Eight Ways to Judge Republican ACA Replacement Plans

If Congress and the Trump Administration are serious about protecting the coverage and benefit gains achieved thus far, their proposed plans should be judged against what the ACA accomplished when they took full control of the U.S. government.

The Affordable Care Act (ACA) has made historic improvements to our nation's health care system. The law has brought numerous benefits to families, state economies, and employers. The rate of people without health insurance is at an all-time low, and health care spending is growing at a slower rate than the many years prior to the ACA's passage.[1]

Rather than build on this progress, the new Congress is insistent on repealing the law without a guaranteed, comprehensive replacement, jeopardizing the health care of millions. President Trump has promised that he has a replacement that will provide "insurance for everybody," and congressional leaders have promised that they will "leave no one worse off."[2] Despite the rhetoric, they have yet to produce a meaningful alternative that demonstrably protects the health care lifeline upon which millions of people depend.

If Congress and the Administration are serious about protecting the coverage and benefit gains achieved thus far, their proposed plans should be judged against what the ACA accomplished when they took full control of the U.S. government. A replacement plan should be acceptable only if it will:

1. Preserve the coverage gains made to date and further decrease the number of people in this country without health insurance

The ACA has substantially reduced the number of people without health insurance.

Any replacement plan must:

- Cover at least as many people as the ACA has and further decrease the rate of people without health insurance. To date, the ACA has provided health insurance to **20 million people** and has led to a historically low rate of people without health insurance at **8.9 percent**.[3]

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2. Ensure that health coverage is at least as comprehensive as what people have under the ACA

People now have a guarantee that their health insurance plans will cover a broad scope of health care services, will not be full of exclusions of the care they actually need, and won't cut off benefits if they ever face a catastrophic illness.

Any replacement plan must:

- Ensure that people in private coverage and Medicaid do not lose coverage for services that they are currently guaranteed and *will not have to pay extra in order to get these benefits*. This includes hospital care, mental health and substance use disorder treatment, maternity care, prescription drugs, and more (see Table 1 in the Appendix on page 6 for a full list of benefits that people are currently guaranteed).
- Ensure people never have to pay deductibles or copays for the full scope of preventive care that must be covered today with no cost-sharing. These include vaccinations, screenings, mammograms, and contraception.
- Guarantee that no one will be subject to an annual or lifetime cap on how much their insurance will pay for care.

3. Ensure that premiums and cost-sharing—like deductibles and copays—are at least as affordable as those under the ACA

Today under the ACA, millions of lower- and moderate-income people are able to afford coverage thanks to either financial assistance to purchase health insurance through the marketplace or a state's expanded Medicaid program. The overwhelming majority of these people also benefit from cost-sharing protections to help make the cost of care, like copays, more affordable. People need assurance that moving forward, they won't be asked to shoulder an even greater share of costs.

Any replacement plan must:

- Provide financial assistance to help *at least* as many lower- and moderate-income people as would be eligible for help through the ACA. In 2019, **24.1 million** lower- and moderate-income people would be eligible to get financial assistance for buying coverage in the marketplace or coverage through the ACA's Medicaid expansion.[4]
- Provide adequate enough assistance to ensure that anyone who could benefit from financial assistance under the ACA would not be forced to pay higher premiums or cost-sharing—like deductibles and copays—compared to what they would pay under the ACA (See Tables 2 and 3 in the Appendix on pages 7 and 8 for a breakdown of premiums and cost-sharing these individuals pay now in Medicaid or in marketplace coverage, based on their income).

People need assurance that moving forward they won't be asked to shoulder an even greater share of costs.

