waiver was highly effective in controlling Medicaid costs and improving beneficiaries' access to more appropriate services (particularly primary care, home, and community-based services).[33]

Another recent example of Medicaid innovation at the state level involves Florida's section 1115 Medicaid Reform Waiver. This comprehensive demonstration program was designed to improve the state's Medicaid delivery system by coupling the use of managed care practices with customized benefit packages, opt-out provisions, and health-related incentives or enhanced benefits for beneficiaries. After five years, the Medicaid Reform Pilot (now operating in five counties while the state awaits federal action on its proposal to extend and expand the waiver statewide) maintained health outcomes at or above the national average for the majority of measured indicators. It improved outcomes for recipients through financial incentives. The program achieved patient satisfaction levels above the national averages of other state Medicaid programs and even commercial health maintenance organizations, while still restraining costs (flattening the cost curve for per-person spending).[34]

The current political climate makes further discretionary approval of Medicaid waivers for such experiments less likely and a broader legislative overhaul of the program's financing more necessary. The Obama administration remains committed to implementing the ACA's plan for massive expansion of Medicaid and further federal control of eligibility, benefits, and even reimbursement policy.[35] Moreover, several other cautionary notes remain before proceeding with overoptimistic assumptions for the primary alternative: sweeping state-driven Medicaid reform.

Health policy should support broader economic policy incentives to work, save, and invest more effectively so as to protect the most vulnerable Americans without increasing their numbers.

Speed Limits for State Medicaid Reform. First, even achieving the most optimistic vision of improvements in Medicaid's health care delivery quality and efficiency cannot overcome the effects of slow or stagnant economic growth, rising levels of disabling health conditions, and lack of improvement in the dependency ratio between working taxpayers and beneficiaries dependent on publicly financed health entitlement programs. Hence, health policy should support broader economic policy incentives to work, save, and invest more effectively so as to protect the most vulnerable Americans without increasing their numbers.

Second, there are clear fiscal and administrative ceilings on the degree to which current Medicaid beneficiaries can be mainstreamed quickly into higher-quality private insurance coverage by offering defined-contribution subsidies that flow directly to them and their chosen insurer. Our long-term goal should be to coax more Medicaid beneficiaries into private insurance coverage by offering defined-contribution subsidies that flow directly to them and their chosen insurer. However, doing so will either cost more money or cover fewer people than both the ACA and the old Medicaid program pretend to do at

cut-rate prices. Better private coverage has to pay health care providers more to deliver better care, and the current level of Medicaid spending—even for the less medically challenged nonelderly, nondisabled portion of its covered population—is far from sufficient to handle the cost of those higher premiums on a large scale.[36]

Third, managed care for an increased share of Medicaid beneficiaries is no panacea. Its effects on costs and quality depend on how well it is executed in practice, as well as the setting in which it occurs. Managed care programs already cover about two-thirds of all Medicaid beneficiaries, and broader efforts to focus managed care on dual eligibles are expanding or getting underway. Yet a recent study by Duggan and Hayford found that shifting Medicaid recipients from traditional FFS benefits programs into Medicaid managed care ones did not reduce Medicaid spending in the typical state.[37] In many cases, managed care programs achieved most of their savings through obtaining lower prices rather than producing reduced quantities of "better managed" health care services.

Finally, greater emphasis on "federalism" in health policy must travel a two-way street. Each state Medicaid program should be accountable for measured improvement in health care quality, whether through better health outcomes or performance metrics, rather than just for close compliance with federal rules and regulations. The latter often have little if any real impact on the lives of beneficiaries and fail to promote efficiency and cost containment.

In a block-grant or capped-allotment approach to Medicaid reform, the primary role of the federal government should be to ensure true accountability and responsibility on the part of states given greater freedom in spending federal dollars. The federal government should offer every state the opportunity to enter into a simplified compact that sets outcome measures and benchmarks and then requires a participating state to report periodically (perhaps quarterly) on its performance in achieving them. Federal oversight should be triggered when there is a significant deviation in the reported versus projected performance. The number of measures should be limited to no more than 10 for each dimension of health care: cost, quality, and access. This will simplify or eliminate the state plan approval process, allowing states and their constituents to concentrate more on what matters most: better health outcomes, better value, and lower costs.

Notes

1. Thomas P. Miller, "How the Tax Exclusion Shaped Today's Private Health Insurance Market" (Joint Economic Committee), December 17, 2003, www.aei.org/files/2007/02/26/20070222_Millerarticle.pdf; Robert B. Helms, "Tax Policy and the History of the Health Insurance Industry," in *Using Taxes to Reform Health Insurance: Pitfalls and Promises*, ed. Henry J. Aaron and Leonard E. Burman (Washington, DC: Brookings Institution, 2008), www.aei.org/paper/health/healthcare-reform/private-insurance/tax-policy-and-the-history-of-the-health-insurance-industry/; and Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (Washington, DC, March 1994), www.cbo.gov/ftpdocs/95xx/doc9527/1994_03_TaxTreatmentOfInsurance.pdf.

2. Supplemental coverage involves either individually purchased or employer–provided "Medigap" coverage, or additional Medicaid assistance for the low-income elderly.

3. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC, June 2012): 3-29, www.medpac.gov/chapters/Jun12_ch01.pdf (accessed September 24, 2012); see also Adam Atherly, "Supplemental Insurance: Medicare's Accidental Stepchild," *Medical Care Research and Review* 58, no. 2 (2001): 131–61 (finding a spending increase averaging about 25 percent among Medicare beneficiaries with supplemental coverage) and Sandra Christensen and July Shinogle, "Effects of Supplemental Coverage on the Use of Services by Medicare Enrollees," *Health Care Financing Review* 19, no. 1 (1997): 5–17 (estimating that use of Medicare services ranged from 17 percent higher for those with employer supplemental coverage to 28 percent higher for those with individual Medigap policies). Other researchers have suggested that at least some of this higher spending is due to risk selection effects that attract less healthy beneficiaries to supplemental coverage, but a recent

MedPAC-sponsored study confirmed that when elderly beneficiaries are insured against Medicare's cost sharing, they use more care and have higher Medicare spending. See Christopher Hogan, "Exploring the Effects of Secondary Insurance on Medicare Spending for the Elderly," Study 09-28 for MedPAC (2009), www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf. The Hogan study estimated that total Medicare spending was 33 percent higher for beneficiaries with Medigap policies than for those with no supplemental coverage after controlling for demographics, income, education, and health status. Beneficiaries with employer-sponsored coverage had 17 percent higher Medicare spending, and those with both types of secondary coverage had 25 percent higher spending.

4. C. Eugene Steuerle and Stephanie Rennane, *Social Security and Medicare Taxes and Benefits over a Lifetime* (Washington, DC: Urban Institute, June 20, 2011), www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf.

5. Although the ACA officially expands Medicaid to cover all households earning up to 133 percent of the federal poverty level, including childless adults, its "income disregard" rules increase the effective ceiling to 138 percent. The 100 percent federal financing eventually phases down to 90 percent by 2019.

6. The Supreme Court ruling on the ACA's Medicaid expansion made participation in the new, expanded Medicaid program more of an option for states, rather than a federal mandate with a heavy penalty for noncompliance (potentially as much as loss of all existing federal Medicaid subsidies for a noncomplying state's *current* Medicaid program). Nevertheless, the incentives to take maximum advantage of the increased subsidies from federal taxpayers remain on the table for participating states.

7. The tax exclusion is passed through to workers as a pretax discount that reduces the net cost of their employer-paid health benefits. Many workers also use a premium conversion option offered by their employer (particularly larger ones) to extend this tax benefit to the share of employer-sponsored insurance premiums that they pay directly. Among employers offering health benefits, 41 percent of small firms (with 3 to 199 workers) and 91 percent of larger firms (200 or more workers) offer plans that allow employees to use pretax dollars to pay for their share of premiums. See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2012 Annual Survey* (Menlo Park, CA: Author, 2012), exhibit 14.2 at 237, http://ehbs.kff.org/pdf/2012/8345.pdf.

8. Whether the premium assistance tax credits provided under the ACA (beginning in 2014) for exchange-based coverage are more or less generous than tax exclusion subsidies for ESI depends on a worker's household income level. In general, the income-based premium assistance tax subsidies are more progressive, in subsidizing lower-income individuals families more generously than the value of a tax exclusion based on their marginal federal income tax rate. See, for example, Eugene Steuerle, "Health Care Reform: Implications of a Two Subsidy System," presentation, AEI Conference, Are the Current Health Reform Bills Fair?" December 4, 2009, www.aei.org/files/2009/12/04/Eugene%20Steuerle-%20AEI%2012-4-09.pdf. See also James C. Capretta, "A 70% Tax on Work," National Review Online, October 5, 2009, www.nationalreview.com/critical-condition/48181/70-tax-work/james-c-capretta, regarding likely disincentives to work as income increases. But ACA rules generally prohibit workers with ESI coverage offers from taking advantage of exchange-based insurance subsidies, and the health law provides no additional tax subsidies for purchases of individual market coverage outside of the ACA-approved exchanges.

9. James C. Capretta and Thomas P. Miller, "The Defined Contribution Route to Health Care Choice and Competition," AEI Beyond Repeal and Replace series (December 2010), 16–17.

10. For example, see Thomas P. Miller, "Improving Access to Health Care without Comprehensive Health Insurance Coverage: Incentives, Competition, Choice, and Priorities," in *Covering America: Real Remedies for the Uninsured,* vol. 2 (Washington, DC: Economic and Social Research Institute, 2002), at 40-45.

11. This budget-deficit-neutral approach assumes "static" scoring of changes in tax policy. Under a more realistic "dynamic" scoring model, the pro-growth incentives triggered by reductions in marginal income tax rates that offset a larger base of taxable income actually would increase overall federal tax revenue.

12. For example, see Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2012*, 16–18.

13. The tax exclusion for ESI also shelters the value of job-based health benefits from the payroll taxes that finance Social Security and Medicare, not just from federal income taxes. Hence, individual deductibility of premium costs under the federal income tax code alone fails to provide equivalent tax treatment for purchasers of individual market health insurance.

14. Of course, if policy goals include being more generous to those more in need and extending tax subsidies for health insurance to new populations, this will mean either moving away from the same flat, fixed-dollar subsidy for everyone or raising the budgetary price tag substantially for a much more generous level of total tax expenditures than under current law. If policymakers insist on budget neutrality in line with this existing baseline, the average per-capita tax subsidy spread across a broader population would need to be lower. In any case, everyone receiving the same amount of "less-generous" tax credits is probably the least likely political scenario of all.

15. The penalties for failing to comply with the insurance-purchasing mandate under the ACA also are rather modest in proportion to the likely average premium cost of required coverage. The penalty will be the greater of a flat-dollar amount or a percentage of the violator's income. After the penalty amounts are phased in over three years (ending in 2016), the flat-dollar version will equal $695, and the percentage-of-income version will equal 2.5 percent of income. The likely result is that a significant percentage of lower-income individuals will calculate that it is much less expensive to pay the penalty than to purchase mandatory insurance. The law's guaranteed-issue incentives for potential purchasers allow them to enroll "just in time" when sick and "go bare" when healthy (and pay less in penalties than in total premiums), further ensuring limited and erratic mandate compliance. See Thomas P. Miller, "The Individual Mandate: Ineffective, Overreaching, Unsustainable, Unconstitutional and Unnecessary" AEI, March 23, 2012, www.aei.org/papers/health/healthcare-reform/ppaca/the-individual-mandate-ineffective-overreaching-unsustainable-unconstitutional-and-unnecessary/.

16. National Bipartisan Commission on the Future of Medicare, *Building a Better Medicare for Today and Tomorrow* (Washington, DC, March 16, 1999).

17. In 1999, a majority of the National Bipartisan Commission members supported a plan with a premium payment formula under which beneficiaries would be expected to pay, on average, 12 percent of the total cost of standard option Medicare plans. (That total cost was calculated as 100 percent of the national enrollment-weighted average of all plan premiums, including both the government/taxpayer and beneficiary shares). Taxpayers would pay the remaining 88 percent. For plans that cost less than 85 percent of the national average weighted plan price, there would be no beneficiary premium at all. For plans with prices above 100 percent of the national weighted average, the taxpayer subsidy share of premiums would be capped and additional beneficiaries' premiums (above the baseline 12 percent share) would include all costs above that national average. For premiums between 85 and 100 percent of the national weighted average, the government's share would increase by roughly $1 for every $3 required of the beneficiary. (For example, a plan with premiums at the 88 percent level would charge beneficiaries premiums at only 3 percent of total plan costs, whereas a plan with total costs at the 96 percent level would charge beneficiaries premiums at 9 percent of plan costs.) See Jeff Lemieux, "Subject: Cost Estimate of the Breaux-Thomas Proposal," National Bipartisan Commission on the Future of Medicare, March 14, 1999, http://rs9.loc.gov/medicare/cost31499.html, referencing "Schedule 2: An Alternative Premium Schedule," February 17, 1999, http://rs9.loc.gov/medicare/images/sched02.pdf.

18. See Roger Feldman, Robert Coulam, and Bryan Dowd, "Competitive Bidding Can Help Solve Medicare's Fiscal Crisis," AEI *Health Policy Outlook* (February 2012), www.aei.org/outlook/health/healthcare-reform/competitive-bidding-can-help-solve-medicares-fiscal-crisis/; Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare: Essential Reform at a Time of Fiscal Crisis* (Washington, DC: AEI Press, 2009).

19. Senator Ron Wyden and Representative Paul Ryan, *Guaranteed Choice to Strengthen Medicare and Health Security for All* (Washington, DC, December 15, 2011), http://budget.house.gov/uploadedfiles/wydenryan.pdf.

20. The latest research by Feldman, Coulam, and Dowd estimates that competitive bidding—a key feature of the Wyden-Ryan plan—could have saved Medicare $339 billion over 10 years, starting in 2010, while maintaining basic benefits and without raising taxes. Fully implemented competitive bidding from 2010 to 2020 would save 9.5 percent of

then-projected Medicare spending. However, the Affordable Care Act is estimated to save 4.2 percent if implemented as the law requires, so competitive bidding would save 5.6 percent more of Medicare spending, as projected under the ACA-adjusted baseline.

21. Richard Burr and Tom Coburn, *The Seniors' Choice Act* (Washington, DC, 2012), www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=dd0753e9-e62b-4640-9659-75099f9bd1a9.

22. Critics of several House Republican budget resolutions in recent years have pointed to those budgets' use of formula-based reductions in the future rate of growth of premium support payments for Medicare spending (such as reducing it to the annual rate of gross domestic product growth, plus either 1 percent or 0.5 percent) to ensure budget savings. However, the ACA also caps future overall spending growth to a similar annual rate beginning in 2015. Its combination of annual automatic reductions in provider reimbursement rates (euphemistically called "productivity adjustments") and other Medicare spending reductions, to be enforced by an Independent Payment Advisory Board, will limit growth in per-capita Medicare spending to a fixed rate (initially set at the midpoint between general inflation in the economy and inflation in the health sector, but starting in 2018 set permanently at per-capita GDP growth plus 1 percent). See, for example, James C. Capretta, "Paul Ryan's Medicare Fix," *National Review*, May 2, 2011, 30–33; Marilyn Werber Serafini, "FAQ: Obama v. Ryan on Controlling Federal Medicare Spending," Kaiser Health News, August 29, 2012, www.kaiserhealthnews.org/stories/2012/may/04/obama-ryan-controlling-federal-medicare-spending-faq.aspx.

23. Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC, April 23, 2012), www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf.

24. See, for example, Avik Roy, "How Medicaid Harms the Poor: A Counter-rebuttal, Part II," The Apothecary blog, March 10, 2011, www.forbes.com/sites/aroy/2011/03/10/how-medicaid-harms-the-poor-a-counter-rebuttal-part-ii.

25. The 100 percent federal support phases down to a 90 percent federal match of state funding within five years, and many state officials doubt that such "generosity" will be sustainable under future federal budgetary pressure.

26. For example, one federal rule provides that medical assistance must be made available to those who qualify for Medicaid as categorically needy and categorically related eligible persons in the same "amount, duration, or scope," and another federal Medicaid rule provides that similarly situated individuals must receive comparable services. See section 1902(a)(10)(B) of the Social Security Act. See also US Social Security Administration, "Medicaid Program Description and Legislative History," *Annual Statistical Supplement*, 2010, www.ssa.gov/policy/docs/statcomps/supplement/2010/medicaid.html. However well-intentioned these uniform federal requirements once might have been, they often frustrate state efforts to created targeted benefits packages for specific populations or put reasonable limits on benefits for certain types of patients. The federal government also restricts state efforts to limit Medicaid beneficiaries' right to choose a health care provider, including the location of the services, even when more narrow alternatives might be more cost effective and improve the quality of care delivered. Another federal rule provides that a Medicaid beneficiary is free to choose any "institution, agency, community pharmacy, or person, qualified to perform the service of services required . . . who undertakes to provide such services" (42 U.S.C. § 1396a(a)(23)).

27. Senate Finance Committee and House Energy and Commerce Committee, *Medicaid Expansion in the New Health Law: Costs to the States* (Washington, DC, 2011), http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20110301medicaid.pdf. The report's estimates, of course, assumed full participation in the Medicaid expansion by all states (because it predated the Supreme Court's decision that made such participation in the new program more of a state "option").

28. However, Medicaid also provided, since its enactment nearly 50 years ago, medical assistance to other categories of low-income Americans not covered by the then-traditional Aid to Families with Dependent Children federal "welfare" program (such as those who are disabled or above age 65).

29. Cynthia Shirk, "Premium Assistance: An Update," National Health Policy Forum Background Paper no. 80,

October 12, 2010; and US Government Accountability Office, "Medicaid and CHIP: Enrollment, Benefits, Expenditures, and other Characteristics of State Premium Assistance Programs," GAO-10-258R, January 19, 2010; Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman, December 2008, http://publications.milliman.com/research/health-rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf. Federal approval of state premium-assistance plan waivers also requires states to demonstrate their cost effectiveness compared to traditional state Medicaid coverage and guarantee that they will offer comparable health benefits and protection against cost sharing.

30. Robert B. Helms, "Medicaid: The Forgotten Issue in Health Reform," AEI *Health Policy Outlook* (November 2009), www.aei.org/outlook/health/healthcare-reform/medicaid-the-forgotten-issue-in-health-reform/.

31. Rhode Island could organize and deliver services in a more targeted and cost-effective manner, across populations and acute and long-term care settings, to address the complex and interrelated needs of beneficiaries throughout their life-cycle. The state also could leverage its purchasing power to create new provider markets or drive change in existing ones through competition. The waiver also allows the state the freedom to implement strategies already successful in the commercial health insurance market that encourage and reward beneficiaries who take responsibility for their own health and welfare. See Tom Miller, "Taking Medicaid Off Steroids," in *The Great Experiment: The States, The Feds and Your Healthcare* (Boston: Pioneer Institute, 2012), 84. Rhode Island also rebalanced its long-term care system. The state improved care management programs for children with special health care needs and adults with disabilities and promoted the availability of community-based services as an alternative to nursing home placement. See The Lewin Group, *An Independent Evaluation of Rhode Island's Global Waiver* (Falls Church, VA, December 2011), 1–3.

