

Health Reform Progress

Beyond Repeal and Replace



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ABSTRACT

From the start of 2017 through the fall of that year, Congress labored to pass legislation to replace large parts of the Affordable Care Act. Ultimately, political obstacles proved insurmountable, and Congress was unable to enact a health reform bill. Soon after that failure, President Trump signed an executive order promoting health care choice and competition and directing the administration to issue rules expanding more affordable options, principally for middle-income families and small employers and their employees.

Over the next 20 months, the administration issued three major rules expanding coverage through Association Health Plans, short-term limited-duration insurance, and Health Reimbursement Arrangements. These rules, combined with Congress eliminating the penalty associated with the ACA's individual mandate, have achieved many key objectives, including enhancing consumer choice of coverage, returning some insurance regulatory oversight from the federal government to states, and making health insurance subsidies fairer.

In addition to these key rules, the Trump Administration has taken several steps to improve the ACA's individual insurance market by reducing people's ability to wait until they are sick to purchase coverage and approving state waivers for programs to separately subsidize high cost enrollees. The administration also has made it easier for people with chronic conditions to benefit from Health Savings Accounts and for states to reform their health insurance markets.

Serious challenges remain, including enrollment abuses and cost overruns from the ACA's Medicaid expansion as well as an individual market in many states where premiums are unaffordable for people not eligible for subsidies. Although there is still a profound need for congressional action to address these problems as well as other policies that drive higher health care costs, the Trump Administration has a strong record of health policy accomplishment and has set a bold vision for health reform centered on empowering consumers and promoting competition among providers.



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Moving Beyond Repeal and Replace

Before President Trump took office, the nation's health sector was being pushed ever further toward greater government control rather than toward consumer choices in a more competitive market.

This was largely due to significant changes mandated by the Affordable Care Act (ACA). The ACA contains scores of provisions that touch nearly every part of the health sector, but its core components center on expanding government-centric coverage. The ACA provided massive new federal spending for states that expanded their Medicaid programs to able-bodied, childless, working-age adults; imposed stringent new federal standards for health insurance; included tax penalties and subsidies to encourage take-up of this insurance; and contained funding mechanisms—both a variety of new and expanded taxes as well as Medicare payment reductions—to partially finance the regime.

In sum, the ACA represented a massive federal encroachment—with its complicated web of mandates, regulations, taxes, and subsidies—on the nation's health sector. The law led to sharp premium increases in the individual market for health insurance, a dearth of coverage options for families, diminished quality of coverage for people with serious medical conditions, a significant reduction in the number of small employers offering coverage to their workers, and an abundance of both improper and wasteful federal spending.

President Trump was elected, in part, on a campaign promise to undo the damage caused by the ACA. However, congressional efforts to repeal harmful aspects of the ACA and replace portions with a more market-based and less Washington-dominated structure proved inadequate to the political challenge. Although the blame for the failure is widespread, from a poor legislative process to a lack of consensus in the center-right policy community, the effort was considerably harmed by bogus estimates produced by the Congressional Budget Office (CBO). In its calculations, CBO attributed far too much importance to the power of the individual mandate to expand coverage, which required most Americans to obtain government-approved health insurance or pay a penalty. Thus, CBO projected highly exaggerated coverage gains attributable to compliance with the individual mandate and therefore exaggerated coverage losses from eliminating the penalty.¹



The main conservative policy goals during the efforts to “repeal and replace” the ACA were:

- Freeing individuals to purchase coverage that works best for them
- Returning health insurance regulatory oversight to the states
- Making federal health insurance subsidies more rational and equitable and giving consumers more flexibility to target government assistance to their preferred coverage, and
- Reforming the Medicaid program and putting federal health spending on a more sustainable trajectory.

Although legislative efforts to repeal and replace the ACA largely ceased by the end of September 2017 when the 2017 budget reconciliation instructions expired,² actions by the Trump Administration since then, combined with the subsequent elimination of the individual mandate penalty, have advanced conservative policy in each of these four areas. The most influential administration-led actions were motivated by President Trump’s October 12, 2017 Executive Order on Promoting Health Care Choice and Competition Across the United States.³

Following this order, the Trump Administration pursued efforts to increase consumer choice and inject more competitive forces into health care markets with several administrative actions detailed below. The administration also pursued policies to help improve the deteriorating individual market by approving state plans to implement state-based risk mitigation programs and by reducing the ability of people to wait until they were sick to purchase coverage. While the administration continues to push the boundaries of what it can do through regulatory and sub-regulatory actions—for example, two weeks after the last element of the October 2017 Executive Order was finalized, the President issued an Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First⁴—there are still significant, market-oriented actions that Congress and states can take to improve the nation’s health sector.