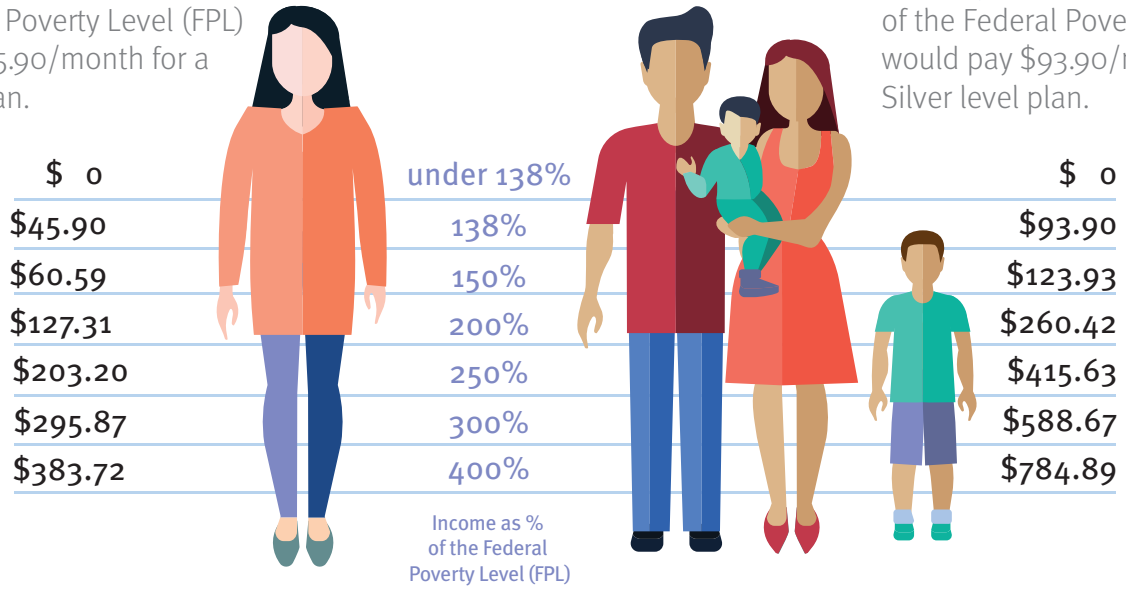
» Ensure that *everyone* with private coverage is protected from paying catastrophic costs. Individuals' cost-sharing must be capped at levels at least as generous as they are under the ACA. For example, in 2017, insurers cannot ask people below 200 percent of poverty to pay more than $2,250 ($4,500 for a family) in cost-sharing for care in a year.

» Close the Medicare doughnut hole by 2020 and ensure that seniors do not face higher cost-sharing for prescription drugs than they face today.

Premiums for coverage for people who get financial assistance under the ACA:*

An **individual** earning 138 % of the Federal Poverty Level (FPL) would pay $45.90/month for a Silver level plan.

A **family of four** earning 138 % of the Federal Poverty Level (FPL) would pay $93.90/month for a Silver level plan.



*Those with incomes under 138 percent of federal poverty have no premiums because they are eligible for Medicaid in states that have expanded Medicaid under the Affordable Care Act (32 states). In the 19 states that have not expanded Medicaid, those between 100 percent and 138 percent of poverty are eligible for marketplace coverage with subsidies to reduce their monthly premiums. Those under 100 percent of poverty are ineligible for assistance and have no option for low-cost coverage. In five states, Medicaid expansion enrollees pay nominal premiums, less than two percent of income. The premiums for those with incomes between 138 percent and 400 percent of federal poverty are based on the second-least expensive silver marketplace plan, after premium subsidies.

4. Ensure that the Medicaid and Children's Health Insurance Program (CHIP) safety-net continue to provide affordable, comprehensive health coverage for all low-income families who are currently entitled to it

Medicaid provides vital coverage to low-income people. For those living in poverty (or just above), Medicaid provides the most comprehensive coverage at the lowest cost to enrollees, the states, and the federal government. Expanded Medicaid under the ACA is critical to ensuring states can provide for their neediest residents. Additionally, federal dollars that fund the Medicaid expansion generate economic activity for states, create jobs, and increase business output and state revenue. Depriving states of the option to expand Medicaid or weakening the Medicaid entitlement would hurt their residents, and their economies.

Any replacement plan must:

- Ensure Medicaid remains a state-federal partnership where federal funding is responsive to state needs and prevents drastic changes to Medicaid's financing structure, such as per capita caps, block grants, or similar limiting mechanisms.
- Maintain Medicaid's current structure, ensuring that all low-income people eligible for the program may enroll.
- Provide all states with federal funding that is at least as generous as the ACA provides to support states maintaining or adopting the popular expansions of their Medicaid programs (see Appendix on page 9 for details on funding levels).
- Maintain current eligibility, benefits, and cost-sharing for all current and future Medicaid expansion programs.

5. Protect people with pre-existing health conditions at all times from discrimination by insurers

The ACA gave everyone a lifelong guarantee that health insurers cannot, under any circumstances, discriminate against them based on pre-existing health conditions.