32. In the first 18 months under the global waiver, estimated savings were $100 million, and the annual rate of growth in total Medicaid spending was reduced by more than half, from 7.94 percent to 3 percent. If the state's Medicaid spending continues on the same path for the next three years, it will amount to a few billion dollars less than the cap agreed to for the five-year demonstration. See Miller, "Taking Medicaid Off Steroids," 84.

33. See The Lewin Group, *An Independent Evaluation*.

34. Tarren Bragdon, *Florida's Medicaid Reform Shows the Way to Improve Health, Increase Satisfaction and Control Costs* (Washington, DC: The Heritage Foundation, November 9, 2011); Florida Agency for Health Care Administration, *Florida Medicaid Reform, Year 4 Annual Draft Report* (Tallahassee, FL, 2012), www.fdhc.state.fl.us/medicaid/medicaid_reform/pdf/reform_draft_annual_report_yr4_070109-063010.pdf, 61, 99, 103 (table 46); Paul Duncan, "Evaluating Medicaid Reform in Florida: Lessons for Other States" (presentation, National Medicaid Congress, Washington, DC, June 8, 2010), http://mre.phhp.ufl.edu/talkspresentations/The%20National%20Medicaid%20Congress_Paul%20Duncan_Final%20PPT_06-08-2010.pdf, slide 17. The Florida waiver also saved the state's Medicaid program up to $161 million annually. If implemented statewide, it could reduce Medicaid spending by up to $1.9 billion annually. If Florida's Reform Pilot experience were replicated nationwide, Medicaid patient satisfaction would soar, health outcomes would improve, and state Medicaid programs could save up to $91 billion annually.

35. For example, section 2304 of the Affordable Care Act expands the definition of "medical assistance" that states participating in Medicaid are required to provide to encompass both payment for services provided and the services themselves. This would appear to require states to provide the actual services, if reimbursement levels for them fail to ensure sufficient access.

36. No single set of comparisons can control fully for other secondary factors, but let's compare the average annual premiums for single (nonfamily) coverage of adults for private, employer-sponsored health insurance with annual costs for Medicaid coverage of adults. In 2010, private employer coverage premiums were $5,049 for single coverage and $13,770 for family coverage. The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2010 Annual Survey*, 2010, 12, http://ehbs.kff.org/pdf/2010/8085.pdf. For Medicaid, per-enrollee spending for health services was estimated to be $6,775 in 2010. But estimated per-capita spending for children ($2,717) and adults ($4,314) was much lower than that for aged ($15,495) and disabled ($16,963) beneficiaries,

reflecting the differing health status of, and use of services by, the members of these groups. See Christopher J. Truffer et al., *2011 Actuarial Report on the Financial Outlook for Medicaid* (Office of the Actuary, Centers for Medicare and Medicaid Services, March 14, 2012), www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf.

37. Mark Duggan and Tamara Hayford, "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates" (National Bureau of Economic Research working paper no. 17236, Cambridge, MA, July 2011), www.nber.org/papers/w17236.

3

Extending Portable Protection against Serious Preexisting Conditions

One of the most politically popular rationales for passage of the ACA was that it provided the only way to solve the serious problem of covering Americans with preexisting health conditions. However, far better targeted solutions are available through a different type of federal-state partnership that relies on redesigned and robustly funded high-risk pools.

Policy Prescriptions:

- Extend HIPAA-style preexisting condition protection to **all** purchasers of insurance with sufficient continuous coverage.
- Provide more robust federal funding of state-run high-risk pools, with premium caps and supplemental income-based subsidies. Begin with a capped appropriation, not an open-ended entitlement.

A Small but Significant Problem

Problems in covering people with preexisting conditions stem primarily from how our largely employer-based, and voluntary, private health insurance system has evolved. For more than half a century, public policy for health insurance has favored employers over individuals as insurance purchasers through complex tax subsidies and insurance regulation. When working Americans lose or change jobs, they also lose or change their employer-based plan coverage. If a worker moves directly from one ESI plan to another, the disruption is usually not a problem, due in part to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as well as long-standing insurance practices even before that law. But whenever someone, by choice or necessity, leaves ESI coverage to purchase health insurance independently, the switch in coverage may present particular risks and challenges for workers with serious preexisting health conditions.

However, the overall problem of coverage for preexisting conditions remains relatively limited, despite some exaggerated rhetoric used to promote enactment of the ACA. It primarily affects a subgroup of less-healthy, working-age Americans. This includes those who do not receive health coverage from their employers, who do not qualify for Medicaid, and who are not able to buy coverage in the individual market because their health conditions cause insurers to charge them much higher premiums, restrict their coverage, or refuse to cover them. With some exceptions, the sick and the healthy pay roughly the same premiums within particular job-based plans.[1]

Moreover, Congress provided an additional protection for workers in the mid-1990s. HIPAA made it unlawful for employer-sponsored plans to exclude coverage of preexisting conditions for workers with sufficient periods of continuous group insurance coverage.[2]

In theory, HIPAA also provided portability rights to people moving from job-based plans to individually owned coverage. But none of the options for states to do this has worked well.[3] Even if a sick person moving from the group to the individual insurance market abides by HIPAA's requirements and remains continuously insured, nothing in pre-ACA federal law prevents insurers from charging this individual more than they charge healthy people. Insurers are prohibited only from denying coverage altogether for a preexisting condition. Pre-ACA law and regulations also provided no premium protections for persons moving between individual insurance policies.

On the other hand, health researchers Pauly, Herring, and Song found little, if any, evidence that enrollees in poor health generally paid higher premiums for individual insurance. Nor did they find that the onset of chronic conditions is necessarily associated with increased premiums in subsequent years.[4] Existing guaranteed renewability requirements in federal and state law already prevent insurers from continuously reclassifying people (and the premiums they pay) based on health risks. And most private insurers already provided such protection as standard business practice before they were legally required to do so.[5]

Although the risks of facing coverage exclusions and prohibitive premiums caused by preexisting conditions are not a universal problem in the individual insurance market, they clearly affect many Americans. Reasonable estimates of those affected range from 2 to 4 million out of a total population of about 260 million people under the age of 65.[6] More important than this number alone, however, is how many more Americans know someone who has faced this situation directly and fear that they could find themselves in the same predicament. This explains the strong public support for changing the way insurance companies treat preexisting conditions. Most people find it unacceptable that other citizens who have tried to act responsibly by staying insured throughout their lives can suddenly find themselves sick, perhaps unemployed, and unable to get adequate coverage.

In any case, both practical limits and basic business incentives restrain excessive underwriting by insurers. Indeed, the most extensive research in this area, by Pauly and Herring, has identified a great deal of pooling of health risks already in the individual market.[7] But some people clearly have not been able to get covered because of the higher health risks they present to potential insurers.

The most effective solution would not be heavy-handed regulation, but rather a new insurance marketplace built around truly portable, individually owned insurance. If individuals and families, instead of their employers, chose and controlled their own insurance plans, people would no longer face the risks that come with coverage that changes along with employment. Individuals could keep their coverage even as their health status changed. They also would need to engage in a more careful process of evaluating and choosing the insurance plan in which they initially enroll, because it would involve much more than a one-year decision. Moreover, insurers would have strong incentives to help keep their enrollees healthy, because some of them could be enrolled for many years.

The overall problem of coverage for preexisting conditions remains relatively limited, despite some exaggerated rhetoric used to promote enactment of the ACA.

But moving to true insurance portability will require fundamental reform of the tax treatment of health insurance to level the playing field between insurance plans owned by employers and those owned by individuals. Some current insurance regulations, information disclosure practices, and insurers' business models will also need reworking. For now, such far-reaching reforms face long political odds—even if the more complex and counterproductive set of insurance rules to be implemented by 2014 under the ACA are reconsidered. Moreover, if the most elegant portability reforms suggested above were adopted instead, they still would not address how to cover people who already suffer from costly health conditions and are uninsured (and thus could not easily afford to purchase their own risk-based portable insurance, even once a new system got up and running).

The immediate, short-term focus of health policy should be people shut out by the current system because of their current health status. Some states have attempted to address the problem by imposing risk-rating restrictions on health insurance premiums. But this approach has proven unsustainable

because it causes private insurers to increase the premiums they charge everyone else, particularly younger and healthier customers, to make up for the losses associated with the enrollment of more expensive cases at below-cost premiums. And when premiums rise for the former types of current and potential customers in a voluntary marketplace, a significant number of these people, weighing the low short-term risk of an expensive illness against the immediately higher cost of buying health insurance, will drop out of coverage altogether. The resulting vicious cycle triggered by excessive regulation that tries to suppress market signals can cause so many consumers and insurers to stop buying and selling insurance that the entire market (particularly the smaller and more precarious individual market) can threaten to collapse.[8]

The ACA adopted a more comprehensive, but similarly flawed, approach to health insurance to solve the preexisting coverage problem by dramatically transforming our entire health care system—even though it is well established that most insured Americans prefer to keep the coverage they have—and by creating an enormous and expensive system of regulations and entitlements. It thus creates even greater risks to the sustainability of private health insurance, with taxpayers ultimately left to pick up the even more expensive costs of oversubsidized, overregulated, and hyperpoliticized health care under the ACA.

High-Risk Pool Alternatives

We can develop a different model for a promising national solution from the experience of a number of states. Over the last two decades, they increasingly turned to an approach that does not require a fundamental transformation of the insurance marketplace: the creation of high-risk pools. Health policy reformers concerned about the problem of preexisting conditions should consider discarding the ACA approach to coverage of preexisting health conditions and replacing it with a system of robust, well-funded high-risk pools.

High-risk pools are basically a policy mechanism for bridging the gap between the high cost of providing insurance to patients with predictably expensive preexisting health conditions and the comparatively lower premiums those patients can afford. The high-risk pool programs cover people who apply after first trying to get insurance elsewhere but are denied coverage or who receive only unaffordable coverage offers. The program's administrators first must determine an applicant's eligibility.[9]

Because everyone in the pool has, by definition, a high-risk profile, its average claim costs are necessarily quite high. However, the premiums that eligible individuals pay directly are capped at various levels above standard rates. For remaining costs above those caps, additional premium payments are fully subsidized from various public revenue sources. The core concept is that people should pay only the premiums they can afford, and the difference between those payments and the real cost of insurance will be made up by taxpayers.

The pools essentially remove most (if not all) of the uncertainty involved in covering the least-healthy consumers from the cost structure financed by normal premium payments. When the predictably high-cost tail of the health cost distribution is taken out of the equation, premiums fall and become more attractive for lower-risk customers, further expanding the pool of premium payers (and again lowering costs for everyone else).[10]

Most State High-Risk Pools Are Underfunded. Although high-risk pools have helped hundreds of thousands of Americans, they still fall far short of meeting the needs they are meant to address. In addition to the large differences among the state plans in terms of eligibility rules, benefit design, premium prices, subsidies, and financing, huge discrepancies also exist in effectiveness. The pools' main shortcoming almost always stems from the large mismatch between the number of people who need them and the amount of money made available to subsidize them. In most cases, these state-level efforts have been neither sufficiently ambitious nor adequately funded.

Those state-run high-risk pools will also be badly undermined and ultimately displaced by the ACA.

Just how many people might face preexisting condition exclusions and might benefit from high-risk pools is not a simple question. The government and private economists have made several serious attempts to arrive at a reliable set of estimates in recent years.[11] Regardless of the particular sources or estimating methods, which all have their limitations, the demand for premium assistance among those with very high expected health costs clearly substantially exceeded the pre-ACA financial capacity of then-operating state high-risk pools.

If we assume, at the high end of estimates, that as many as 4 million more people might need (and seek) high-risk pool coverage, the annual cost of public subsidies could be as high as $17 billion. But some variables might include whether the new enrollees will be somewhat less costly than current ones (since their health status might be less dire), whether benefits and cost-sharing levels are more or less generous than under recent high-risk pool coverage, and whether additional income-based subsidies for enrollees are included.

Given the large price tag and the fiscal stresses most state governments continue to experience after a deep recession, it should be no surprise that state-based pools have been underfunded and closed off to many potential beneficiaries. Indeed, the most common complaint about pre-ACA high-risk pools was that their coverage remained too expensive and too limited. To control costs, all pre-ACA state high-risk pools imposed preexisting condition exclusion periods, ranging from two months to one year, for enrollees who forfeited (or never accrued) portability rights under HIPAA. Facing fiscal pressures, many states were also not aggressive in trying to boost high-risk pool enrollment through advertising and outreach to potential enrollees, nor were they eager to pay commissions as generous as those private insurers paid to insurance agents who brought in customers.

In short, while high-risk pools offer a plausible and promising conceptual model for covering people with preexisting conditions, their real-life implementation has (at least to date) left much room for improvement. Advocates of pro-market health care reform should therefore urge states to properly design and operate high-risk pools and call on the federal government to properly fund them. Such pools would offer an effective, yet far less expensive and intrusive, approach to the problem of covering preexisting conditions than the tack taken by the ACA. Well before the latter's most important provisions (including an individual mandate to purchase insurance, expanded premium subsidies, and tighter federal regulation of insurers' practices) take effect in 2014, the law's poorly designed attempt to construct a short-term version of high-risk pools—under either federal guidance to the states or more direct administration by the federal government—has already faltered.

The most effective solution would not be heavy-handed regulation, but rather a new insurance marketplace built around truly portable, individually owned insurance.

High-Risk Pools under the ACA. The ACA's approach to insurance coverage for Americans with preexisting conditions (and everyone else, too) differs from previous state efforts in one important way: starting in 2014, health insurance coverage will no longer be voluntary; almost every American must either carry insurance or pay a fine. In theory, mandating insurance enrollment is supposed to prevent the young and healthy from fleeing the marketplace when their premiums are increased to cover higher-cost cases (thus preventing any regulation-induced meltdown of private insurance markets).

But many insurance experts argue that the insurance mandate will not work as designed because too many young and healthy people will still choose to stay out of the system. For them, it could make financial sense to go without coverage because penalties for failing to comply are much less than the cost to

purchase mandated coverage. Additionally, the ACA would allow them to enroll later as needed, without any additional restrictions on their access to coverage. The Obamacare plan could therefore bring about much of the same dysfunctional regulatory cycle that previously relied on guaranteed issue and community rating restrictions in state-level initiatives and produced disappointing, if not dismal, results.[12]

While high-risk pools offer a plausible and promising conceptual model for covering people with preexisting conditions, their real-life implementation has (at least to date) left much room for improvement.

Furthermore, as part of a political ploy to mask the ACA's full cost and keep the 10-year Congressional Budget Office score for the proposed bill below $1 trillion, the new insurance system and expensive taxpayer subsidies to finance it will not go into effect until 2014. ACA architects knew they had to offer something to voters on the preexisting condition front in the interim. To fill this gap, they resorted to the mechanism they had long derided: high-risk pools. The final law required that high-risk pools for people with preexisting conditions operate until January 1, 2014, when the new insurance rules and subsidies would go into effect.

These new high-risk pools operate very differently from those already established in 35 states that were designed to operate with even more limited resources. Under ACA rules, the new state pools cannot allow any exclusions or waiting periods for coverage of preexisting conditions. Cost-sharing is restricted. Age-based premium rating would be more constrained, and insurers in the new risk pools would be required to pay at least 65 percent of the costs of covered medical treatments and procedures (clashing with some states' established practices that require patients to pay for a greater portion of their treatments). Most importantly, enrollees can be charged only standard rates.

In effect, the ACA aimed to impose on the high-risk pools many of the restrictions it will place on insurance coverage, benefits, and premiums in the new health exchanges to be established in 2014 under the new law—but starting three and a half years before the latter are fully drafted and implemented. However, the ACA limited high-risk pool eligibility to individuals already uninsured for at least six months, and an eligible enrollee must have a preexisting condition, as determined by the guidance of the secretary of the Department of Health and Human Services (HHS).

By most initial estimates, the law also appeared to underfund substantially the high-risk pools it requires, authorizing a total of only $5 billion for three and a half years of operation. In April 2010, the HHS chief actuary released a cost projection for the new program, predicting that the $5 billion the law allocates for three and a half years of high-risk pools would in fact be exhausted in the program's first or second year. The actuary estimated that only 375,000 people shut out of insurance elsewhere would obtain health care coverage through the high-risk pools, a number that would fall far short of the estimated 2 to 4 million people in the targeted population.[13]

However, early experience under the new risk pools turned out quite differently. As of April 30, 2011 (a little more than one year after the ACA was enacted), enrollment in the renamed Pre-Existing Condition Insurance Plans (PCIP) program was a little over 20,000.[14] More recent Obama administration estimates set the latest figure around 90,000 as of September 30, 2012.[15] Enrollment has remained dramatically short of expectations, even after HHS redesigned its PCIP rules to lower premiums even more and make it easier for applicants to document their preexisting conditions.

A July 2011 report by the Government Accountability Office suggested that the primary reasons for lower-than-expected enrollment were the statutory requirement that applicants be uninsured for at least six months, affordability concerns, and lack of awareness

of the PCIP program.[16] However, the most likely explanations are that the estimated size of the population denied coverage due to a preexisting condition is much smaller in practice than the inexact estimates of various national surveys suggest and that the primary reason for lack of coverage is its unaffordable cost to potential purchasers *in general* (rather than just to those with particular high-risk conditions). Offers of free or very heavily subsidized coverage might encourage more substantial enrollment (leaving aside their budgetary costs). But the broader affordability problem is much greater than the slightly higher surcharges in premiums facing most individuals with preexisting conditions.

High-Risk Pools That Will Not Run Dry. A better solution should begin with *redefining* the problem. We should avoid the temptation of trying to achieve multiple policy objectives with a single tool, which fails to target scarce resources more effectively and sustainably. True high-risk pools should be limited to covering the most likely highest-risk individuals, as identified before their enrollment. They do not work as well as a mechanism for subsidizing the health care costs of low-income individuals more broadly or for covering the uninsured in general. They address a problem that is real, but apparently much smaller than most observers previously have estimated. The issue of limited access to private health insurance for individuals with preexisting conditions has been exaggerated and exploited to advance a much broader political agenda. The real goal of this agenda is to more extensively control private insurance coverage and pricing for everyone else.

The present and future failings of the ACA's high-risk pool component are functions of its careless design, not an indictment of the fundamental concept. A more effective solution remains a better-designed, robustly funded, and more narrowly targeted system of state high-risk pools, not the new law's massive and misguided transformation of American health care. The guiding principle for a more effective approach is straightforward: Americans who stay in continuous insurance coverage should not be penalized for developing costly health conditions. Several key policy components to achieve this objective include:

- Congress must fix several of the flaws in HIPAA. Workers should be able to leave job-based plans for the individual market without being penalized for failing to exhaust their COBRA rights, which allow a worker to keep buying into a previous employer's health plan for a limited period of time.[17] If a worker moves directly from an employer-provided plan to an individual policy, that individual should not be denied coverage based on a preexisting condition.