Freeing Individuals to Purchase Coverage That Works Best for Them

The ACA required all non-grandfathered plans to meet a list of coverage requirements, including covering a federally-determined essential health benefit (EHB) package and a set of federally-determined preventive services without cost-sharing, as well as significant restrictions on how that coverage could be priced. The ACA's individual mandate penalized people unable or unwilling to purchase the expansive coverage required by the law. The unprecedented penalty almost took down the entire law in 2012 after a legal challenge⁵ against it, and still is the subject of litigation working its way through the courts.ⁱ The individual mandate penalty, defined as a tax by Chief Justice Roberts, turned out to be extremely regressive. Nearly 80 percent of the households paying the penalty had an annual income below \$50,000.⁶ The Tax Cut and Jobs Act of 2017 zeroed out the individual mandate penalty, providing a significant financial benefit to lower-income and middle-income families subject to it.⁷ Eliminating the penalty also reduced the bias in the tax code in favor of ACA-compliant coverage over other types of health coverage and financing arrangements.

The Trump Administration finalized two rules in the summer of 2018 that further increased consumers' coverage options:

ASSOCIATION HEALTH PLANS: In June 2018, the Department of Labor finalized a rule creating a new pathway for employers, including many sole proprietors, to join together and offer coverage through an Association Health Plan (AHP).⁸ This rule provided smaller employers another pathway to gain the regulatory advantages and economies of scale that large employers receive when offering health insurance. Specifically, this pathway allowed any employers within a state or common metropolitan area to form an AHP regardless of their line of businesses and allowed these AHPs to include sole proprietors. Unfortunately, in March 2019, a federal judge ruled this new pathway to be an invalid interpretation of ERISA.ⁱⁱ

ⁱ The State of Texas and 19 other states filed suit saying that the individual mandate was unconstitutional after the passage of the Tax Cut and Jobs Act, arguing that the individual mandate tax penalty was eliminated so the mandate could no longer function as a tax. Moreover, these states argued that the entire Act had to fall because the ACA could not function properly without the mandate. On December 14, 2018, Judge Reed O'Connor of the Northern District of Texas agreed and struck down the entire ACA. He stayed his ruling pending appeal. On July 9, 2019, the U.S. Court of Appeals for the 5th Circuit heard oral arguments in the case.

ⁱⁱ In July 2018, a coalition of 12 Democratic attorneys general filed a lawsuit challenging the final AHP rule for violating the Administrative Procedures Act. The attorneys general argued that the DOL's interpretation of "employer" was inconsistent with ERISA and the rule was intended to undermine the ACA. On March 28, 2019, Judge John D. Bates of the District of Columbia found that the AHP rule was "clearly an end-run around the ACA" and struck



The Labor Department has appealed.⁹

SHORT-TERM LIMITED-DURATION INSURANCE: In August 2018, the Departments of Health and Human Services (HHS), Labor, and the Treasury finalized a rule expanding consumers’ ability to purchase short-term, limited-duration insurance (STLTI).¹⁰ STLTI coverage is primarily useful for the nearly 30 million uninsured, those between jobs, and those most hurt by rising premiums and lack of affordable coverage. The plans, which are not required to comply with the ACA’s expensive mandates, had been available for decades, with federal law permitting a contract period of up to 364 days. However, in the closing months of the Obama Administration, those same three departments restricted the purchase of STLTI plans to no more than 90 days and restricted consumers’ ability to renew their coverage.¹¹ The Obama Administration likely undertook this action to choke off competition with ACA-compliant coverage since these products were increasingly attractive to consumers, generally providing lower premiums and much broader provider networks than ACA plans.

The August 2018 STLTI rule largely reversed the Obama Administration’s rule, restoring the 364-day contract period, permitting renewal of plans for up to three years, and clarifying that people could combine STLTI with separate insurance products—often dubbed “renewal guarantees”—that protect people from future medical underwriting.ⁱⁱⁱ After interviewing insurers and other stakeholders, CBO and the Joint Committee on Taxation (JCT) “expect that a range of new short-term insurance products will be sold as a result of the new rule” and that the products “will resemble a typical nongroup insurance plan offered before 2014.”¹² CBO projects that 95 percent of people moving from the individual market to the short-term market will buy coverage that meets CBO’s definition of private health insurance and provides true financial protection and with premiums “as much as 60 percent lower than premiums for the lowest-cost bronze plan” for those who are eligible.¹³

According to the White House Council of Economic Advisers (CEA), “By freeing people to renew their plans for up to three years, the administration’s actions will reduce application costs, lower the risk of loss of coverage, and allow for more innovation in plan design.”¹⁴ On July 19, 2019, U.S. District Court Judge Richard Leon dismissed a lawsuit around the STLTI rule, writing, “Not only is any potential negative impact

down most of the rule. Judge Bates found that allowing any employers within a state or common metro area to join together did not meaningfully limit the types of associations that could qualify to sponsor an ERISA plan and that the working owner provision is inconsistent with ERISA, which is to regulate benefit plans that derive from employment relationships. On April 26, 2019, the Department of Justice filed a notice of appeal of the Court’s decision.