A replacement plan must:

- Prevent private insurers from discriminating against the 133 million people with pre-existing conditions.[5] This means that plans can never deny coverage, charge higher premiums, or exclude coverage of certain benefits depending on someone's health condition, regardless of whether he or she previously had a gap in coverage.

6. Prevent insurers from discriminating against women and older people

Prior to the ACA's passage, private insurers were able to employ unfair practices and charge exorbitantly higher premiums to women and older people. These practices left many women and older people with no affordable coverage options.

Depriving states of the option to expand Medicaid or weakening the Medicaid program would hurt their residents and their economies.

A replacement plan must:

- Prevent private insurers from charging women higher premiums than men.
- Prevent private insurers from charging older individuals even higher premiums compared to younger people. Today under the ACA, health insurers cannot charge older adults premiums more than three times the rate of young people.

7. Ensure people have adequate assistance enrolling in and using their health coverage

Today, all people are guaranteed certain protections when they enroll in health insurance plans. When they search for a plan through the marketplace or Medicaid, they can compare plan offerings and get unbiased assistance enrolling. Once in a health plan of any type, they have access to a fair, unbiased process for settling any disputes.

Any replacement plan must:

- Provide consumers with robust assistance in order for them to enroll in and use health coverage.
- Provide consumers with help settling any problems that arise with their enrollment or coverage, including a fair and unbiased system for resolving disputes.

8. Ensure efforts to rein in health care spending tackle true drivers of health care spending, improve care quality, and never simply shift costs to consumers

The ACA made significant progress in addressing rising health care spending through initiatives that change the way care is paid for and delivered, so that providers are rewarded for delivering high-quality, evidence-based care instead of a high quantity of services. Moving forward, we must continue to focus on improving how care is paid for and delivered in order to rein in spending. Merely shifting growing costs to patients will only place greater financial strain on families and hurt their access to needed care. This is not a real solution to reducing health care spending in this country.

Any replacement plan must:

- Preserve funding and support for initiatives that seek to bend the cost curve through improving how care is paid for and delivered. An alternative plan must also preserve funding and support for the agencies that support such initiatives, including the Center for Medicare and Medicaid Innovation (CMMI).
- Maintain funding and support for national efforts to promote the use of evidence-based medicine, including the work of the Patient-Centered Outcomes Research Institute (PCORI).

Merely shifting growing costs to patients will only place greater financial strain on families and hurt their access to needed care.

Appendix

TABLE 1: Essential Health Benefits Covered in Medicaid Expansion and All Plans Sold in the Individual and Small Group Markets under the ACA: Replacement Plan Must Not Cut These Benefits
Physician Visits and Outpatient Care
Emergency Care
Hospital Care
Maternity Care
Mental Health and Substance Use Disorder Treatment
Prescription Drugs
Rehabilitative and Habilitative Care
Lab Services
Free Preventive Care
Pediatric Dental and Vision Care
People in the Medicaid expansion get additional benefits, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for children up to age 21, nonemergency medical transportation, and federally qualified health centers (FQHC) and rural health clinic services. Many states have chosen to go above and beyond what is required by providing Medicaid expansion enrollees with some coverage for long-term care, vision and oral health care, and hearing aids.

TABLE 2: Premiums with Financial Assistance under the ACA: Replacement Plans Must Provide Equal or Greater Assistance with Premiums

Percent of Poverty	Annual Income: Individual	Annual Income: Family of Four	Premium
Under 138%	Under $16,394	Under $33,534	$0 (No Premiums)*
138%-150%	$16,394-$17,820	$33,534-$36,450	3.36 - 4.08 percent of income**
150%-200%	$17,820-$23,760	$36,450-48,600	4.08-6.43 percent of income**
200%-250%	$23,760-$29,700	$48,600-$60,750	6.43-8.21 percent of income**
250%-300%	$29,700-$36,640	$60,750-$72,900	8.21-9.69 percent of income**
300%-400%	$36,640-$47,520	$72,900-$97,200	9.69 percent of income**

*Assumes individuals under 138 percent of poverty are eligible for Medicaid expansion, which has no premiums. In non-expansion states, individuals between 100-138 percent of poverty are still eligible for subsidies to purchase marketplace coverage. In these states, premiums would be 2.04 percent of income for individuals between 100-138 percent of poverty.