- States should impose limits (based on broader federal guidelines) on underwriting for other people who move from the employer-based market to the individual market. Those limits should involve capping the premiums charged to high-risk customers at some fixed level—at or somewhat above applicable standard rates in the individual market, regardless of income, if they do not have previous continuous coverage (see penultimate bullet in this section). State governments then should consider providing supplemental sliding-scale subsidies to low-income individuals who need additional premium assistance.

- Insurers should be allowed to take higher health risks into account when calculating premiums for previously uninsured individuals, while high-risk pool access ensures that those with expensive health conditions are not completely priced out of the market. (Identifying people at very high risk could also help insurers better tailor health care interventions to encourage these customers to change their behavior and lower their risks over time.) Individuals anticipating more expensive health care costs could and should pay somewhat more than

others to handle their costs (through higher premiums and more cost sharing), but with some realistic and equitable ceilings on how much is too much and guidelines for when public subsidies should begin.

- The gap between a customer's contribution and the actual cost of insuring that individual should be bridged with taxpayer dollars through high-risk pool programs in the states. These programs must be funded sufficiently to function properly. With state budgets overdrawn and overstretched for several more years ahead, such initial funding will have to come from Washington in the form of a series of modestly generous, but capped, annual appropriations. Capping the amounts would help head off the dangers of open-ended entitlement incentives to overspend, and policymakers should reconsider a switch to state matching funds in later years. Given the recent mistaken estimates of the likely costs of such a program, this funding should start at a more conservative level. Only after the program has undergone the necessary trial and error of implementation and practice—providing a better sense of the pools' actual needs and costs—should lawmakers reexamine the funding commitments.

- The new risk pools must be structured to prevent participating private insurers from dumping unwanted (but not truly high-risk) customers into the public-subsidy system. For example, suppose an insurer believes that an applicant's health status argues for charging that applicant a premium higher than a given threshold for subsidy assistance. In that case, the insurer should be allowed to direct the customer to the state's high-risk pool program. The job of confirming eligibility for the subsidy should be contracted out by the state to a neutral third party experienced in medical insurance underwriting, with private insurers collaborating to predetermine the criteria for high-risk selection. If the third party finds no basis for designating the applicant an unusually high risk, the insurer seeking the evaluation would be required to take the applicant at no more than the maximum rate allowed above the standard premium level for other average-risk insured customers. (And if the insurer makes failed claims too often, it would pay additional penalty fees to the state, thus discouraging excessive risk dumping.)

- Properly structured high-risk pools also have the potential to concentrate resources and attention on the most important, highest-cost cases. They could identify and gather exactly those individuals who need additional disease management, navigational assistance, and specialized care from centers of excellence. In addition, initial reliance on private insurers' screening and designation of high-risk applicants would retain risk-reduction incentives for both insurers and patients while tempering the bureaucratic rigidities of complex risk-adjustment calculation.

- Insurers participating in the individual market would need to offer coverage without a new risk assessment to anyone who has maintained a private insurance policy for some minimum period ("continuous coverage" protection) and is applying for new coverage under a different policy. This would mean that steady participants in private insurance markets would face a risk evaluation no more than once; they would then have the right to renew or change their policies at the same rate class from any licensed insurer. This approach would provide strong incentives to maintain

insurance coverage to avoid the risk of becoming subject to higher risk-based premiums or coverage exclusions based on future changes in health status. It would also offer a less intrusive but still effective alternative to the ACA's individual mandate to purchase insurance.

- Finally, when these reforms are first implemented, there will need to be a one-time enrollment period to allow people who have fallen through the cracks over the years to reestablish their rights by maintaining continuous coverage. Those who have forfeited their coverage would get at least one fair chance to become insured under the new rules (though at somewhat higher rates than those who had preserved their rights). But once this initial enrollment window closes, everyone would know that people who remain continuously insured are protected and that those who choose not to become insured are risking preexisting condition exclusions or higher risk-based insurance premiums in the future.

This approach to covering preexisting conditions would not be inexpensive. But its price would be minimal compared to that of the new health care law's extensive web of regulations and subsidies. Using high-risk pools to cover people who are uninsured because of preexisting medical conditions would head off the transfer of even more power over our health care system to bureaucrats in Washington. It would enlist states in a partnership to provide necessary coverage to their most vulnerable citizens. Moreover, it would not disrupt insurance arrangements that are working well for the vast majority of Americans and would leave in place the many other protections already available to people in the much larger employer-based insurance market.

Notes

1. James C. Capretta and Tom Miller, "How to Cover Preexisting Conditions," *National Affairs* no. 4 (Summer 2010), www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions.

2. If a person stays covered by job-based plans long enough, with only short periods of interruption in this continuous coverage, that person can move between jobs without fear of losing insurance protection or of having to wait longer than other new hires for coverage for ailments developed before taking a new job (if the new employer also offers health coverage to its workers). The new employer's plan must provide coverage on the same terms as are offered to other employees.

3. One problem is that HIPAA requires that a worker first exhaust the right to temporary continuous coverage under the former employer's plan (through a federal program called COBRA). Available since the mid-1980s, COBRA lets a worker keep buying into a previous employer's insurance plan, generally for up to 18 months after leaving that job, before entering the individual insurance market without being subject to a preexisting condition exclusion. For several reasons (COBRA premiums are higher for what is generally richer employer-based coverage than many ex-employees leaving a job can afford; former employees no longer receive any employer contribution to pay the premium or a subsidy through the tax exclusion for employer-sponsored coverage), many workers may take the risk of declining the COBRA coverage option and end up waiving their HIPAA rights as well.

4. Bradley Herring, Xue Song, and Mark Pauly, *Changes in Coverage in the Individual and Group Health Insurance Markets and the Effect of Health Status* (Washington, DC: Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, April 2008), http://aspe.hhs.gov/daltcp/reports/2008/HIcover.pdf.

5. Mark V. Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington, DC: AEI Press, 1999), 18. See also Scott E. Harrington and Gregory R. Niehaus. *Risk Management and Insurance* (New York: Irwin/McGraw-Hill, 1999).

6. Capretta and Miller, "How to Cover Pre-existing Conditions," 115.

7. Pauly and Herring, *Pooling Health Insurance Risks*.

8. Capretta and Miller, "How to Cover Pre-existing Conditions"; Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Baltimore, MD: Office of the Actuary, Centers for Medicare and Medicaid Services, April 22, 2010), www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

9. Common pre-ACA eligibility criteria in the states included (in addition to having been rejected for coverage, based on health reasons, by private insurers) having been refused coverage except at rates exceeding the subsidized premium offered in the state's high-risk pool; having received private coverage offers, but only with restrictive riders or preexisting condition limitations; having particular medical conditions presumed to result in rejection by health insurers; or being a dependent of a person eligible for high-risk pool coverage. The pools also often cover people who, having maintained continuous coverage under HIPAA rules, need to find new insurance arrangements in the individual market.

10. John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler, "The Effect of Medicare Coverage for the Disabled on the Market for Private Insurance" (National Bureau of Economic Research working paper no. 14309, Cambridge, MA, September 2008).

11. In 2009, the Government Accountability Office estimated that nearly 4 million additional individuals (above the 199,418 already enrolled in state high-risk pools) could be eligible for enrollment in a high-risk pool based on their uninsured status and preexisting health condition. See US Government Accountability Office, "State High-Risk Health Insurance Pools," GAO-09-730R, July 22, 2009. At the lower end of such estimates, health economist Mark Pauly first calculated that about 4 percent of the below-age-65 population have high-cost chronic health conditions, but then concluded that a much smaller fraction of them ("many thousands") actually face this problem when seeking coverage in the individual health insurance market. See Mark V. Pauly, *Health Reform without Side Effects* (Hoover Institution, 2010), 19–21. Far less-credible overestimates have been offered by the Department of Health and Human Services in 2009 and 2011 and Families USA in 2012. For example, see US Department of Health and Human Services, "At Risk: Pre Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage without Health Reform," January 18, 2011, www.healthcare.gov/law/resources/reports/preexisting.html. See also Thomas P. Miller and James C. Capretta, "Curing the Pre-existing Conditions of ObamaCare," The American, September 10, 2012, www.aei.org/article/health/healthcare-reform/ppaca/curing-the-pre-existing-conditions-of-obamacare; Thomas Miller and James C. Capretta, "Changing the Name—But Not the Political Game," Health Affairs Blog, July 30, 2010, www.aei.org/article/health/healthcare-reform/changing-the-name—but-not-the-political-game; Tom Miller and James Capretta, "Plugging the Leaks in High-Risk Pools," AEIdeas, July 1, 2010, www.aei-ideas.org/2010/07/plugging-the-leaks-in-high-risk-pools-2/.

12. Anthony T. Lo Sasso, "An Examination of State Non-Group and Small-Group Health Insurance Regulations" (working paper, American Enterprise Institute, Washington, DC, January 3, 2008), www.aei.org/paper/health/an-examination-of-state-non-group-and-small-group-health-insurance-regulations/.

13. Foster, *Estimated Financial Effects*.

14. US Government Accountability Office, *Pre-existing Condition Insurance Plans: Program Features, Early Enrollment and Spending Trends, and Federal Oversight Activities* (Washington, DC: GAO-11-662, July 2011), www.gao.gov/new.items/d11662.pdf.

15. US Department of Health and Human Services, "State by State Enrollment in the Pre-existing Condition Insurance Plan, as of September 30, 2012," November 16, 2012, www.healthcare.gov/news/factsheets/2012/11/pcip11162012a.html.

16. US Government Accountability Office, *Pre-existing Condition Insurance Plans.*

17. See note 3.

4

A Different Approach to Insurance Regulation: Stronger Incentives, Enhanced Information

Unfortunately, critics of the ACA often begin and end their consideration of a replacement plan with much shorter and more simplified versions of these types of reforms of public subsidies for health coverage and more-targeted protection against pre-existing health conditions. As important as those issues are, full replacement of the ACA needs to go much further. Choice, competition, personal responsibility, and accountability in health care need to be enhanced by a newer approach to regulation that relies on stronger market-based incentives and more useful information about the relative cost, quality, and value of different health care options. A simple return to the pre-ACA world of conventional, state-based regulation of fully insured health coverage in most states is not enough.

Policy Prescriptions:

- Facilitate interstate competition in state-based health insurance regulation.
- Consider interstate compact assistance, rather than sweeping federal legislation.
- Arm consumers with improved, unbiased information on how insurers perform in serving their customers so that their decisions can reward or punish market competitors
- Accomplish necessary health benefits exchange goals (more informed choices, stronger competition) through less government-centric mechanisms. Keep them as voluntary, nonexclusive, and information-based options instead of single-track gateways to tighter regulation, income redistribution, and political dependency.

Continuous Coverage Incentives

The individual-coverage mandate in the ACA hopes to provide a political shortcut that bypasses or obscures these issues while providing the glue to secure a massive expansion in government overregulation of the health care sector. Such an unprecedented and sweeping mandate is based on mistaken premises, faulty economic analysis, shortsighted politics, and seriously flawed health policy. Enactment of the individual mandate as the centerpiece of the ACA remains administratively challenging, politically implausible, and economically unnecessary.[1]

The continuing debate over the individual mandate and its underpinning of the ACA's other provisions for health insurance regulation, health care financing, and delivery system restructuring requires a more realistic understanding of the limits of government coercion and the balance of power between government and citizens in our political system, as well as the long-standing societal values that sustain both. Other effective ways to ensure necessary health insurance coverage for more Americans are less onerous, less unpopular, and less constitutionally questionable.

A better mix of policy reform ingredients would begin by relying first on persuasive incentives rather than coercive commands. These incentives include extending protection against new medical underwriting because of changes in health status to those in the individual market if they maintain qualified, continuous insurance coverage. Improved access to usable information about the cost, quality, and value of

health care, as well as better prioritized insurance coverage subsidies, also are essential.

Choice and Competition for Health Insurance Regulation

One-size-fits-all approaches to health insurance regulation are prone to limiting consumer choices and imposing excessive regulatory burdens, whether they operate at the national level (particularly through the ACA) or at the state level (through traditional state regulation of fully insured insurance products and their carriers). Limiting the size and scope of an exclusive franchise for health insurance regulation to state boundary lines does not by itself promise to make regulation more accountable or market sensitive. Empowering consumers with a greater diversity of affordable health benefit choices will require exposing exclusive state health care regulation based on geography to competition from other potential brands of regulation offered in other states.

Enactment of the individual mandate as the centerpiece of the ACA remains administratively challenging, politically implausible, and economically unnecessary.

The traditional role of states in health insurance regulation has been increasingly limited to the small-group and individual insurance markets. The growth of self-insured health benefits plans sponsored and financed by almost all large employers and many mid-sized ones has reduced the overall reach of state regulation. The Employee Retirement Income Security Act (ERISA), enacted by Congress in 1974, generally preempts most state regulation of employers offering such plans. Until enactment of the ACA, it also ensured that, with a few exceptions, federal health policy toward self-insured employer-sponsored coverage would tilt toward a less prescriptive regulatory approach that encouraged greater flexibility in health benefits design, financing, and administration.

On the other hand, employers and workers in smaller firms (particularly those with fewer than 50 employees) have had to bear the brunt of excessive health insurance regulation in many states. Smaller firms generally are unable to self-insure and gain ERISA preemption protection from benefit mandates, restrictions on rating and underwriting, and other regulatory burdens at the state level. Although insurers and consumers of individual-market products also are subject to state regulation, the more fragile nature of this smallest market has in most cases limited the degree to which the tightest state restrictions on risk rating, mandated benefits, and insurer practices apply to individual market products.

In general, increased state regulation in recent decades has raised the cost of health insurance and limited the range of benefits package design. Various state government regulatory attempts to force low-risk insureds to subsidize high-cost insureds often were counterproductive. The attempts used devices like guaranteed issue (people who apply for insurance once they are sick must be offered the same terms as the continuously insured) and modified community rating (higher premiums for younger and healthier people to lower those of older, sicker, and generally wealthier people). They triggered premium spirals that drove younger, healthier, and lower-income workers out of the voluntary insurance market.[2] Many states also increased the number and scope of mandates to cover specific types of benefits and providers, further increasing the added regulatory cost contribution to rising insurance premiums. Excessive state regulation at times has also encouraged exit from the market by smaller insurers, increased consolidation in the insurance industry, and distorted market-based prices. In other words, state health insurance regulation more often has been at least part of the problem, rather than part of the solution.

A better alternative for addressing patterns of state-based regulatory failure is not a new round of heavy-handed federal rule-making or preemption

(such as is included in the ACA), but rather facilitation of competitive federalism—revitalized state competition in health insurance regulation that reaches across geographic boundary lines. Such regulatory competition would limit the excesses of geographically based monopoly regulation. Currently, insurance consumers (at least in the non–self-insured market) are subject to a single state government's brand of insurance product regulation. Solely by virtue of where they live, they are stuck with the entire bundle of their home state's rules. Short of moving to another state, they are unable to choose ex ante the type of health insurance regulatory regime they might prefer and need as part of the insurance package they purchase.

Competitive federalism could facilitate diversity and experimentation in health insurance regulatory approaches. It would discipline the tendency of insurance regulation to promote inefficient wealth transfers and instead favor individual choice over collective decisions driven by interest-group politics. In short, it would improve the quality of health insurance regulation, enhancing the availability and affordability of health insurance products. Insurers facing market competition across state lines would have strong incentives to disclose and adhere to policies that encouraged consumers to buy their products and services. Employers and individuals purchasing insurance would migrate to state regulatory regimes that did not impose unwanted mandates but, instead, fit the needs of consumers. State lawmakers would become more sensitive to the potential for insurer exit. At a minimum, interstate regulatory competition would provide an escape valve from arbitrary or discriminatory regulatory policies imposed at state or federal levels.

Several political shortcuts to the reform of state-based health insurance regulation would be counterproductive. They include broad-based federal preemption of state activity, which might achieve short-term political objectives but fail to sustain them structurally over time. Optional federal chartering, in which health insurers can bypass state regulation for a single federal regulator and build a single national market for their products, is another tactic. But this approach ignores the danger of creating long-term incentives for a new and bigger monopoly regulator that will only re-create past problems on a larger scale with even less accountability.

Key design requirements for regulatory competition in health insurance should include

1. *Clear Regulatory Primacy.* Only one sovereign (the lead, or primary, state regulator) has jurisdiction over a particular set of health insurance transactions, and its law controls the primary regulatory components of the regime governing them. Other jurisdictions—called "secondary" states—provide regulatory reciprocity (also known as the "principle of mutual recognition" in the European Union) by respecting and enforcing that primary state's insurance charter and accompanying rules. Such reciprocity works through private arbitrage of jurisdictional competition, rather than politically mandated harmonization that suppresses competition.

2 *Domicile-Based Regulatory Choice*. Health insurers choose their statutory domicile, which influences the bundle of laws and regulations attached to the products they sell and make these rules part of the purchasing option they present to consumers.[3] Insurers and their consumers can exercise the right of free exit: they can vote with their feet and their pocketbooks by moving between domiciles. Insurers can relocate to alternate jurisdictions at relatively low cost. Consumers may choose not only the state in which they live but also the legal rules attached to the insurance products they buy.

3. *Primary State Incentives and Responsibilities*. States must receive some benefits, such as tax revenues, from competing to produce specific laws and regulations that reduce insurers' business costs and increase the value of their products. Conversely, states also must feel within their own borders a sufficient level of any negative consequences of the regulatory regimes they choose to adopt and export to consumers in other states.[4]

4. *Thorough Disclosure and Informed Choice*. Competition among insurers to attract marginal, but more informed, consumers must operate to protect other consumers who are less aware or informed of the particular regulatory regime linked to their insurance arrangements. Rather than presenting a single set of contract terms on an all-or-nothing basis, insurers can offer consumers a menu of alternative policies priced to reflect different regulatory approaches.

5. *Multistate Solvency Arrangements*. Solvency regulation should remain decentralized and kept at the state level to avoid federal domination over other regulation in the name of protecting consumers and taxpayers. Regulatory competition for insurance product design, pricing, and pooling could be accommodated within the current state-based guaranty fund system in a manner that limits an individual state's opportunities to impose costs on other jurisdictions.

Competitive federalism could facilitate diversity and experimentation in health insurance regulatory approaches.

Several mechanisms or paths could help achieve more vigorous interstate regulation competition. One approach advanced several times over the last decade has involved federal legislation setting an "insurer domicile" rule in place of a "site of transaction" rule for determining applicable state law and regulatory authority. At least, this could be a default setting for multistate transactions for which the respective parties do not otherwise designate operative law. It would authorize a health insurer offering an insurance policy in one primary state (the primary location for the insurer's business) to offer the same policy type in a secondary state. The product, rate, and form filing laws of the primary state would apply to the same health insurance policy offered in the secondary state.

