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from multiple health plans back to "no plan"

March was a tumultuous time for health care with the demise—at least for now—of the American Health Care Act (AHCA).

In my Eye on Washington column prior to the legislation's quick rise and fall, I discussed various replacement bills Republicans have raised in Congress, including the Better Way released in 2016, which served as the basis for the AHCA, and other legislation proposed by Sen. Bill Cassidy (R-La.) and Sen. Susan Collins (R-Me.) and by Sen. Rand Paul (R-Ky.).

In mid-March, seeing that the AHCA was in trouble, the House leadership and White House attempted to modify the bill to gain the support of the Freedom Caucus. That move not only failed to achieve its purpose but also lost the bill support from some House moderate Republicans in the process. When it became clear that Speaker Paul Ryan (R-Wis.) didn't have the votes to pass the legislation, it was pulled from the House agenda.

Despite the introduction of competing legislation in the Senate, the AHCA was the vehicle Senate majority leader Mitch McConnell (R-Ky.) had planned to use, and his plan was to send the House legislation directly to the Senate floor. Had the plan succeeded, the Republicans would have re-created the same political dynamics that Democrats had created with the Affordable Care Act (ACA): a major piece of social legislation that was supported by one party and strongly opposed by the other. It should have been expected that this move would elicit the same response among Democrats that the ACA had created among Republicans: unwavering opposition to the bill, fueled by undying enmity. The AHCA also would have increased the number of uninsured by 24 million over the next decade—hardly a positive dynamic for Republicans or the people affected.

With the AHCA's quick exit, both the House and the Senate have put further deliberations regarding an ACA replacement bill on hold, although discussions of reintroducing the AHCA or a variant for consideration began almost immediately after the bill was withdrawn.

Meanwhile, the ACA remains the "law of the land."[a] Several states are trying to expand their Medicaid programs, including Kansas, Georgia, and North Carolina, although the Kansas governor vetoed the expansion.

The Trump administration also must decide whether to try to stabilize the exchanges enough to be functional for the 2017 open enrollment period, which begins Nov. 1. The congressional Republicans challenged cost-sharing reduction payments because Congress had not specifically appropriated funds for this purpose. The challenge was upheld in the lower courts, and the question is whether the Congress will now make the appropriation or find another means to continue this support for lower income individuals to purchase insurance. Because any replacement bill or legislation that provides major changes to the ACA will take time to put in place, having a stabilized individual marketplace in the interim will be to everyone's benefit.

Although an anathema to many, including the Trump administration, the ACA's individual mandate should be enforced until another

a. Conway, M. "'Obamacare Is the Law Of The Land' for the Foreseeable Future," Politico, March 24, 2017.

mechanism that strongly encourages enrollment can be put in its place. A forcing mechanism is needed to bring most people into the market to support current rules against preexisting condition exclusions and any form of pricing differentials for expected health care use other than the 3:1 premium variation allowed for age. Nonetheless, the latest information suggests nearly twice as many people claimed exemptions from the mandate when filling taxes last year than were penalized under the mandate—approximately 12.7 million versus 6.5 million.[b]

It is ironic that the AHCA's proposed use of a 30 percent premium surcharge for one year for people who didn't maintain continuous coverage used in place of the mandate seemed almost as unpopular as the mandate itself. Other strategies have been mentioned to accomplish similar objectives, including auto-enrollment with an opt-out where individuals who don't actively choose an insurance plan would be enrolled in a plan that costs only whatever subsidy that are entitled to receive. Another alternative is to use Medicare's strategy for its voluntary programs—Parts B and D. A senior who does not choose a program in the year he or she turns 65 or loses employer-sponsored coverage and then decides to purchase Part B or D coverage later pays a penalty for every month the purchase was delayed.

The release of a proposed market stabilization rule by the U.S. Department of Health & Human Services (HHS) in February seems to indicate the administration understands the importance of stabilizing the market in the short run. It includes provisions that require pre-enrollment verification for people using special enrollment periods, shortening the open enrollment period, and letting insurers collect past-due premiums before enrolling a person in the same health plan, and it provides greater flexibility to plans in meeting the ACA required actuarial value. It was projected that the final rule would be out in April.

b. Mangan, D., "Tax Forms Show Fewer People Paid Obamacare Tax Penalties, More Received Obamacare Aid," CNBC, Jan. 11, 2017.

Meanwhile, the repeal-and-replace drumbeat continues in the background. Further consideration might be given to the Cassidy-Collins bill. The bill would allow states to continue with the ACA, receiving their Medicaid funding and 95 percent of their subsidy money or to receive 95 percent of their federal money to pay people to use their refundable tax credits to purchase high-deductible health plans paired with a health savings accounts. Alternatively, states could do something else, but without federal funding.

In the short term, and perhaps longer term, the administration could focus on using the ACA's 1332 waiver to encourage states to experiment with alternative ways to provide ACA-like coverage. The Obama administration required that 1332 waivers be budget neutral only across the tax credits rather than allowing the Medicaid population and the subsidy/credit population to be treated as a single group. It also required waivers to be budget neutral in each year rather than over the several-year period that is common with 1115 Medicaid waivers. But these requirements were put in place using "guidance" rather than rule making and can be readily changed.

HHS Secretary Tom Price and CMS administrator Seema Verma are expected to allow greater flexibility in the waiver process and to encourage states to make greater use of waivers. If the subsidized insurance market were deemed an extension of the Medicaid population, Price and Verma might allow for more flexible movement of money between these two groups, which could bring some of the stability that has characterized the Medicaid expansion to the churn that has characterized so much of the exchange market.

Healthcare reform has been temporarily sidelined, but the need to reform, repair, or replace the ACA remains the same. ■

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