**Annual premium for second-least expensive silver marketplace plan, after premium subsidies

TABLE 3: Cost-Sharing with Financial Assistance under the ACA: Replacement Plans Must Provide Equal or Greater Assistance with Cost-Sharing

Percent of Poverty	Annual Income: Individual	Annual Income: Family of Four	Actuarial Value of Coverage	Avg. Deductible, 2016***	Avg. Out-of-Pocket Limit, 2016***
Under 138%	Under $16,394	Under $33,534	97%*	Nominal cost-sharing capped at 5% of income*	
138%-150%	$16,394-$17,820	$33,534-$36,450	94%**	$221	$874
150%-200%	$17,820-$23,760	$36,450-48,600	87%**	$709	$1,795
200%-250%	$23,760-$29,700	$48,600-$60,750	73%**	$2,491	$4,850
250%-300%	$29,700-$36,640	$60,750-$72,900	70%**	$3,064	$6,160
300%-400%	$36,640-$47,520	$72,900-$97,200	70%**	$3,064	$6,160

*Assumes individuals under 138 percent of poverty are eligible for Medicaid expansion. In non-expansion states, individuals between 100-138 percent of poverty are still eligible for marketplace coverage with cost-sharing reduction subsidies to lower out-of-pocket costs. In these states, actuarial value of coverage for individuals between 100-138 percent of poverty is 94 percent, average deductible and out-of-pocket limits are equivalent to amounts for people between 138-150 percent of poverty. Actuarial value of Medicaid coverage based on analysis prepared by Actuarial Research Corporation (ARC) for Congressional Research Service.

Evelyne Baumrucker and Bernadette Fernandez, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*, (Washington, DC: Congressional Research Service, June 2013).

**Actuarial value of silver-level marketplace coverage, after any cost-sharing reduction subsidies to reduce out-of-pocket costs for people below 250 percent of poverty.

***For individuals between 138 - 400 percent of poverty, average deductible and out-of-pocket spending limits are based on average amounts across silver plans in all federal-facilitated marketplaces. Source: Matthew Rae, Gary Claxton, Cynthia Cox, Michelle Long, and Anthony Damico, *Cost-Sharing Subsidies in Federal Marketplace Plans, 2016* (Washington, DC: Kaiser Family Foundation, November 2016), available online at http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans-2016/

TABLE 1: Federal Funding for Medicaid Expansion under the ACA

Year	Percent of Medicaid Expansion Costs Paid by Federal Government
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 onward	90%

Endnotes

1 Emily P Zammitti, Robin A. Cohen, Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2016*, (Hyattsville, MD: National Center for Health Statistics, November 2016), available online at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf; Peterson-Kaiser Health System Tracker, *What is Behind the Recent Slowdown in Health Spending* (Washington, DC: Peterson-Kaiser Health System Tracker), available online at http://www.healthsystemtracker.org/chart-collection/what-is-behind-the-recent-slowdown-in-health-spending/?slide=1, last accessed January 19, 2017.

2 Robert Costa and Amy Goldstein, *"Trump vows insurance for everybody in Obamacare replacement plan,"* Washington Post (January 15, 2017), available online at https://www.washingtonpost.com/politics/trump-vows-insurance-for-everybody-in-obamacare-replacement-plan/2017/01/15/5f2b1e18-db5d-11e6-ad42-f3375f271c9c_story.html?utm_term=.3c86c69209dd and Craig Gilbert, *Paul Ryan: Obamacare phaseout will leave 'no one worse off'*, USA Today (Dec. 5, 2017), available online at http://www.usatoday.com/story/news/politics/2016/12/05/paul-ryan-obamacare-phaseout-leave-no-one-worse-off/95002488/

3 Namrata Uberoi, Kenneth Finegold, and Emily Gee, *Health Insurance Coverage and the Affordable Care Act, 2010-2016* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, March 2016), available online at https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf. Emily P Zammitti, Robin A. Cohen, Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2016*, (Hyattsville, MD: National Center for Health Statistics, November 2016), available online at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf

4 Families USA analysis of Urban Institute data. Number is the aggregate of Urban Institute estimates of the following for 2019: Individuals with non-group market coverage who are eligible for premium tax credits under the Affordable Care Act (ACA); Number of newly eligible people enrolled in Medicaid expansion ; and the number of uninsured eligible for premium tax credits or Medicaid expansion, based on difference in number of uninsured eligible for financial assistance with coverage under the ACA, versus under a reconciliation bill that repeals premium tax credits and Medicaid expansion.

5 Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, January 2017), available online at https://aspe.hhs.gov/sites/default/files/pdf/255396/Pre-ExistingConditions.pdf

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