Another route to interstate competition in insurance regulation might be built on decisions by individual states to allow insurance companies licensed in other states to conduct business in their state. Under such "regulatory due deference," regulators in secondary states would treat proof of licensure and good standing in the primary state as prima facie evidence of qualification for licensure in the secondary state; however, they can still require additional routine documents, fees, and compliance of the primary state's insurance department with broadly accepted accreditation standards. Initially, an individual state's decision to grant regulatory due deference would be similar to a declaration of unilateral free trade in health insurance products. The state would be eliminating or reducing its regulatory restrictions on out-of-state insurance to benefit its citizens and to provide a model for other states to emulate.

Several states have explored legislative offers to authorize sale and purchase of insurance provided by out-of-state insurers.[5] Similar reciprocal agreements among states could be bolstered and expanded through more formal interstate compacts. These contracts between states are authorized under the US Constitution as the equivalent of a treaty between sovereign powers. They require the consent of Congress if they increase the political powers of the contracting states or encroach upon the "just supremacy" of the United States.

The special-interest politics of health insurance regulation often mean that states whose residents would benefit the most from jurisdictional competition are least likely to participate in either interstate compacts or regulatory due deference. Nevertheless, preliminary evidence points to some potential gains from facilitating a rearrangement of the regulatory deck of cards.[6] The effect of interstate competition will be greatest on states that are regulatory outliers, rather than being distributed more evenly across all states. Out-of-state insurers also will face market-based difficulty in penetrating new state markets without preestablished provider networks.

Proposals for interstate competition in state health insurance regulation also will face predictable "race to the bottom" warnings. However, those who prefer the set of choices within the current health insurance regulatory system can continue to use them. Other consumers who see advantages in new and different regulatory approaches should be allowed to try those. Reputational concerns will provide both constraints and incentives for the choice of regulatory regimes by established insurance firms. Insurers can gain little on a long-term basis by contracting for a particular set of laws and forums to govern their insurance that most consumers know would unduly favor a particular insurer over its customers.

Normal competitive pressure would discourage private insurers from repeatedly switching their state insurance regulator on an opportunistic, short-term basis. Insurers would profit from issuing credible promises not to remove to another state so that they can reduce doubts about the enforceability of certain provisions of their insurance contracts. Insurers also would tend to incorporate in states with an established tradition of regulatory stability and where their economies were more dependent on the insurance industry.

State regulators could coordinate their law-enforcement activities to deal with interstate jurisdiction problems. They also could require compliance with the standards of a centralized body, like the National Association of Insurance Commissioners, to assist necessary uniformity in certain areas. Or Congress could establish a default rule for enforcing certain actions (such as those involving consumer fraud or other improper market conduct) that affect consumers in a secondary state but involve insurance policies regulated by a primary state. The rule would authorize insurance regulators in the secondary state to treat the insurer as if it were primarily licensed there.

Defenders of the current regulatory structure, let alone the even more dubious one ahead under the ACA, cannot simply assume that a hypothetically perfect, well-designed system of more restrictive state (or federal) health insurance regulation will materialize in the future. They should be challenged to demonstrate its measurable benefits compared to a more decentralized system of regulatory competition—a system much more likely to deliver the contractual assurances, services, and features for which buyers are willing to pay.

The real goal is better regulation, not to eliminate it. Insurance regulators, too, should meet more of a competitive market test. After all, too many states have already been running a different race to the bottom in terms of more disappointing outcomes for health care costs, coverage, choices, and competition when saddled with too much regulation.

The effect of interstate competition will be greatest on states that are regulatory outliers, rather than being distributed more evenly across all states.

Recalibrating Information-Based Health Insurance Regulation

Neither the pre-ACA version of exclusive state government regulation of fully insured health coverage nor the ACA's plan for a more dominant role by federal government regulators offers a better path forward for consumer-friendly and value-based insurance regulation. Even several other recent proposals for regulatory competition among the various states offer at best only a tool to move in this direction, while generally failing to define its broader objectives and guiding principles.

Increasing choice and competition in health insurance is necessary, but not sufficient, to improve the health care options available to consumers. Patients also need better choices regarding who delivers their health care and better information about how well they do it. The primary problems with our health care delivery system do not involve the quality or cost of health care services alone as much as their overall value (the relative combination of cost and

quality for a given episode of treatment). US patients receive a lot of beneficial medical services, but they may carry high costs, vary unpredictably in quality, and too often fail to reflect good value.

US patients receive a lot of beneficial medical services, but they may carry high costs, vary unpredictably in quality, and too often fail to reflect good value.

Health care frequently is dispensed and received within a complex, fragmented delivery system that lacks sufficient transparency to allow its participants to make sense of what really matters and what is going on. We often just do not know enough about what works and who performs better, if not best, in treating patients. The system still lacks sufficient data, effective measures, and workable standards to assess the value of health care treatment options and help patients choose their providers. Even when such information exists, it is not widely available or usable at the consumer level.

Better, not necessarily more or perfect, information about the value of health care services as they actually are delivered in everyday medical practice could substantially improve consumers' choices and their health outcomes. In most other sectors of the economy, transparent and usable information strengthens competition and improves the overall level of services. On the demand side, information-based incentives can shape the spending decisions of patients and other purchasers. Enhanced information also can produce positive supply-side effects within the physician and hospital communities if health care providers learn that they are not doing as well as some of their peers in terms of respected measures of quality.

The ACA's scheme for micromanaging private health care products, processes, and providers relies primarily on tighter federal regulation of health insurance. A better alternative would empower and encourage state policymakers to move toward an information-based approach to their own brands of health insurance regulation. Of course, the traditional tasks of state regulators in ensuring the solvency of insurance carriers, enforcing contractual promises, resolving disputes, and policing fraudulent practices would remain important. But we need to encourage a transition, at least on the margins, toward rebalancing the state-level regulatory approach and emphasizing a larger role for investigating and prescreening the performance of insurance market sellers and the quality and cost of their products.

Instead of simply approving or rejecting potential carriers, products, and practices, policymakers should rely more on the decisions of individual customers to reward or punish market competitors, once the customers have been better armed with unbiased informational assistance from state regulators. Rather than delivering more mandated benefits, standardized forms, and rating prohibitions, state and federal regulators should recalibrate their mission toward developing and disseminating better information on how insurers perform in serving their customers. The guiding rule is to expand informed consumer choices, not mandate or limit them.

The objective of providing greater information transparency in health care is saluted by almost everyone but achieved by too few parties. Both federal and state government officials can improve the development and dissemination of more accessible and actionable health care information, but they should not be the sole arbiters of what it means and how it is used. Aggregation of as much health care data as can be accurately and securely derived from multiple sources is an essential, but still preliminary, step in developing a more transparent and value-conscious health care system. Such data—whether from administrative processing of claims, medical charts, prescription drug transactions, clinical lab findings, patient registries, or electronic health records—needs to be collected just once, but used often.

Some early efforts at the federal level may help make more provider-identifiable Medicare data available to qualified intermediaries.[7] However, ACA provisions to do so still suffer from a "Washington knows

best" mind-set that sees private sources of health care data primarily as contributors to the federal government's ultimate determinations of cost, quality, and value. Instead, the government and private parties should be equal partners in assessing the meaning and use of whatever a richer, more comprehensive stream of data might tell patients, providers, and payers about how well different parts of the health care system are performing. The early stages of ACA implementation in this area remain biased toward setting *national strategies* and limiting the scope and scale of data shared with private-sector analysts. They focus too much on comparative effectiveness of medical treatments at broader population levels in theory and too little on the comparative efficiency and effectiveness of health care providers in treating individual patients in practice.

While national policymakers await fulfillment of overly optimistic promises of wider adoption rates and meaningful use of electronic health information tools, states can make their own important contributions to the process of collecting and sharing data. They can set a better tone for cooperative data sharing but competitive interpretation and use of it by private parties. States should start with more tangible state-level measurement and reporting of the relative costs of routine and frequent health care services, actual out-of-pocket costs consumers are likely to face, and how patients evaluate their own care experience with different providers. They should focus on enhancing the "public goods" production of aggregated data from both government-funded and privately paid health care transactions. These can supply the raw material from which others (such as competing private insurers) can derive more refined measures of all-in costs, health outcomes, patient experience, and relative provider performance.

Some states have made modest progress in simpler price transparency measures, which summarize indicators of the relative prices charged by different providers for discrete medical procedures and unbundled health care services.[8] However, this often falls well short of what patients and payers really need to know—the overall cost per episode of care. Knowing the individualized list price for a procedure is one thing, but it's another thing to know what that price means in terms of the likely *total costs* over the entire continuum of care. This is particularly true for chronic conditions involving multiple providers whose individual contributions might not be well coordinated.

Federal and state government officials can improve the development and dissemination of more accessible and actionable health care information, but they should not be the sole arbiters of what it means and how it is used.

Other states fall short by reporting only average or median charges (but not what is actually paid under negotiated contract prices) for various hospital services. Even reporting of the total amounts that hospitals receive from all payers still may fail to include separately billed charges for related services by physicians and other professionals during inpatient stays or outpatient visits.

States generally run two of the largest health care programs in their region: a state Medicaid program and health insurance plans for state government workers. Most of them also are involved in guiding, if not directly operating, an all-payer claims database (APCD) in their state. So they already possess a large supply of underlying data about health care costs, quality, and value in their market areas, but they generally fail to do enough with it to help generate more useful and usable information for health care purchasers and providers. Although state government agencies have not demonstrated any particularly great comparative advantage in making more refined and sophisticated assessments of health care value, they could contribute greatly to helping other parties do so through their role in paying health care bills,

administering benefits programs, and assembling claims transactions data for their state-run programs.

In most states, the most important building block for information transparency efforts involves the sophistication and capabilities of the state's APCD. Those databases are usually created by state mandate and generally rely on data derived from various medical claims, along with eligibility and provider files, from private and public payers. Although some states have created various types of hospital report cards on cost and quality or web portals with price and quality information ranging from health insurance options to select medical treatments, the assumed scope, scale, and predictive power of their current APCDs can easily be overestimated. The limited range and depth of the billing and discharge records on which they primarily rely fall short of the type of patient-identifiable clinical information or data on health care outcomes that policymakers, providers, payers, and patients often envision. Lag times between initial data collection and its release to users can limit real-time analysis of cost and utilization patterns. But the costs to collect more comprehensive information about all health care delivered in a state may exceed the likely payoff. For example, data that travel through other hands too far from the originating source may be prone to misinterpretation. In addition, other potential data sources, such as self-funded health plans and negotiated hospital charges subject to contractual "gag clauses," may remain outside the reach of state-level APCDs.

Achieving greater information transparency also requires greater tolerance for its practical limits. We cannot measure everything, let alone measure it well.

Nevertheless, more energetic and imaginative states can use APCDs to improve understanding of the overall health of their citizens, such as rates of disease and diagnoses and even underlying causes of morbidity. One perennial limiting factor is that this information is an important source of power; hence, some parties are not eager to pool and share it. Recent expansion of the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project suggests some additional ways to merge and synthesize state APCD data into more useful measures of health care effectiveness and efficiency at both the system and provider levels. States looking to improve the information base for their patients, payers, and providers should pursue greater federal grant support to enhance the clinical content of state-level administrative claims data (such as by requiring that key "present on admission" indicators be included in hospital claims records and linking hospital-based claims data to other laboratory services data sources).

State APCDs should first determine which health policy questions their resources and skills can answer effectively. Instead of focusing too much on facilitating elusive, long-term evaluations of the clinical effectiveness of particular treatments, they might start with more tangible measurement and reporting of the relative costs of routine and frequent health care services, the actual out-of-pocket costs that consumers are likely to face in their own insurance plan, and how patients evaluate their care experience with different health providers.

Health information transparency reforms cannot work in isolation. They must overcome the lack of strong financial incentives for many consumers with comprehensive health insurance (and modest cost-sharing expenses) to focus on total costs, along with increased concentration in health care provider markets that gives dominant providers greater pricing power and enhances geographic market segmentation.

Achieving greater information transparency also requires greater tolerance for its practical limits. We cannot measure everything, let alone measure it well. Information is not free. And because it often represents sources of power and profit, it may not always be pooled and shared readily. But working within the constraints of existing data sources, improved measurement and reporting at the state level, along with

expanded access to federal health program data, could help achieve reasonable minimum thresholds for measurement validity. Establishing baseline standards that provide sufficient consistency but do not stifle further innovation could facilitate payer-provider collaboration on practical, consensus approaches that will help move us beyond the end of the beginning of performance measurement. Such a "best available" measurement approach has driven measurement and performance improvement in other sectors of the economy. This approach would be vastly preferable to remaining in the dark about performance variation until more exacting levels of statistical precision can be met.[9]

Better-designed provider-level measurement can make the cost-containment tools of differential reimbursement, high-performance tiered networks, value-based benefit design, clinical reengineering, and the responsible choices they offer more visible and effective. All of those tools need a more transparent and credible evidence base to make the judgments they signal sufficiently acceptable and appealing to patients, providers, and other purchasers. Such measurement can also begin to construct a model of state health care regulation that relies more on providing useful information to consumers instead of simply mandating or limiting their choices. This change in mind-set on regulatory reform and transparency would be a powerful agent to foster greater choice and competition in health care.

Making Effective Connections: With or without Health Benefits Exchanges

The ACA version of health benefits exchanges is a classic example of a limited, but potentially good, idea mutating into a politically driven gateway to overregulation, income redistribution, and greater control by the federal government of health care decisions. The more benign concept of exchanges envisioned them as mechanisms to help coordinate a common marketplace in which willing insurance buyers and sellers might choose to reach private agreements. Exchanges could expand the range of limited choices available to most workers employed by smaller firms, as well as to individuals seeking coverage outside the workplace. They might also serve as impartial clearinghouses for information comparing the features and performance of various health insurance plans in a particular market area. Finally, they could help connect individuals with taxpayer subsidies available for their insurance choices and even consolidate multiple sources of financial contributions for someone's coverage (multiple employers, public subsidies, personal funds) into a single payment platform.

The ACA version of health benefits exchanges is a classic example of a limited, but potentially good, idea mutating into a politically driven gateway to overregulation, income redistribution, and greater federal control of health care decisions.

The original case for establishing health insurance exchanges pointed to clear problems of affordability, access, and choice in current private insurance markets for individuals and small businesses. Although individual insurance markets could not possibly perform as badly as the health policy elites (who recoil from them like vampires avoid garlic) commonly believed, their customers have been burdened by high loading costs for marketing and administration by insurers. The limited role of individual insurance as a residual market product for customers lacking better options elsewhere in the pre-ACA insurance world also strained its ability to pool and manage risk consistently. The small-group insurance market was, and still is, whipsawed by counterproductive state-government regulation, a shrinking base of overburdened small-employer customers, and a shortage of competitive insurance choices.

Health insurance exchanges are not new ideas. Various types have been proposed for years as intermediaries to manage the relationship between insurers and their customers and perhaps to better organize insurance markets. However, finding consensus in identifying problems is not the same as agreeing on the actual terms of sustainable solutions. Exchanges can be dialed up or down the regulatory spectrum. At one end, they might simply provide some standardized comparative information on the benefits, premiums, and service quality offered by insurers in a particular market. A little further up the scale, they might distribute private payments and public subsidies, simplify insurance purchasing and enrollment, and reduce transaction costs. At the other end, they could become the exclusive engineers charged with redesigning and overseeing most, if not all, insurance sales and purchases.

One option is to simply stand back and hope that federally run exchanges will be unsuccessful and collapse for a combination of political, legal, and administrative reasons.

The policy parameters involving the role and power of an insurance exchange include whether it is voluntary or mandatory. Does it have an exclusive franchise, or must it compete for customers? Over what geographic territory and for which market segments does it operate? Does it exercise substantial market power as a purchaser or even more political power as a regulator? Does it try to pool similar risks or cross-subsidize very different ones? Does it limit or expand choices of carriers, plans, and benefits? The more you want to try to do, the more regulatory complexity you have. You risk overloading each decision with another more sweeping one down the road until the exchange starts to look like a public utility commission.

The ACA designed its version of state exchanges to play a much greater, and more controversial, role. Their duties include

- Ensuring compliance with tighter federal regulation of health insurance;
- Expanding state Medicaid programs;
- Enforcing the individual coverage mandate;
- Administering the new health law's income-based subsidies;
- Policing insurers' premium prices; and
- Eventually controlling a much larger share of the private insurance market.

In just about every case under the ACA, the decision was made to go for more rather than less, under the assumption that state-run or federally run exchanges would not be able to adequately "reform" the insurance marketplace if they left too many stray sheep outside their fences. The ACA rules interpreted a level playing field and common rules regarding pricing and benefit design as requiring the rest of the private insurance market to conform to the exchange's politically designated operating rules, rather than the other way around. Competing against what is most commonly done in the rest of the marketplace and leaving consumers to choose what they prefer apparently would be too hard and fail to deliver the desired political outcome. Of course, whether any resulting selection by consumers is called "adverse" depends on whether the criterion used is political or personal.

The ACA's statutory text and subsequent regulatory guidance are full of limits and specifications for the range of the required "essential" and other permitted tiers of qualified benefits, along with tight restrictions on cost sharing. The main factor in setting some eligibility limits (individuals without offers of employer coverage or participating small firms with no more than 100 employees) was budgetary. The on-budget costs to taxpayers for moving even more millions of Americans into new, more heavily subsidized, exchange-based coverage on a faster timetable would be too transparently unaffordable, administratively daunting, and politically disruptive.[10] In any case, the ACA's rules for guaranteed-issue and not-so-adjusted community rating will be applied nationwide, even to

fully insured (if not yet self-insured) private plans operating outside the ACA's exchanges.

The ACA exchanges initially were marketed as a means to provide new choices to people largely shut out of the traditional employer-sponsored group health insurance market, as well as to smaller businesses struggling to offer or maintain group coverage for their workers. But the law authorizes states to expand offers of exchange-based coverage to businesses with more than 100 employees, starting in 2017. Critics of the expanding role of federal regulation, mandates, and subsidies under the ACA regime argue that this would open the door wider for Washington's dominant market share and more complete regulatory control in whatever remains of "private" insurance markets later this decade. When combined with narrow grandfathering and grace periods for many existing insurance benefits plans (temporarily protecting them from the newer ACA requirements for fully insured health plans[11]) that are biased toward an early expiration date, the real goal of the federally directed exchanges appears to be to construct a roach motel of centralized regulation, where private plans and their enrollees may check in but are not allowed to check out.

It turns out that to control one thing, and then another thing, and then more and more unanticipated things, many congressional legislators and their designated bureaucrats believe they will have to control almost everything.

Not surprisingly, many state officials balked at participating in the ACA's model for "state-run" exchanges, which appeared to be part of a top-down bureaucratic approach for taking control of state insurance markets under the guise of implementing the new health law, rather than offering a more decentralized, market-driven alternative. Several dozen state governors and state legislatures either opposed outright the creation of ACA-compliant exchanges or urged a cautious, go-slow approach to further implementation until more details were provided (or the Supreme Court decided to overturn the health law as unconstitutional).

At this point, it appears that a large majority of states will not meet the ACA's initial deadline of January 1, 2013, for federal certification that their state-based exchanges will be ready to operate one year later, when the law's expansion of exchange-based health insurance coverage is supposed to begin. HHS has proposed several alternative ways to establish health exchanges by that date, including state-federal partnerships (in which states perform at least some of the required exchange functions) and federally facilitated exchanges (mostly a new name for federally run exchanges).[12] However, any of those approaches to developing functional health benefits exchanges under the ACA faces major obstacles:

Political suspicion remains widespread in many states that the temptation for regulatory overreach in exchange-like mechanisms cannot be kept in check.

1. Most states will either refuse to set up their own exchanges or prove unable to do so for political or technical reasons.

2. The administrative challenges in orchestrating necessary data streams from multiple sources (to determine applicants' eligibility for federal subsidies), creating essentially "new" insurance markets, and handling a potential surge in demand for such coverage remain daunting and unprecedented.

3. Serious legal questions about the actual statutory authority of federally run exchanges to administer premium subsidies remain unresolved, and they are likely to dilute the power of any arguments that states must set up their own exchanges to avoid losing control over a federally run exchange in their state.[13]

What should states do?[14] One option is to simply stand back and hope that federally run exchanges will

be unsuccessful and collapse for a combination of political, legal, and administrative reasons. This is politically appealing in states where opposition to this part of the ACA runs strong, although it leaves unaddressed what other sorts of health insurance reforms may still be needed within states.

Another option is to approve initial versions of their own state-based exchanges that operate under very different and more market-friendly rules that are not likely to comply with current Obama administration regulatory guidance.[15] For example, such state-run exchanges would be likely to adopt an "any willing seller" approach to insurer eligibility, rather than operate as an active, exclusive purchaser that prescreens participating insurers to gain bargaining leverage and ensure their compliance with standardized coverage benefits and premium rate limits. They would operate more like a market facilitator of new coverage options (for state residents seeking individual coverage and for small businesses looking for alternatives to traditional group coverage), rather than as administrators of an expanded quasi-public insurance program similar to Medicaid. Flexibility, choice, and open competition would be more important than standardization, selective contracting, and compulsion.

Such exchange-like mechanisms would involve willing consumers, private providers, and employer sponsors as partners rather than as subjects. Administrators would focus on normal oversight to ensure compliance with existing state and federal laws, without trying to expand them further. Exchange rules would be adopted to mesh with current state rules for the rest of the state-regulated market, rather than the opposite. Health benefits guarantees would be kept to a minimum, with a broad interpretation of rough actuarial equivalence ensuring opportunities for innovation and preference-sensitive variation.

Such state exchanges would rely much more on developing and disseminating consumer-empowering, impartial information about coverage options, rather than on enacting and enforcing choice-limiting regulation. Once a state sets the very basic parameters for insurance plans, it would allow carriers to innovate and differentiate their products, as long as they adequately inform potential consumers at the point of purchase. State administrators would focus on enhancing consumer education, engagement, and empowerment with information tools. They would contractually outsource most of the technical operations to private vendors and maintain the difference between providing a single shopping point for convenience and requiring an exclusive destination for political control.

Nevertheless, political suspicion remains widespread in many states that the temptation for regulatory overreach in exchange-like mechanisms cannot be kept in check, given the ACA's underlying plan to use them primarily as an enforcement arm for its insurance rules and a distribution channel for its income-based premium subsidies. Quite simply, any state officials involved in establishing a state-run exchange in jurisdictions opposed to most of the ACA's mandates and regulations will be seen as aiding and abetting the latter, rather than vigorously resisting them.

Hence, many states wanting to improve their insurance markets for individuals and small firms will need to consider establishing a different type of mechanism. It would operate primarily to ensure that beneficiaries can be connected seamlessly with taxpayer subsidies for health insurance and useful information for making their coverage choices. To avoid the pitfalls of setting up an exclusive political franchise, states should provide these subsidy connectors only as a competitive option within the larger insurance marketplace. They may also encourage the further growth of nonexclusive private exchanges as either competitors or replacements for state-sponsored ones. If any such exchanges or other mechanisms serve a useful role and provide competitive advantages, consumers will choose to purchase insurance through them. Their market share would be determined by the decisions of willing buyers, rather than the designs of political brokers. Consumers can redesign their local insurance markets by voting with their own money.

Notes

1. See Thomas P. Miller, "The Individual Mandate: Ineffective, Overreaching, Unsustainable, Unconstitutional and

Unnecessary" AEI, March 23, 2012, www.aei.org/papers/health/healthcare-reform/ppaca/the-individual-mandate-ineffective-overreaching-unsustainable-unconstitutional-and-unnecessary/.

2. Anthony T. Lo Sasso, "An Examination of State Non-Group and Small-Group Health Insurance Regulations" (working paper, American Enterprise Institute, Washington, DC, January 3, 2008), www.aei.org/paper/health/an-examination-of-state-non-group-and-small-group-health-insurance-regulations/.

3. Other options for insurers might include using "choice of forum" or "choice of law" clauses in their standard insurance contracts to determined the applicable forum and law, respectively, that governs transactions.

4. For these reasons, a secondary state regulator should not be able to have exclusive rights to premium tax revenue collected from an out-of-state insurer selling policies in that state. Such revenue either should be shared with a primary state regulator or allocated on the basis of the actual regulatory costs incurred by the respective states. In addition, eligible policies regulated by primary states must actually be offered for sale there, and it may be necessary to ensure that at least a minimum percentage of the sales revenue of an insurer they regulate is derived from such primary state transactions. Primary states should also be required to contribute their pro rata share of any secondary state assessments for high-risk pool coverage or other mechanisms to ensure HIPAA-guaranteed access to care for their vulnerable populations.

5. Tom Miller, "Choice and Competition in Health Care," in *The Great Experiment: The States, The Feds and Your Healthcare* (Pioneer Institute, 2012): 62–63.

6. Stephen T. Parente et al., "Consumer Response to a National Marketplace for Individual Health Insurance," *Journal of Risk and Insurance* 78, no. 2 (2010): 1–23. See also Aparna Mathur, "Comments on Consumer Response to a National Marketplace for Health Insurance," American Enterprise Institute, July 31, 2008, www.aei.org/files/2008/07/31/20080731_MathurPresentation.pdf.

7. Department of Health and Human Services, "Medicare Program; Availability of Medicare Data for Performance Measurement; Final Rule," *Federal Register* 76, no. 235 (December 7, 2011): 76542–71, www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31232.pdf.

8. More than 30 states require some type of public reporting of hospital charges or reimbursement rates. Some states' all-payer, all-claims databases extend in part to reporting of emergency room and ambulatory procedure charges. For example, the state of Minnesota's web portal lists the average payment made by health insurance plans for over 100 common medical procedures, including lab services, office visits, mental health care, and obstetrical services. South Dakota's hospital pricing website in 2008 expanded its listing of median prices for the top 25 inpatient procedures at hospitals in the state to other outpatient procedures. Wisconsin was among the first set of states to require individual hospitals to submit data on their prices and lengths of stay, but the information did not begin to reach the general public effectively until the state delegated that task to the Wisconsin Hospital Association in 2003. See National Conference of State Legislatures, "State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges," September 2011, www.ncsl.org/default.aspx?tabid=14512.

9. Thomas P. Miller, Troyen A. Brennan, and Arnold Milstein, "How Can We Make More Progress in Measuring Physicians' Performance to Improve the Value of Care?" *Health Affairs* 28, no. 5 (2009): 1429–37; Thomas P. Miller, "Transparency in Health Care: What Consumers Need to Know," AEI, April 18, 2007 (adapted from Heritage Foundation lecture of October 5, 2006), www.aei.org/speech/health/transparency-in-health-care.

10. As the Obama administration's principles for health reform were converted into legislative language, the White House had to master a difficult political balancing act. This involved reassuring many Americans anxious about disruptions to their current health coverage and care arrangements or about mounting federal budget deficits, while offering more generously subsidized health benefits to lower-income constituents. The reassurance component necessitated reaching an initial truce with employer-sponsored insurance plans. Keeping employers' "private" money on the table also helped limit the net budget cost of the first installment of insurance coverage growth. Relying on expanded Medicaid eligibility as a less expensive way to accomplish about half of the total targeted coverage expansion allowed federal dollars to be stretched further, given Medicaid's very low reimbursement rates for providers. The public-plan option was politically

radioactive to highly energized grassroots opponents, who feared that the legislation would quickly lead to a single-payer system. Moreover, the combination of vastly expanded "public plan" Medicaid coverage and much tighter political regulation of "private" insurers in subsidized health insurance exchanges accomplished most of the larger political objective of increasing dependency on politically brokered health care, with fewer of the red lights signaling a more direct and expensive expansion of Medicare-like coverage to displace private insurance intermediaries. The final law relied on ambiguity, deferred decision making, and administrative complexity to lessen political concerns about a federal takeover of traditionally private spheres of health care decision making. However, gaining permanent regulatory authority over a vast expanse of health care operations and decisions—regardless of how many blanks needed to be filled in later—fulfilled a crucial political imperative for Democratic party leaders. It also facilitated the continued, less-threatening appearance of private operation of most current health care arrangements, albeit under tighter—and potentially expanding—political management. See Thomas P. Miller, "Health Reform: Only a Cease-Fire in a Political Hundred Years' War," *Health Affairs* 29, no. 6 (2010): 1–5.

11. Annie L. Mach and Bernadette Fernandez, "Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act," Congressional Research Service, November 1, 2011. See Appendix B, "Applicability of Market Reforms to Health Plans" (19).

12. Health and Human Services Department, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* (Final Rule March 27, 2012), www.federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans.

13. Critics of an Internal Revenue Service final rule issued in May 2012 argue that it directly contradicts the actual statutory language of the Affordable Care Act for exchange-based health insurance. See Jonathan H. Adler and Michael F. Cannon, "Taxation without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA" (Case Research Paper Series in Legal Studies Working Paper 2012-27, July 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2106789; *State of Oklahoma ex rel Scott E. Pruitt v. Kathleen Sebelius and Timothy Geithner* (Case No. CIV-11-030-RAW, Amended Complaint for Declaratory and Injunctive Relief), www.healthreformgps.org/wp-content/uploads/Amended_complaint.pdf; and James F. Blumstein, Testimony before House Committee on Ways and Means, Health Subcommittee, September 12, 2012, http://waysandmeans.house.gov/uploadedfiles/house_ways_and_means_testimony92112.pdf.

14. Thomas P. Miller, "State Decisions on Health Exchanges: Early Indicators for Obamacare's Post-election Health," AEIdeas, November 13, 2012, www.aei-ideas.org/2012/11/state-decisions-on-health-exchanges-early-indicators-for-obamacares-post-election-health/.

15. Scott Gottlieb and Tom Miller, "How to Reform ObamaCare Starting Now," *Wall Street Journal,* October 14, 2010.

5

The Bigger Picture

The "replace" reforms described thus far operate more or less within the parameters of how health care is financed in general and how most of it is covered by insurance in particular. A narrow focus on those important, but not exclusive, forces shaping health outcomes for most Americans can lose sight of what else needs to be improved within our overall health care system.

For example, health care delivery needs to become less expensive, more consistent, better coordinated, and easier for patients to navigate. Many of the ACA's provisions for delivery-system reform rely too much either on bureaucratized, top-down management of health care or unproven science fair experiments that lack scalability. Its prescriptions remain biased toward political rewards for compliance with process requirements rather than economic incentives to develop and disseminate innovative practices that improve outcomes.

The next stage of health reform should reexamine better ways to encourage coordinated care, patient-centered medical homes, value-based reimbursement, and loosening of scope-of-medical-practice rules, instead of abandoning them completely and lapsing back to the pre-ACA status quo. In particular, a reformed fee-for-service Medicare program will need greater administrative flexibility in pursuing less-uniform payment and care management policies.

The supply side of health care reform also must address the problem of increased concentration, and too little competition, in many health care markets. Over the last decade, this problem has been growing primarily in hospital-based health care services. The ACA's push for more integrated care delivery systems through accountable care organizations may result in more anticompetitive horizontal combinations that increase market power instead of greater efficiencies through vertical integration. The health law also encourages the wrong kind of competition among providers—repositioning to gain political favor and special advantages from federal regulators and health program administrators rather than competing in the marketplace to better meet the demands of consumers.

Traditional antitrust enforcement tools have proven inadequate for the task of ensuring vigorous competition, and it remains unlikely that they can undo the effects of recent waves of mergers involving hospitals and related health systems. However, policymakers should consider several other types of remedies, including cracking down on anticompetitive contractual practices that limit price competition and new entry (for example, most-favored-nation clauses and antisteering provisions), curbing unwarranted extensions of the state action doctrine to shield anticompetitive conduct, and enforcing antitying limits on bundling of unrelated hospital services in highly concentrated markets.[1] Expanding the market for health care competition by reducing regulatory barriers to interregional "medical tourism" also would help.

Medical liability reform has a necessary role to play in a replace package. However, it is not much of a cost saver, but primarily a long-overdue correction to substantial flaws in our civil justice system that somewhat unpredictably hold physicians and other providers hostage to provide compensation for unfortunate medical outcomes, regardless of whether any actual negligence occurred. Exclusive reliance on caps on damages for noneconomic injuries may provide some short-term relief in lowering malpractice insurance premiums, but they may prove too arbitrary. Imposing them at the national level (except for federal programs like Medicare and Medicaid) also threatens to infringe on the traditional role of states

in handling such issues. Other medical liability reforms, like health courts, early-offer incentives, and a no-fault schedule of damage claim amounts, merit further consideration.

We should not adopt just the rhetorical shell of federalism to blindly relocate the delegated management of our health care from Washington-based officials to another set of politicians who happen to operate at the state level instead.

Health care reformers of all varieties tend to overlook the complexities of transitioning from long-standing policies and practices to new ones. We cannot simply leap into untested policies and mechanisms while displacing overnight the existing arrangements on which many Americans rely. Perhaps the best recent example of single-minded haste is the enthusiasm of some market-oriented reformers to end the employer-based health insurance system and move to individually purchased insurance much sooner than is realistic. The more prudent and politically sustainable approach is to work toward leveling the playing field in tax, regulatory, and reimbursement policy for all types of health insurance arrangements, regardless of who purchases insurance and what type of coverage they buy. Even as the individual market grows larger, well-functioning employer-based health plans will maintain a substantial presence in the marketplace. We should trust individual workers and their families, along with their employers, to determine how effectively employment-based insurance continues to serve their needs and preferences and accordingly set the pace and scale of future transitions.

Similarly, we should not adopt just the rhetorical shell of federalism to blindly relocate the delegated management of our health care from Washington-based officials to another set of politicians who happen to operate at the state level instead. A shallow "leave it to the states" model of health reform can too easily translate into, "We don't really know how to fix health care, either, but let's hope for a miracle from someone else."

Of course, state-based health policy reform will not get off the ground until many ACA provisions that tighten the federal noose around health care are repealed and replaced. But if state policymakers ignore the underlying drivers of health care costs or try to manage just as many politically complex and personal health decisions at their level of government, they will fail as badly as federal policymakers have. When state leaders remember that their primary role is to defend the freedom of their citizens to be the ultimate decision makers in personal health care matters, the rest of us will have a fighting chance at establishing patient-centered health policy that is more decentralized, competitive, and accountable.

No matter how much money taxpayers decide they can afford to throw at the wall of insurance coverage problems, the real keys to affordable health care are delivering necessary medical treatment quicker, simpler, cheaper, more consistently, and more effectively and bolstering the self-managed health of the entire population. Less-affordable health insurance is a secondary symptom, not the primary cause, of high-cost health care. We should insist as private purchasers and taxpayers that insurers and health care providers find ways to offer different mixes and methods of care and coverage that cost less and are worth more.

Instead of trying to prop up a controversial and ineffective individual mandate to promise (if not deliver) more comprehensive and costly benefits, we should focus on the most important unmet tasks of true health reform: improving the value of health care (and its related insurance financing) that is delivered to patients so that more people can and will purchase it voluntarily and investing in other more effective ways to boost their lifetime health.

Policymakers also should look beyond health insurance financing and regulatory issues to consider other policy instruments that promote healthier behavior,

health literacy, skill formation, and improved decision making. Key factors that shape the behavior and capabilities of individuals over their entire life cycle of health include education, nutrition, family, culture, and early childhood development. We need to rebalance our health investment portfolio to focus on what matters most in improving and maintaining health.[2]

Finally, many of the broader solutions to the affordability of private health insurance as well as the sustainability of our public health entitlement programs reside in the realm of more effective macroeconomic policy. Economic growth will not solve the most intractable health policy problems, but it can provide better job opportunities, rising disposable incomes, increased personal saving, more productive investment capital, and regeneration of the stock of human capital (skills, habits, and traits) needed to compete internationally and reinvigorate the independent sector of civil society. Policies that improve the overall ratio between independently productive citizens and those who must depend on them offer the best insurance policy of all.

Notes

1. Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions*, AEI Beyond Repeal and Replace series, June 2012, www.aei.org/papers/health/healthcare-reform/concentration-in-health-care-markets-chronic-problems-and-better-solutions.

2. "Beyond More Health Insurance Coverage, toward Better Health Outcomes" (Event, American Enterprise Institute, Washington, DC, July 23, 2008), www.aei.org/events/2008/07/23/beyond-more-health-insurance-coverage-toward-better-health-outcomes-event/; Tom Miller, "Who Pays? Who Benefits? Distributional Issues In Health Care: Article: Measuring Distributive Injustice on A Different Scale," *Law and Contemporary Problems* 69, no. 231 (Fall 2006): 241–3.

About the Author

Thomas P. Miller is a resident fellow at the American Enterprise Institute, where he focuses on health policy, with particular emphasis on such issues as information transparency, health insurance regulation, health care entitlement reform, and market-based alternatives to the policies of the Patient Protection and Affordable Care Act. He is the coauthor of *Why ObamaCare Is Wrong for America* (Broadside Books, 2011) and directs AEI's Beyond Repeal & Replace project. Miller was a member of the National Advisory Council for the Agency for Healthcare Research and Quality from 2007 to 2009 and a senior health policy adviser for the John McCain presidential campaign in 2008. Before joining AEI in 2006, Miller served for three years as senior health economist for the Joint Economic Committee of the US Congress. He also has been director of health policy studies at the Cato Institute and director of economic policy studies at the Competitive Enterprise Institute. He is a member of the National Academy of Social Insurance and the State Bar of Georgia.

Social Policy & Administration issn 0144-5596
DOI: 10.1111/spol.12237
Vol. 50, No. 4, July 2016, pp. 428–451

Obamacare and the Politics of Universal Health Insurance Coverage in the United States

Daniel Béland[a], Philip Rocco[b] and Alex Waddan[c]

[a]Johnson-Shoyama Graduate School of Public Policy, University of Saskatchewan, Saskatoon, Canada
[b]Health Policy Institute, University of Pittsburgh, Pittsburgh, USA
[c]Department of Politics and International Relations, University of Leicester, Leicester, UK

Abstract

In the USA, universal coverage has long been a key objective of liberal reformers. Yet, despite the enactment of the Patient Protection and Affordable Care Act (PPACA) (commonly known as 'Obamacare') in 2010, the USA is not set to provide health care coverage to all, even if and when that reform is fully implemented. This article explores this issue by asking the following question: Why was a clear commitment to universal coverage, the norm in other industrialized countries, excluded as a core objective of the PPACA and how has post-enactment politics at both the federal and the state level further shaped coverage issues? The analysis traces the issue of universal coverage prior to the debate over the PPACA, during the 2008 presidential race, and during consideration of the bill. The article then looks at the post-enactment politics of coverage, with a particular focus on how states have responded to the planned use of the Medicaid programme to expand access to care. The article concludes by discussing how an explanation of the limits of the PPACA, in terms of both its commitment to universal coverage and, more importantly, the failure to provide comprehensive health insurance to all, requires an understanding of complex institutional and policy dynamics.

Keywords

Patient Protection and Affordable Care Act; *Obamacare*; *Health insurance*; *Universal coverage*; *Politics*; *United States*

Introduction

The unique nature of the US health care system in the industrialized world is well-known, with the country relying much more heavily on the private sector, especially in terms of funding access to care, than elsewhere. This includes

Author Emails: daniel.beland@usask.ca; pbr8@pitt.edu; aw148@leicester.ac.uk

liberal welfare regimes such as Australia, Canada and the UK (Street 2008), which all have forms of government-supported universal access to health care. In the USA, the hybrid public-private health care system has long faced severe problems, making the issue of health care reform a recurring feature on the political agenda with a series of presidentially-driven efforts to bring about comprehensive change, which concern both cost control and insurance coverage (Blumenthal and Morone 2009). But agreement that there is something wrong has not translated easily into consensus on how to put things right. There have been some important policy innovations, most notably the establishment in the mid-1960s of the Medicare and Medicaid programmes (Marmor 2000), but reformers advocating publicly-guaranteed universal health coverage have been continually thwarted. So, in the spring of 2010 when President Obama signed the Patient Protection and Affordable Care Act (PPACA) (commonly known as 'Obamacare'), a major piece of health care reform, into law it was, as Vice President Biden expressed it, a 'big deal'. Yet, although the PPACA is by far the most ambitious health care reform enacted in the USA since Medicare and Medicaid, this reform stops short of guaranteeing universal health coverage. Indeed, the limits of the original legislation were tightened by the June 2012 Supreme Court decision that undermined the expansion of Medicaid so central to the coverage side of the PPACA (Waddan 2013).

The initial estimates of the PPACA's impact never claimed that the law, even if faithfully implemented, would lead to universal coverage. At the time of passage, the Congressional Budget Office (CBO) predicted that over 30 million Americans would gain insurance coverage one way or another, but this would still have left about 23 million people uninsured in 2019. Overall, the CBO (2010) projected that 92 per cent of the non-elderly population would be insured, or 95 per cent, if undocumented immigrants were excluded from the calculation. Hence, while the PPACA did set out to reshape the American health care system to give greater access to health coverage to many lower-income households, it was nevertheless clear that the USA would still have more people without guaranteed health coverage than in any other industrialized nation. Furthermore, as it became evident that many state governments were refusing to co-operate with the implementation of the law, the CBO increased its estimate of the likely number of uninsured in 2019 from 23 to 29 million (CBO 2013).

This article explores the politics of coverage surrounding the PPACA before, during and after its enactment in the spring of 2010. We ask the following question: Why was a clear commitment to universal coverage, the norm in other industrialized countries, excluded as a core objective of the PPACA and how has post-enactment politics at both the federal and the state level further shaped coverage issues? To begin, we briefly characterize the absence of universal coverage within the PPACA and several potential explanations for this outcome. Next, we specify the data and methods we used in our analysis. We present our results, tracing the issue of universal coverage prior to the debate over the PPACA, during the 2008 presidential contest, and during consideration of the bill. We then look at the post-enactment politics of coverage, with a particular focus on how states have responded to the

planned use of the Medicaid programme to expand access to care. The article then discusses how an explanation of the limits of the PPACA, in terms of both its commitment to universal coverage and, more importantly, the failure to provide comprehensive health insurance to all, requires an understanding of complex institutional and policy dynamics.

How Universal is Coverage Under the PPACA?

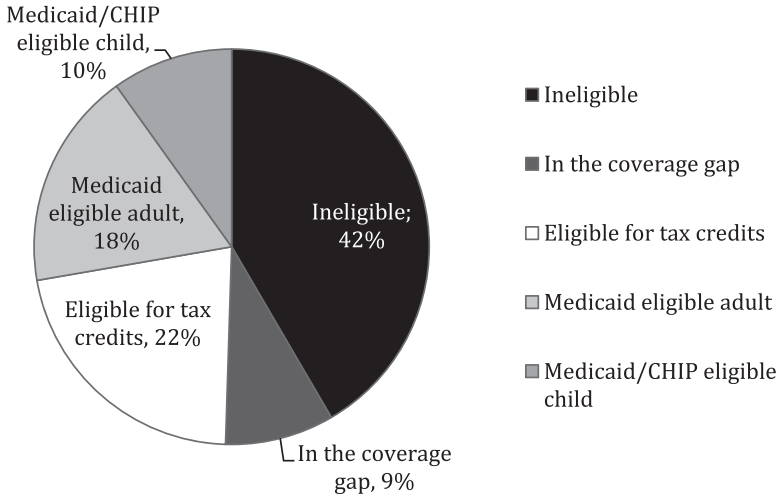
In their early assessment of the likely implications of the PPACA, Jacobs and Skocpol (2010: 120) reflect that the law ranked as 'one of the most important pieces of social legislation since Social Security, Civil Rights, and Medicare. It promised to put the USA on a new path – toward affordable health care for all Americans'. Furthermore, the re-election of President Obama in 2012 meant that the law would not be repealed. Yet, however momentous the passage of the law, there are several key indicators, which were inherent to the methods used to expand insurance coverage, which suggest the limits of its coverage. By universal coverage, we mean a system that covers all citizens, as is the case in countries with welfare states as different as Canada, Denmark, Sweden and the UK (Béland *et al.* 2014; Marchildon 2014). For us, universal health coverage must include *everyone*, which means it is not a matter of degree. In other words, coverage is universal, or not. Beyond the fact that all citizens should be covered, a certain level of uniformity is necessary for a system to qualify as universal, even if this level of uniformity varies from country to country (Béland *et al.* 2014).

In the case of the USA, there are several important considerations we must keep in mind. First, eligibility for benefits under the PPACA remains highly segmented (figure 1). The law does not radically change the manner in which most Americans accessed health care as it assumes that most working-aged Americans employed by mid-size and large employers continue to receive their insurance as a benefit of employment, despite the evidence of the declining efficacy of that insurance model (Gottschalk 2007; Morris 2006). The law did in fact contain incentives for employers to cover their workforce. Larger firms face penalties if they do not offer insurance, while smaller businesses are helped to insure workers through the use of temporary subsidies (Simon 2010: 7–8). In early July 2013, however, the implementation of the so-called employer mandate was abruptly pushed back from 2014 to 2015 (Calmes and Pear 2013).

Second, the PPACA relied heavily on means-testing in determining who it would help get coverage. By 2019, according to the CBO's 2010 initial projections, 24 million people would get their health insurance through state or federally run exchanges, which acted as regulated insurance markets (CBO 2010). These began in 2014 and cater to people not covered by their employer or a government programme. The PPACA provides for the federal government to subsidize people to help pay the premiums for qualified health plans, thereby again expanding, if indirectly, its role as a payer for care. These subsidies are available, on a sliding scale, to people with an income of up to 400 per cent of the federal poverty level (FPL). Importantly, and extending government intervention in the insurance market, insurers are restricted in

Figure 1

Eligibility for Patient Protection and Affordable Care Act coverage among non-elderly uninsured, 2015



Source: Garfield *et al.* 2016.
Note: CHIP = Children's Health Insurance Program.

how much they can vary premiums in order that the cost is not prohibitive for people with pre-existing medical problems (Marmor and Oberlander 2010). State governments were initially tasked with establishing the exchanges; however, in states that failed to implement the exchanges, the federal government had to step in and do the job. People getting their insurance through exchanges are able to choose from a variety of private insurance plans, but in contrast to some early versions of reform plans, the final PPACA did not provide a public insurance option. If the exchanges functioned as they were designed in the PPACA, they would see the government acting in a manner that significantly reduced the number of Americans without access to health insurance. Again, however, this government largesse would be distributed on an income-tested basis.

Third, while there were additional measures within the law that explicitly expanded coverage and the role of government as a payer through the Medicaid programme, the nature of those benefits varies significantly across the states. Under the PPACA's Medicaid expansion, everyone with an income of less than 138 per cent of the FPL became eligible for the programme, if their state supported the expansion of the programme. This expansion, which began in 2014, was to be funded by the federal government for the first three years. After that initial period, the federal government would pay 90 per cent of the additional Medicaid costs resulting from the new rules, but this was still a considerably better deal for the states than the cost-sharing arrangements

between the federal and state governments that characterized the existing Medicaid programme. In addition to the incentives contained in this package, states were to be 'persuaded' of the virtues of this plan by the threat that they would lose all federal Medicaid funding if they did not sign on to the new rules. According to the CBO (2010), this change would result in coverage for an additional 16 million Americans by 2019.

Clearly, therefore, the Medicaid expansion represented a significant increase in the federal government's commitment to paying for health insurance for millions of Americans. Furthermore, the change was not simply one of scale. In promising to cover *everyone* below the threshold, Medicaid would judge people only according to their income, rather than also testing their deservingness. Yet if this latter point edged Medicaid somewhat away from being a welfare programme that made judgments about why people were poor, it would still be reliant on means testing, and so remained far from being universal in design or principle.

Fourth, the PPACA also introduced new regulations for the insurance industry designed to facilitate access to insurance coverage and to prevent insurers from discriminating against 'bad risks'. One aspect of the law that was quickly implemented and hailed as a success, was that children will be allowed to remain covered by their parents' insurance until the age of 26 (Langmaid 2011). Also, various means by which insurers might attempt to avoid insuring or limiting their liability for particular individuals were prohibited. For example, insurers can no longer refuse to cover people with pre-existing illnesses and cannot impose annual or lifetime caps on their payments for individuals. These were important measures, but reflect the segmented nature of how people received health coverage.

Lastly, the PPACA required that individuals pay for insurance rather than gamble on their medical well-being. Yet this excludes particular groups and centres on fines which, while they increase over time, are still cheaper than the cost of purchasing insurance (Roy 2012). In September 2012, the CBO estimated that 6 million people would pay a penalty under the mandate in 2016 (Baker 2012), simultaneously both undermining the concept of collectivizing risk and meaning that these people themselves would remain uninsured.

Explaining the Absence of Universal Coverage in the PPACA

There has been much scholarly attention devoted to the question of why the USA developed such an exceptional health care system, with its comparatively limited level of government intervention and an absence of universal coverage. For some, it stems from cultural preferences, national values and 'American exceptionalism' (Ladd 1994; Lipset 1996), or at least is a reflection of how Americans have been sceptical of comprehensive government interference at critical points in time in the evolution of health policy (Jacobs 1993). Others emphasize the power of vested interests opposed to government activity (Kirkman-Liff 1997), while another school of thought brings the divisive issue of race to the fore (Boychuk 2008). Yet the predominant set of explanations has focused on the distinctive quality of American

governing institutions (e.g. Steinmo and Watts 1995). The literature on institutions and health policy suggests three potential explanations for the absence of universal coverage we see in the case of the PPACA. These explanations are not mutually exclusive, yet each stands to reveal a distinctive relationship between American politics and the lack of universal coverage in the PPACA.

Partisan competition

Most significant attempts to expand health insurance coverage in the USA have emerged from highly partisan policy battles (Kriner and Reeves 2014). Especially when electoral competition is intense, parties have incentives to formulate policies and coalitions in a short amount of time (Barrilleaux *et al.* 2002). By the same token, partisan electoral competition can create additional hurdles for bipartisan policy-making, given that minority parties have little incentive to give the majority a policy victory to celebrate in the next election (Lee 2009). These twin patterns push parties to adopt policy proposals that are essentially incremental in nature. For instance, some accounts of the PPACA note that, among other factors, electoral pressure may have affected the willingness of Democrats to bargain with key stakeholders on the terms of health reform (Jacobs and Skocpol 2010). Partisan competition can also shape post-enactment politics, as turnovers in control of government can lead to policy reversals (Berry *et al.* 2010).

Institutional fragmentation

While governing institutions in the USA are relatively open to new policy ideas, the process for policy enactment and implementation is highly fragmented, with numerous veto points at which opponents of reform can mobilize against it (Immergut 1992; Steinmo and Watts 1995). As a result, policies representing a significant move away from the *status quo* are often difficult to enact. A move towards universal health insurance in a system characterized by a strong reliance on private benefits such as the USA could thus be seen as politically risky (Hacker 2002). Institutional fragmentation can also shape policies once they are enacted, by giving opponents of major reform the opportunity to scale back initial gains – either by litigating in the courts or blocking implementation in federal agencies or in the states (Béland *et al.* 2016). In the case of the PPACA, the durable legacy of state-level management of key public programmes, notably the Medicaid programme, could have contributed to the absence of universal health coverage (Thompson 2013).

Policy packages

Reforms such as the PPACA are defined by their complexity. A policy idea that gained popularity among health reformers in the USA during the years leading up to health reform was that of the 'triple aim', that improvements in cost, access and quality would need to be undertaken together (Berwick *et al.* 2008). The heterogeneity in reform ideas has brought together diverse

coalitions (Oberlander 2010). At the same time, however, it has meant that ideas that are appealing to a majority coalition may not always be packaged with others that are equally appealing. In fact, the ideas endorsed by a majority coalition at time *t* may depend on how they were packaged together at time *t-1* (Weir 1993). During debates over the PPACA, expanding coverage was an important policy idea, but it was hardly the only one (McDonough 2011). Moreover, while universal coverage was appealing to liberal proponents of health reform, it was also hitched to other reform ideas, such as radically reforming service delivery within Medicaid and employer-sponsored health (Lane 2009).

Data

To explore these three explanations for the absence of universal coverage in the PPACA, we drew on analyses of key documents from the period prior to policy enactment (2007–08); the two years in which health reform was formally considered by Congress (2009–10); and the five years since enactment (2010–15). We chose these sources because they allow us to explore specific dimensions of the PPACA's design that affect the scope of coverage, including the role of individual subsidies and requirements related to employer-sponsored insurance; the availability of a public insurance plan; and the expansion of Medicaid. For the pre-enactment period, we reviewed policy statements made during the 2008 presidential elections (n = 5). During the enactment period, we reviewed key bills considered by Congress (n = 8) that express a variety of positions on key dimensions of universal coverage (Cannan 2013). We also review coverage projections for several major proposals (n = 7). Lastly, during the post-enactment period, we review state decisions on the Medicaid expansion (n = 50) and state applications and approvals for waivers of Medicaid provisions under section 1115 of the Social Security Act (n = 5).[1] Detail on the sources used is provided in the Appendix, table A1.

To structure our analysis of these sources, we considered four empirical implications of the three explanations (see table 1 for summary). First, each of the explanations implies a different level of Democratic support for universal coverage prior to enactment of the policy. Whereas the institutional fragmentation and partisan competition explanations assume that Democrats are relatively unified in their support of universal coverage pre-enactment, the policy packages explanation suggests that – because universal coverage may be hitched to other policy ideas not preferred by Democrats – it may be incorrect to assume support for universal coverage *ex ante*.

A second implication concerns how universal coverage fits with other key pieces of the legislation. In the policy packages explanation, plans for more extensive coverage are packaged with ideas that are unacceptable to Democratic leaders. By contrast, the other explanations assume that plans with greater coverage are also largely agreeable to Democrats on other dimensions.

Third, there are different expectations for when Democrats should reject proposals for universal coverage. Because the institutional fragmentation explanation assumes that limits to universality will emerge as the result of bargaining, alternatives to universal plans should only emerge after clear veto

Table 1

Empirical implications

	Partisan competition	Institutional fragmentation	Policy packages
1. Dems relatively unified on universal coverage pre-enactment?	Yes	Yes	No
2. Universal coverage proposals include ideas objectionable to Democrats?	No	No	Yes
3a. Democrat leaders reject universal coverage in response to veto threats?	No	Yes	No
3b. Democrat leaders reject universal coverage in response to electoral risks?	Yes	No	No
4. Do new limits to coverage emerge during implementation?	No	Yes	No

threats emerge and not beforehand. By contrast, both the partisan competition and policy packages explanations imply that Democratic leaders will adopt more limited forms of coverage, even if veto threats do not emerge. In both cases, this is because leaders are seeking to craft legislation that is appealing to a large majority of the Democratic caucus and will not invoke clear electoral punishments.

Lastly, the explanations imply different findings about post-enactment reductions in coverage. Whereas the institutional fragmentation explanation would suggest that significant reductions in coverage could occur through legal challenges to the law and the implementation process, both the partisan competition and policy packages explanations would assume that the universality of coverage is largely shaped earlier in the legislative process.

Results

In this section we consider the four empirical implications of the three explanations described above. We begin by characterizing Democratic positions on health reform prior to the consideration of the PPACA. Next, we consider the combination of universal coverage with other key features of the reform. We then consider evidence on the timing of Democratic reform proposals. Lastly, we address limits to coverage that emerged after policy enactment.

Pre-enactment positions on universal coverage

Carefully reviewing the state of play on universal coverage prior to the consideration of the PPACA in 2009 and 2010 reveals the absence of a strong commitment to universal coverage among Democrats. Given the history of legislative failure and political disrepute associated with President Clinton's effort at comprehensive health care reform, it was not at all certain that the

next Democratic president would attempt to introduce significant change in this issue area and, perhaps, bring about universal coverage. Neither of the Democratic nominees in 2000 or 2004 had featured the issue in their platforms, but Hillary Clinton did push health policy reform to the front of the political agenda in her campaign for the Democratic presidential nomination in 2008. At one point, she declared that her commitment to major reform was the most important difference between her candidacy and Barack Obama's. Obama responded by stressing that he too would make health care affordable for all Americans, though even during the general election campaign he remained cautious about specific aspects of how this would be done (Jacobs and Skocpol 2010: 34–8). This was the case concerning 'the notion of an "individual mandate" that would require all Americans, in due course, to have insurance' (Jacobs and Skocpol 2010: 36). Forcing healthy people who could afford to buy insurance to actually do so was an important way of collectivizing risk as their premiums would help keep down costs for the less healthy. Obama understood this, but worried that this type of compulsion would be hugely unpopular and his campaign even went as far as to attack Clinton's plans for a mandate in the primary campaign (Brill 2015: 45). In fact, candidate Obama never pledged that, if enacted, health care reform would actually bring about universal health insurance coverage in the USA.

A further institutional factor limiting the possible scope of reform concerned the issue of what was to be reformed. The option of a dramatic switch to a single payer system, which would have sent a distinctive message that the purpose of reform was to provide a universal and relatively equitable health system, was never seriously considered. Dismantling the existing health care apparatus was seen as almost impossible due to existing policy legacies (i.e. the weight of private insurance actors and interests within the health system), meaning that reform had to build on the inefficient mix of private and public programmes already in place (Jacobs and Skocpol 2010: 66–75).

The lack of a strong and explicit commitment to universal coverage among Democrats constituted a sharp contrast with the Clinton era, during which universal coverage appeared as a core, explicit objective of President Clinton's Health Security proposal (Skocpol 1997: 60). In his 1994 State of the Union address, Clinton famously declared that he would veto any reform devised by Congress that did not 'guarantee every American private health insurance that can never be taken away' (Ifill 1994). As the next section suggests, disunity among Democrats on universal coverage during the 2008 campaign may have something to do with the way that various dimensions of that coverage were packaged together in pre-existing legislative proposals.

Packaging universal coverage: individual and employer-sponsored coverage

Despite the absence of a single-payer option from the discussion, a significant feature of how the debate over health reform evolved during and after the 2008 campaign is that policy ideas supporting a more comprehensive level of coverage were scattered between proposals made by both major parties. Under Obama's plan, individuals without employer-sponsored insurance would be eligible for premium subsidies in the form of tax credits – on a

progressive sliding-scale – which they could use to buy private or public plans on newly created insurance marketplaces (Commonwealth Fund 2008).

Yet while new subsidies and exchanges would help to address the problem of those currently uninsured, both Obama's plan and the Democratic platform maintained a highly segmented approach to insurance coverage, insisting that families and individuals 'have the option of keeping the coverage they have or choosing from a wide array of health insurance plans, including many private health insurance options and a public plan' (2008 Democratic Party Platform). Increasing employers' responsibility for providing health insurance was based in part on the understanding that the *status quo* for most Americans did not require a remedy. As David Cutler, a Harvard economist and senior adviser to Obama, argued in a *Health Affairs* article:

> Most employers that provide coverage are already providing good coverage. They would be unaffected by the Obama plan – although their costs would fall. Those that cannot afford to provide good care would have new options – an insurance exchange with good choices, lower costs, and basic guarantees. (Cutler 2008)

In addition to subsidizing the individual purchase of health care for those with inadequate employer coverage, Democrats suggested increasing access to health care by expanding Medicaid (2008). As a means-tested programme, Medicaid by definition serves the least well off. Yet as of 2008, no two states had the same rules and regulations with regard to the running of their Medicaid programmes. For example, prior to the PPACA, Minnesota allowed parents of dependent children with incomes up to 215 per cent of the FPL access to Medicaid. In contrast, neighbouring South Dakota, which was not the least generous state, had eligibility levels at 50 per cent of the FPL (Kaiser Commission on Medicaid and the Uninsured 2013a). On the other hand, Medicaid incrementally has increased its levels of coverage, even during the 1980s, with Republican presidents in office (Jaenicke and Waddan 2006). In turn, this led some reformers to see Medicaid as a vehicle for expanding health care coverage to the uninsured rather than looking to Medicare as the model to follow (Grogan and Patashnik 2003).

Republicans, on the other hand, did not endorse specific subsidy levels, a public option, or Medicaid expansion. Yet, in contrast to the Democratic plan, Republicans did include a transition away from employer-based insurance. To do so, they borrowed elements of the Healthy Americans Act, a bipartisan bill drafted by Senators Ron Wyden (D-OR) and Bill Bennett (R-UT) in 2007 and supported by a bipartisan group of six Democrats and six Republicans (Klein 2008). The Wyden-Bennett plan (see table 2) supported replacing employer-sponsored coverage with an individual mandate and generous tax credits and subsidies to enable individuals to purchase insurance (Wyden and Bennett 2009). Moreover, Wyden-Bennett replaced Medicaid with free private coverage to individuals living at less than 100 per cent of the FPL. While Republicans did not include the individual mandate, generous subsidies, or the same approach to Medicaid reform, they did support removing employers from the equation, suggesting that 'the current tax system

Table 2

Features of various health reform plans, 2009–10

Plan	Individual subsidies	Transition to non-employer based system?	Public option	Medicaid expansion
Healthy Americans Act, S 391 (Wyden-Bennett bill, 2007 and 2009)	Yes: for people earning up to 400% FPL	Yes: eliminates tax exclusion, replaces with tax deduction for health insurance; new tax payments from employers to federal government	No	No: limits Medicaid coverage and fully subsidizes private coverage for households earning <100% FPL
Senate HELP Bill (Unnumbered Draft, 2009)	Yes: for people earning up to 500% FPL	No: employers must contribute to premiums (few details specified)	Yes	Yes: covers households earning <150% FPL
Patients' Choice Act (Ryan-Coburn bill, 2009)	Yes: tax credits plus subsidies for people earning up to 200% FPL	Yes: eliminates tax exclusion, replaces with refundable tax credit for health insurance	No	No: limits Medicaid coverage
House Tri-Committee Discussion Draft (2009)	Yes: for people earning up to 400% FPL	No: employers with over $500,000 in payroll must pay 65% of family premiums or a penalty based on payroll	Yes	Yes: covers households earning <133% FPL
America's Healthy Future Act, S 1796 (Baucus bill, 2009)	Yes: for people earning up to 400% FPL	No: imposes fine on employers with 50+ employees when employees receive subsidy	No	Yes: covers households earning <133% FPL
Common Sense Health Care Reform and Affordability Act, HR 4038 (GOP House Bill)	No: refundable credits to families earning less than $50,000	No	No	No

(Continued)

Table 2

(Continued)

Plan	Individual subsidies	Transition to non-employer based system?	Public option	Medicaid expansion
Affordable Health Care for America Act, HR 3962	Yes: for people earning up to 400% FPL	No: employers with over US$500,000 in payroll must pay 65% of family premiums or a penalty based on payroll	Yes	Yes: covers households earning <150% FPL
Patient Protection and Affordable Care Act, HR 3590 (Engrossed Senate Bill, 2009)	Yes: for people earning up to 400% FPL	No: imposes fine on employers with 50+ employees when employees receive subsidy	No	Yes: covers households earning <133% FPL
PPACA (signed into law, 2010)	Yes: for people earning up to 400% FPL	Mandatory: employers with 50+ employees must offer 60% of cost of covered services and coverage must be affordable or pay penalty based on number of employees receiving subsidy	No	Yes: covers households earning <138% FPL

Source: See Appendix table A1.

discriminates against individuals who do not receive health care from their employers, gives more generous health tax benefits to upper income employees, and fails to provide every American with the ability to purchase an affordable health care plan' (2008 Republican Party Platform).

Thus, by the time health reform was being debated, one core element of a more inclusive approach to coverage – transitioning away from employer-sponsored insurance – was linked to policy proposals most Democrats found unappetizing, and remained separate from other important elements of coverage expansion, including a public option and Medicaid expansion (table 2). Early Democratic proposals from the Senate Committee on Health, Education, Labor and Pensions (HELP) and a trio of House committees tended to adopt the Democratic platform approach, blending individual subsidies, a public option, and Medicaid expansion, but maintaining the employer-based system – albeit with new contribution requirements for large employers. By contrast, Republican plans such as those authored by Representative Paul

Ryan (R-WI) and by Senator Tom Coburn (R-OK) kept the Wyden-Bennett approach to dismantling employer-sponsored insurance – but failed to include the same approach to subsidies or Medicaid reform that would have allowed for major coverage expansions and a near elimination of the employer-sponsored insurance system (see figure 2).

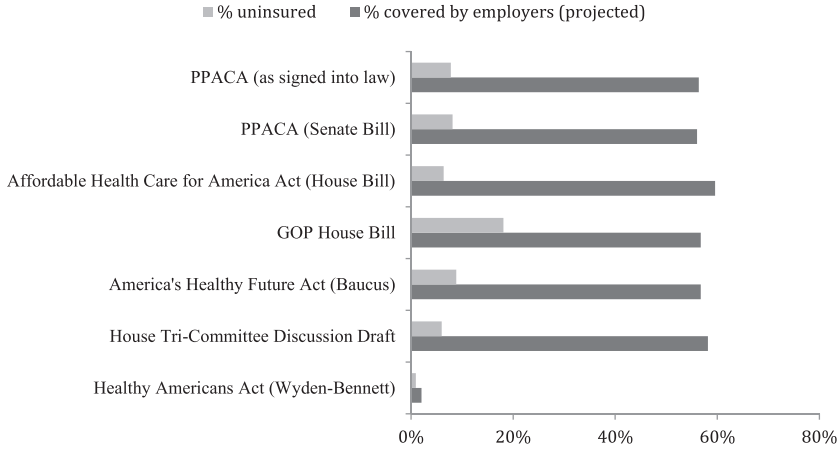
Despite bipartisan support for moving away from employer-sponsored insurance, and projections that Wyden-Bennett would significantly reduce the number of uninsured compared to other Democratic and Republican proposals (see figure 2), Wyden-Bennett was eliminated early in the legislative process. In the summer of 2009, liberal interest groups in Wyden's home state of Oregon complained that he was 'joining forces with [Republicans] to try to scuttle health care reform' (Falcone 2009). The President also criticized the Wyden-Bennett plan, suggesting that 'families who are currently relatively satisfied with their insurance but are worried about rising costs ... would get real nervous about a wholesale change' (Lane 2009). Indeed, it would appear that – despite the potential for increasing coverage by eliminating employer-sponsored insurance – it failed to attract liberal support due to the other policies in the Wyden-Bennett package.

Timing, the public option, and the individual mandate

Whereas reforms of employer-sponsored insurance struggled due to policy packaging effects, our analysis of timing suggests that institutional fragmentation helped to demolish the public option, while partisan competition undermined the strength of the individual mandate. The public option was

Figure 2

Projected coverage in various health reform proposals



Source: See Appendix Table A1.

an idea developed by academics and left-leaning think tanks that advocated allowing the federal government to sell health insurance directly to individuals in competition with private insurers. For supporters and critics alike, the public option was a 'Trojan horse for a single-payer plan' (Brasfield 2011: 458), and debate about its merits became increasingly contentious during 2009. That summer saw impassioned protests against reform fuelled by the emerging Tea Party movement (Urbina 2009), which emboldened opponents of reform as the administration, and Democrat leaders in Congress, appeared to have lost control of the ideological discourse. Nevertheless, the evidence in table 2 shows that the public option survived throughout the duration of the fight in the House of Representatives, and was ultimately included in the House-passed legislation.

Given that a majority of House Democrats voted in favour of the public option, the party competition explanation – which suggests that partisan pressure for short-term victories blocked universal coverage in the PPACA – is incomplete. In fact, examining institutional fragmentation sheds greater light on this provision. In 2009, the Democrats had a 257 to 178 majority in the House, meaning that some House Democrats could stray. As well, and crucially, at the end of 2009, the party had 60 votes in the Senate. This was so vital because heightened partisanship in Congress since the early 1990s meant that any Republican support was always extremely unlikely (Sinclair 2006). It was also key because the extensive use of the filibuster meant that 60 votes had become the marker for legislative success in the Senate (Wawro and Schickler 2006). Even so, it was vital to retain all 60 Democratic coalition votes in the Senate, in order to prevent potential Grand Old Party filibusters. This was always highly problematic for the public option, given the objections of a number of Senate Democrats, and critically of the Independent Joe Lieberman of Connecticut. The Senate's organization and procedures, in effect, gave a small number of Senators individual veto power. And even though the president expressed support for the principle he was, in the end, willing to let it die to secure passage of the bill in the Senate (Personal interview with Democratic congressional staffer, August 2010).

The public option episode is highly instructive. First, it illustrates in detail the ever-present intricacies of the pivot points in the legislative process with so much depending on the actions of a small number of lawmakers, a situation related to the absence of UK-style party discipline. And second, it shows how even in the 2009 version of the Democratic Party, there were sceptics about how far the government should intervene in the health care marketplace. In the end, therefore, conservative opposition did not stop reform, but the legislative endgame, which necessitated prioritizing the measures in the Senate rather than House version of reform, meant that some of the more liberal ideas in the latter's original bill, which 'included a (limited) public option, more generous benefits, more extensive national administration, and higher taxes on the privileged', were excluded in the final law (Jacobs and Skocpol 2010: 72–3).

By contrast, the scaling back of the individual mandate did not emerge after veto threats. Rather, it emerged after 'focus groups and internal polls' conducted by Democrats revealed public fears that health insurance would remain unaffordable and that under both House and Senate bills, those

who did not comply with the mandate would face 'a year in fail, penalties up to $1,900 per family, and garnishment of wages' (Chaddock 2009). As a result, Senator Charles Schumer (D-NY) proposed an amendment to legislation in the Senate Finance Committee, which weakened penalties for uninsured Americans – making numerous exemptions to penalties for those who could not find a plan with a premium less than 8 per cent of their adjusted gross income and eliminating criminal penalties on insured people not eligible for a waiver during the first year of the new law (Pear and Calmes 2009). The result of the amendment, which passed on a 21 to 1 margin, was that 2 million fewer uninsured Americans would not be covered by the reform (CBO 2009). To many in the Obama administration, the weakening of the mandate placed the reform's coverage expansion in jeopardy (Brill 2015: 126). Yet, as the Finance's Committee's vote on the Schumer amendment shows, Obama was correct to predict that a tough mandate would be politically unpopular.[2]

Changes in coverage after enactment

Five years after the passage of the law it is evident that its various parts led to a significant reduction in the number of uninsured, but that a greater number of Americans would remain uninsured than had been initially projected in the spring of 2010, meaning that the country's health care system would fall short of providing universal coverage. In September 2015, the Census Bureau reported that 10.4 per cent of people in the USA – 33 million people – were uninsured at the end of 2014, which was a significant drop on 41.8 million in 2013 (Radnofsky 2015). According to a Department of Health and Human Services (HHS) analysis, between October 2013 and September 2015 'the uninsured rate for African Americans declined by just over 10 percent, for Hispanics it declined 11.5 percent and for whites the rate declined by 6 percent' (Carey 2015). Furthermore, HHS Secretary, Sylvia Burwell promised that, beginning in November 2015, there would be a concerted effort to reach out to eligible individuals not yet participating in the insurance exchanges. Secretary Burwell did, however, also acknowledge that some people would still be hard pressed to afford insurance even taking into account the subsidies available through the exchanges (Carey 2015).

Institutional fragmentation helps to account for the emergence of further limits to universality during the post-enactment period. One unexpected problem for the administration was that over half the states had decided against running their own exchanges, leaving it to an underprepared federal government to organize the exchange in the different states (Kliff 2013). Additionally, all small group and individual insurance packages were to cover a selection of 'essential health benefits' but the law did not define what these were, leaving this for HHS. Furthermore, and illustrative of the complexities of devising uniform standards to cover the wide variety of ways in which insurance is organized, only a year after enactment, authorities had over 1,400 waivers that allowed health plans to provide maximum levels of coverage that fell below the minimum mandated in the PPACA (Pear 2011). Similarly, as a result of pressure from employers during the regulatory review process, the

Obama administration twice delayed implementation of the employer mandate; this increased the number of individuals eligible for premium tax credits, yet it significantly undermined the PPACA's reliance on existing, employer-sponsored insurance as a means of expanding access to coverage (Jost 2013, 2015). While these were important matters in terms of the levels of insurance coverage people receive, there were even more fundamental developments with regard to whether people would actually receive the health coverage apparently promised by the PPACA at all.

By 2015, the federal government was much better equipped to run the exchanges, but states' lack of co-operation extended to other areas. In particular, and with a real impact on individuals' access to health cover, there was widespread resistance to the Medicaid expansion, which had been predicted to cover 16 million people by 2019 (CBO 2010). The framers of the PPACA had not anticipated this resistance. They had assumed that the carrot of federal dollars to pay for the newly eligible Medicaid recipients, coupled with the stick of the threat of withdrawal of existing federal Medicaid money if states did not expand their programmes, would mean that all states would comply. Instead, the Supreme Court's June 2012 ruling in the case of the *National Federation of Independent Business v Sebelius*,[3] which brought together the different constitutional challenges made against the PPACA, challenged the very idea behind the PPACA's Medicaid expansion. The headline case made against the law concerned the individual mandate, which was ruled constitutional by a 5 to 4 majority. Thus, the immediate interpretation of the ruling was that the administration had triumphed. But the Court's decision also gave considerably greater credibility to challenges to the Medicaid expansion than constitutional experts had predicted. The Court ruled that the PPACA's requirement that states participate in the expansion or lose all their current federal Medicaid funding was too great an exertion of federal government power (Landers 2012). With this, the Court empowered opponents of the PPACA significantly, giving the states a real choice about whether or not to participate in Medicaid expansion. In James Morone's pithy phrase, 'Stingy states may choose to stay stingy' (Morone 2012). Morone's comment reflects the fact that there was considerable variation in how states, prior to the PPACA, defined Medicaid eligibility. While Medicaid is often described as a programme for the poor, less than half of non-elderly Americans living in households with an income below the FPL were covered prior to the PPACA (Kaiser Commission on Medicaid and the Uninsured 2013b).

When the expansion formally came into effect in January 2014, 24 states did not participate. Although it is important to take factors other than partisanship into account when explaining these states' decisions (Béland *et al.* 2016), the results of the 2010 elections, which significantly increased Republican representation in state legislatures and saw an increase in the number of states with Republican governors, meant that the PPACA was being implemented in a politically hostile environment in many states. By September 2015, the carrot of new federal dollars, along with some flexibility from the federal government in allowing state waivers to deviate from the original rules of the PPACA, meant that the number of states that decided not to participate in the expansion had dropped to 19. That said, the deviations involved in

these waivers invited further segmentation of Medicaid benefits, and in some cases included significant limitations on benefits as well as requirements for premium contributions and co-payments that did not exist in states that had accepted the Medicaid expansion (see table 3).

The 19 states not taking the expansion or the waivers included Florida, Texas and Georgia, with over 1.2 million, 1.1 million and 680,000 residents, respectively, who would have been eligible for Medicaid but who were likely to remain uninsured (Families USA 2015). Because lawmakers had expected Medicaid to cover people with incomes below the FPL, there was no alternative provision in the PPACA to cover poor households which would not come under the Medicaid umbrella. This meant that people with incomes below the FPL were not eligible for the subsidies to get insurance through an exchange, which were reserved for people with incomes from 100 per cent to 400 per cent of the FPL. Thus, while millions of people did gain new health coverage under Medicaid expansion, the combination of the Supreme Court decision in 2012 and the resistance of many states to the expansion meant that five years after the law's enactment, millions more people remained uninsured than had been anticipated.

Discussion

Based on the above analysis, it is clear that the absence of universal coverage in the PPACA cannot be explained by one single factor. This is the case

Table 3

Characteristics of Medicaid section 1115 waivers approved by the federal government

	Arkansas	Iowa	Indiana	Michigan	Pennsylvania
Health insurance coverage					
Coverage provided via exchange	X	X			
Premiums or contributions at >100% FPL	X	X	X	X	X
Co-payments	X	X	X	X	X
Health care related accounts	X		X	X	
Coverage limits					
Lock out from coverage		X	X		X
Waiver of retroactive coverage			X	X	X
Limited benefits for non-frail adults	X	X	X	X	X
Waive non-emergency transportation requirement	X	X	X		X
Other waiver provisions					
Healthy behaviour incentives		X	X	X	X
Work requirement			*		*

Source: See Appendix table A1.
Note: * Centers for Medicare & Medicaid Services approval permitted Indiana and Pennsylvania to use non-federal funds to develop a programme to encourage employment, but not to require employment as an eligibility condition.

because the lack of universal coverage is the product of a series of policy decisions that each necessitates a distinct explanation. The best way to show this is to systematically return to the three alternative explanations discussed above.

Partisan competition

Partisan competition provides the strongest compelling explanation of the weakening of the individual mandate. The Senate Finance Committee abandoned a stronger mandate only after receiving information about the potential political consequences of imposing strong punishments on individuals who could not afford insurance. By contrast, partisan competition does not explain the emergence of other limits to universal coverage. For instance, the fact that House and Senate Democrats supported the public option is not consistent with the claim that partisan pressure blocked universal coverage in the PPACA. In fact, from a partisan standpoint, however, what is perhaps the most striking is the scope of the policy divisions within the Democratic camp, which did not strongly unite around shared reform ideas such as universality. These divisions made threats of Senate filibusters a significant part of the debate over the public option. The strong impact of the 2010 state elections on PPACA implementation does illustrate the importance of partisan control of different levels of government in post-enactment politics, but at the same time, there is strong evidence that post-enactment struggles in the states over Medicaid coverage are not just about partisan competition (Béland *et al.* 2016).

Institutional fragmentation

Institutional fragmentation is more useful than partisan competition to account for a number of decisions leading to the lack of universal coverage that characterizes the PPACA. For instance, institutional fragmentation largely explains the death of the public option (in this case the 60-vote requirement in the Senate and the lack of a means for the Senate Democratic leadership to enforce discipline on its caucus), which could have helped to move the health care system in the direction of a single-payer model, over time. Institutional fragmentation related to the politics and the policy legacies of federalism also helps to explain the advent of further limits to the extension of coverage during the post-2010 implementation period.

Policy packages

This explanation about the articulation of reform ideas into discrete policy packages also helps account for the absence of universal coverage. For example, plans to shift away from the model of employer-sponsored insurance, which is at the heart of the USA's uneven and unequal health care system, were packaged along with policy proposals that many Democrats found highly problematic. Hence discussion of reforming this major part of the prevailing health care arrangements remained separate from other crucial matters, such as Medicaid expansion and the public option.

The PPACA is clearly a major piece of legislation that will improve the economic security of millions of Americans by providing them with affordable access to health insurance. Yet, it falls short of bringing about universal coverage. Explaining why this is so, even after such a president was finally able to bring about significant reform, remains a crucial policy issue demanding close attention. As the ongoing politics of implementation of the PPACA remain in flux, on the ground there is reason for scholars to further investigate the continuing relevance of the three explanations offered in the article to explain why millions of Americans are likely to remain uninsured for the foreseeable future, meaning that the USA remains the 'exception' in this context in the industrialized world.

Appendix

Table A1

Sources for document analysis

Document title	Link
2008 campaign statements ($n = 5$)	
Democratic Platform	http://www.presidency.ucsb.edu/ws/?pid = 78283
Republican Platform	http://www.presidency.ucsb.edu/ws/?pid = 78545
Obama Platform on Health Care	https://kaiserfamilyfoundation.files.wordpress.com/2013/01/obama_health_care_reform_proposal.pdf
Clinton Plan	http://www.washingtonpost.com/wp-dyn/content/article/2007/09/17/AR2007091700118.html
McCain Plan	http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411755-An-Analysis-of-the-McCain-Health-Care-Proposal.PDF
Policy alternatives ($n = 8$)	
Healthy Americans Act, S 391 (Wyden-Bennett bill, 2007 and 2009)	https://www.congress.gov/bill/111th-congress/senate-bill/391/text
Senate HELP Committee Draft	voices.washingtonpost.com/ezra-klein/HELP bill.pdf
Patients' Choice Act (Ryan-Coburn bill, 2009)	https://www.govtrack.us/congress/bills/111/hr2520/text
House Tri-Committee Discussion Draft (2009)	https://kaiserhealthnews.files.wordpress.com/2009/07/hrdraft1xml.pdf
America's Healthy Future Act, S 1796 (Baucus bill, 2009)	https://www.congress.gov/bill/111th-congress/senate-bill/1796/text

(Continued)

Table A1

(Continued)

Document title	Link
Common Sense Health Care Reform and Affordability Act, HR 4038 (GOP House Bill, 2009)	https://www.govtrack.us/congress/bills/111/hr4038/text
Affordable Health Care for America Act, HR 3962 (House Bill, 2009)	http://housedocs.house.gov/rules/health/111_ahcaa.pdf
Patient Protection and Affordable Care Act, HR 3590 (Engrossed Senate Bill, 2009)	https://www.congress.gov/bill/111th-congress/house-bill/3590/text/eas
Patient Protection and Affordable Care Act (signed into law, 2010)	https://www.congress.gov/bill/111th-congress/house-bill/3590/text?overview=closed
Coverage analyses ($n = 7$)	
Healthy Americans Act (Wyden-Bennett)	http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/UpdateHealthyAmericansAct.pdf
House Tri-Committee Discussion Draft	https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/07-26-infoontricommproposal.pdf
America's Healthy Future Act (Baucus)	https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/09-16-proposalsfcchairman0.pdf
GOP House Bill	http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10705/hr3962amendmentboehner.pdf
Affordable Health Care for America Act (House Bill)	https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/hr3962rangel0.pdf
PPACA (Senate Bill)	https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/41877-reid-letter.pdf
PPACA (as signed into law)	http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12033/12-23-selectedhealthcarepublications.pdf
Medicaid expansion waivers ($n = 5$)	
Arkansas	http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/
Iowa	http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/
Indiana	http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/
Michigan	http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/
Pennsylvania	http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/

(Continued)

Table A1

(Continued)

Document title	Link
Medicaid expansion decisions ($n = 50$)	
	https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html

Note: All websites accessed 26 April 2016.

Acknowledgements

The authors thank Rachel Hatcher and the reviewers for their comments and suggestions. Daniel Béland acknowledges support from the Canada Research Chairs Program. Philip Rocco acknowledges support from the Stern Family Foundation.

Notes

1. Waivers are a means by which states apply to the federal government, in this case the Department of Health and Human Services, for permission to exercise some discretion in the implementation of policy.
2. For detail on the application of the mandate, see Kaiser Family Foundation 2015.
3. *National Federation of Independent Business v Sebelius*, 567 US (2012).

References

2008 Democratic Party Platform (2008), http://www.presidency.ucsb.edu/ws/?pid=78283 (accessed 26 April 2016).

2008 Republican Party Platform (2008), http://www.presidency.ucsb.edu/ws/?pid=78545 (accessed 26 April 2016).

Baker, S. (2012), CBO: 6M people will pay penalty under health law's mandate, *The Hill*, 19 September.

Barrilleaux, C., Holbrook, T. and Langer, L. (2002), Electoral competition, legislative balance, and American state welfare policy, *American Journal of Political Science*, 46, 2: 415–27.

Béland, D., Blomqvist, P., Andersen, J. G., Palme, J. and Waddan, A. (2014), The universal decline of universality? Social policy change in Canada, Denmark, Sweden and the UK, *Social Policy & Administration*, 48, 7: 739–56.

Béland, D., Rocco, P. and Waddan, A. (2016), *Obamacare Wars: Federalism, State Politics, and the Affordable Care Act*, Lawrence. KS: University Press of Kansas.

Berry, C. R., Burden, B. C. and Howell, W. G. (2010). After enactment: The lives and deaths of federal programs, *American Journal of Political Science*, 54, 1: 1–17.

Berwick, D. M., Nolan, T. W. and Whittington, J. (2008), The triple aim: Care, health, and cost, *Health Affairs*, 27, 3: 759–69.

Blumenthal, D. and Morone, J. (2009), *The Heart of Power: Health and Politics in the Oval Office*, Berkeley, CA: University of California Press.
Brasfield, J. (2011), The politics of ideas: Where did the public option come from and where is it going, *Journal of Health Politics, Policy and Law*, 36, 3: 455–9.
Boychuk, G. (2008), *National Health Insurance in the United States and Canada Race, Territory, and the Roots of Difference*, Washington, DC: Georgetown University Press.
Brill, S. (2015), *America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System*, New York, NY: Random House.
Calmes, J. and Pear, R. (2013), Crucial rule is delayed a year for Obama's health law, *New York Times*, 2 July, http://www.nytimes.com/2013/07/03/us/politics/obama-administration-to-delay-health-law-requirement-until-2015.html (accessed 26 April 2016).
Cannan, J. (2013), A legislative history of the Affordable Care Act: How legislative procedure shapes legislative history, *Law Library Journal*, 105, 2: 131–73.
Carey, M. A. (2015), HHS vows push to enroll more uninsured in Obamacare this fall, *Kaiser Health News*, 22 September, http://khn.org/news/hhs-vows-push-to-enroll-more-uninsured-in-obamacare-this-fall/ (accessed 26 April 2016).
Chaddock, G. R. (2009), Senate Democrats backpedal on health insurance mandate, *Christian Science Monitor*, 2 October, http://www.csmonitor.com/USA/Politics/2009/1002/senate-democrats-backpedal-on-health-insurance-mandate (accessed 26 April 2016).
Commonwealth Fund (2008), *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America*, Washington, DC: Commonwealth Fund.
Congressional Budget Office (CBO) (2009), Preliminary analysis of the chairman's mark for the America's Healthy Future Act, as amended, 7 October, https://www.cbo.gov/publication/41335?index=10642 (accessed 26 April 2016).
Congressional Budget Office (CBO) (2010), H.R. 4872, Reconciliation Act of 2010, 18 March, http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf (accessed 26 April 2016).
Congressional Budget Office (CBO) (2013), CBO's February 2013 estimate of the effects of the Affordable Care Act on health insurance coverage, https://www.cbo.gov/sites/default/files/51298-2013-02-ACA.pdf (accessed 26 April 2016).
Cutler, D. (2008), The McCain critique: Out of touch and short of ideas, *Health Affairs Blog*, 25 September, http://healthaffairs.org/blog/2008/09/25/the-mccain-critique-out-of-touch-and-short-of-ideas/ (accessed 26 April 2016).
Falcone, M. (2009), Liberals dog Wyden on bill, *Politico*, 28 July, http://www.politico.com/story/2009/07/liberals-dog-wyden-on-bill-025490?o=1 (accessed 26 April 2016).
Families USA (2015), A 50-state look at Medicaid expansion, July, http://familiesusa.org/product/50-state-look-medicaid-expansion (accessed 26 April 2016).
Garfield, R., Damico, A., Cox, C., Claxton, G. and Levitt, L. (2016), New Estimates of Eligibility for ACA Coverage among the Uninsured, 22 January, Kaiser Family Foundation, http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/ (accessed 27 April 2016).
Gottschalk, M. (2007), Back to the future? Health benefits, organized labor, and universal health care, *Journal of Health Policy, Politics and Law*, 32, 6: 923–70.
Grogan, C. and Patashnik, E. (2003), Between welfare medicine and mainstream entitlement: Medicaid at the crossroads, *Journal of Health Politics, Policy and Law*, 28, 5: 821–58.
Hacker, J. (2002), *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States*, New York, NY: Cambridge University Press.

Ifill, G. (1994) State of the Union: The overview; Clinton vows fight for his health plan, *New York Times*, 26 January.
Immergut, E. (1992) Comparing health care systems: What nations can learn from one another, *Journal of Health Politics, Policy and Law*, 17, 4: 613–36.
Jacobs, L. (1993) *The Health of Nations*: *Public Opinion and the Making of American and British Health Policy*, Ithaca, NY: Cornell University Press.
Jacobs, L. and Skocpol, T. (2010), *Health Care Reform and American Politics*: *What Everyone Needs to Know*, New York, NY: Oxford University Press.
Jaenicke, D. and Waddan, A. (2006), Recent incremental health care reforms in the US: A way forward or false promise? *Policy and Politics*, 34, 2: 241–64.
Jost, T. (2013), Implementing health reform: A one-year employer mandate delay, *Health Affairs Blog*, 2 July, http://healthaffairs.org/blog/2013/07/02/implementing-health-reform-a-one-year-employer-mandate-delay/ (accessed 26 April 2016).
Jost, T. (2015), IRS again delays minimum essential coverage reporting requirement, and other ACA developments (updated), *Health Affairs Blog*, 29 December, http://healthaffairs.org/blog/2015/12/29/irs-again-delays-minimum-essential-coverage-reporting-requirement-and-other-aca-developments/ (accessed 26 April 2016).
Kaiser Commission on Medicaid and the Uninsured (2013a), Where are the states today? Medicaid and CHIP eligibility levels for children and non-disabled adults, https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7993-03.pdf (accessed 26 April 2016).
Kaiser Commission on Medicaid and the Uninsured (2013b), Medicaid: A primer, March, http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf (accessed 26 April 2016).
Kaiser Family Foundation (2015), The requirement to buy coverage under the Affordable Care Act, 2015 and beyond, https://kaiserfamilyfoundation.files.wordpress.com/2012/01/the-requirement-to-buy-coverage-under-the-affordable-care-act-2015.pdf (accessed 26 April 2016).
Klein, E. (2008), Health care's odd couple, *The American Prospect*, 15 February.
Kliff, S. (2013), It's official: The feds will run most Obamacare exchanges, *Washington Post*, 18 February.
Kirkman-Liff, B. (1997), *The United States*. In C. Ham (ed.), *Health Care Reform*: *Learning from International Experience*, Milton Keynes: Open University Press.
Kriner, D. L. and A. Reeves (2014), Responsive partisanship: Public support for the Clinton and Obama health care plans, *Journal of Health Politics, Policy and Law*, 39, 4: 717–49.
Ladd, E. C. (1994), *The American Ideology*, Storrs, CT: The Roper Center for Public Opinion Research.
Landers, R. (2012), The denouement of the Supreme Court's ACA drama, *New England Journal of Medicine*, 367, 3: 198–9.
Lane, D. (2009), Obama calls Wyden health plan radical, *The Oregonian/OregonLive*, 1 July, http://www.oregonlive.com/politics/index.ssf/2009/07/obama_calls_wyden_health_plan.html (accessed 26 April 2016).
Lipset, S. M. (1996), *American Exceptionalism Re-examined*: *The Double-Edged Sword*, New York, NY: WW Norton.
Langmaid, T. (2011), CDC: Health reform extends coverage to young Americans, *CNN*, 14 December, http://edition.cnn.com/2011/12/14/health/health-insurance/index.html?hpt=hp_t1 (accessed 26 April 2016).
Lee, F. E. (2009), *Beyond Ideology*: *Politics*, *Principles*, *and Partisanship in the US Senate*, Chicago, IL: University of Chicago Press.
Marchildon, G. P. (2014), The three dimensions of universal Medicare in Canada, *Canadian Public Administration*, 57, 3: 362–82.

Marmor, T. R. (2000), *The Politics of Medicare*, 2nd edn, New York, NY: Aldine de Gruyter.
Marmor, T. R. and Oberlander, J. (2010), The health bill explained at last, *New York Review of Books*, 19 August.
McDonough, J. E. (2011), *Inside National Health Reform*, Berkeley, CA: University of California Press.
Morone, J. (2012), Seven consequences of the health care ruling, *New York Times*, 28 June, http://campaignstops.blogs.nytimes.com/2012/06/28/seven-consequences-of-the-health-care-ruling/ (accessed 26 April 2016).
Morris, C. (2006), *Apart at the Seams: The Collapse of Private Pension and Health Care Protection*, New York, NY: The Century Foundation Press.
Oberlander, J. (2010), Long time coming: Why health reform finally passed, *Health Affairs*, 29, 6: 1112–16.
Pear, R. (2011), Program offering waivers for health law is ending, *New York Times*, 17 June.
Pear, R. and Calmes, J. (2009), Senate panel softening insurance penalties, *New York Times*, 1 October, http://www.nytimes.com/2009/10/02/health/policy/02health.html?_r=0 (accessed 26 April 2016).
Radnofsky, L. (2015), Percentage of uninsured in U.S. dropped in first year of Obama's health-care plan, *Wall Street Journal*, 16 September, http://www.wsj.com/articles/percentage-of-uninsured-in-u-s-drops-in-2014-1442416629 (accessed 26 April 2016).
Roy, A. (2012), Obamacare's dark secret: the individual mandate is too weak, *Forbes*, 8 July, http://www.forbes.com/sites/theapothecary/2012/07/09/obamacares-dark-secret-the-individual-mandate-is-too-weak/ (accessed 26 April 2016).
Simon, K. (2010), *Implications of Health Care Reform for Employers*, Washington, DC: Center for American Progress, https://www.americanprogress.org/wp-content/uploads/issues/2010/05/pdf/health_employers.pdf (accessed 26 April 2016).
Sinclair, B. (2006), *Party Wars: Polarization and the Politics of National Policy Making*, Norman, OK: Oklahoma University Press.
Skocpol, T. (1997), *Boomerang: Health Care Reform and the Turn against Government*, New York, NY: W. W. Norton.
Steinmo, S. and Watts, J. (1995), It's the institutions, stupid! Why the United States can't pass comprehensive national health insurance, *Journal of Health Politics Policy and Law*, 20, 2: 329–72.
Street, D. (2008), *Balancing acts: Trends in the public-private mix in health care.* In D. Béland and B. Gran (eds), *Public and Private Social Policy: Health and Pension Policies in a New Era*, Basingstoke: Palgrave Macmillan, pp. 15–44.
Thompson, F. (2013), *Medicaid Politics, Federalism, Policy Durability and Health Reform*, Washington, DC: Georgetown University Press.
Urbina, I. (2009), Beyond the beltway, health debate turns hostile, *New York Times*, 7 August.
Waddan, A. (2013), Health care reform after the Supreme Court: Even more known unknowns, *Health, Economics, Politics and Law*, 8, 1: 139–43.
Wawro, G. and Schickler, E. (2006), *Filibuster: Obstruction and Lawmaking in the U.S. Senate*, Princeton: Princeton University Press.
Weir, M. (1993), *Politics and Jobs: The Boundaries of Employment Policy in the United States*, Princeton: Princeton University Press.
Wyden, R. and R. F. Bennett (2009), Working across the aisle for health reform, *Washington Post*, 5 August.