ⁱⁱⁱ For a fuller review of the STLTI rule and particularly the renewal guarantee component and how STLTI plans benefit people with pre-existing conditions, see: <https://www.wsj.com/articles/first-do-no-harm-to-obam-acare-1539298783>.



from the 2018 rule minimal, but its benefits are undeniable.”¹⁵ Judge Leon also pointed out that the ACA exempted some types of health insurance from its regulatory reach, writing, “lawmakers were not rigidly pursuing the ACA-compliant market at all costs, e.g. at the risk of individuals going without insurance.”¹⁶

CEA estimated the net economic benefit from the elimination of the individual mandate penalty combined with the AHP and STLDI rules.¹⁷ In its assessment, CEA measured how consumers themselves value their health insurance options—finding that the total net value of these three actions will be nearly \$500 billion over the next decade, or an average of about \$3,500 per household.¹⁸

Returning Regulatory Authority to the States

The ACA’s plethora of insurance rules, including its mandated benefits and pricing restrictions, replaced state regulation with Washington’s standardized regulatory framework. One of the main goals of the repeal and replace efforts was to return regulatory authority to the states. Although the ACA’s insurance rules remain in place, the administration has used rulemaking to provide greater state flexibility on the margin, such as providing more state flexibility around EHB requirements.^{iv} Crucially, both AHPs and short-term plans discussed above are subject to state regulation.

The Trump Administration has made it more likely for states to pursue health reforms that waive certain provisions of the ACA using authority given to states in section 1332 of the ACA.^v Section 1332 of the ACA permits states, with approval from HHS and Treasury, to pursue alternative policy designs through “State Innovation Waivers.” In order to obtain a waiver, four guardrails must be satisfied: 1) coverage must be at least as comprehensive as EHB coverage; 2) cost-sharing protections must be at least as affordable as those provided by the ACA; 3) at least a comparable number of people must be covered; and 4) the program must be deficit neutral to the federal government. The states can obtain federal “pass through” money to reallocate premium tax credit (PTC) funds to enhance consumer choice and affordability.

^{iv} Under the 2019 final Notice of Benefit and Payment Parameters rule, HHS allowed states three additional options to select an EHB-benchmark plan: states can select another state’s entire 2017 EHB-benchmark plan, replace one or more of its EHB categories using another state’s 2017 EHB-benchmark plan, or select an entirely new EHB-benchmark plan. See : <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf>.

^v Subject to a variety of conditions, 1332 waivers allows states to waive the rules regarding the qualified health plans, such as the EHB requirements as well as provisions such as the individual and employer mandates and the premium tax credits.



The Obama Administration issued guidance in 2015 that made 1332 waivers virtually unusable for states.¹⁹ This guidance tightened the guardrails by, for example, instituting population subgroup tests as well as an overall test. Based on this guidance, even if a state pursued a plan that made coverage more affordable overall, it would fail to meet the guardrails if it was made less affordable for a subgroup.

In October 2018, the Trump Administration rescinded the old guidance, putting in place new rules that it hoped would spur state innovation. The administration indicated it was looking for state waivers that would provide increased access to private coverage, such as AHPs and STLDI; encourage sustainable spending growth by promoting more cost-effective coverage and eliminating state regulations that reduce choice and competition; support and empower those most in financial or medical need; and promote consumer-driven health care. The administration has laid out several concepts for states that would allow them to redirect PTCs to other types of plans and to reorient subsidies to consumer accounts and away from direct payments to insurance companies.²⁰

Crucially, the administration's new guidance replaced a strict enrollment standard from the 2015 guidance with an access standard. In other words, the guardrails to receive a 1332 waiver now can be satisfied if a comparable number of people have *access to coverage* that is as affordable and as comprehensive as under the baseline scenario, rather than assessing the number of individuals actually enrolled in affordable and comprehensive coverage. A state waiver also can be approved if it fails the comprehensiveness and affordability standards for some population subgroups so long as the guardrails are satisfied in the aggregate. While seven states have received 1332 waivers to implement risk mitigation programs (discussed below), no state has yet to submit to HHS a 1332 waiver proposal that takes advantage of the new flexibilities.

Fairer and More Flexible Government Subsidies For Health Insurance

Setting aside federally-run programs such as Medicare, Medicaid, the Veterans Administration, Tricare, the Indian Health Services, and others, the federal government currently provides two large tax advantages for certain types of health insurance: the exclusion of the cost of employer-sponsored insurance (ESI) premiums from federal income and payroll taxes and the ACA's PTC for people with incomes below 400 percent of the federal poverty level (FPL) who purchase health insurance on an ACA exchange. Both tax advantages encourage the purchase of more expansive health insurance and inflate total spending, and both need reform.



The ESI exclusion produces upward pressure on health care costs²¹ and results in health insurance crowding out cash wages.²² Because of the exclusion, employers generally select the health insurance plans available to their employees, curtailing employee choice. Moreover, the plans constructed to meet employers' needs may not be the types of coverage their employees would value the most. Eighty percent of firms offering coverage only provide workers a single type of plan, most likely a preferred provider organization (PPO) plan.²³

The ACA contained an excise tax—dubbed the Cadillac tax—on employer coverage for premiums beyond a relatively high threshold. The Cadillac tax was designed to discourage the purchase of excessive health insurance and to provide a source of revenue to offset the ACA's spending provisions. The Cadillac tax was intended to take effect in 2018, with a 40 percent excise tax on policies valued above \$10,200 for single coverage and \$27,500 for family coverage. In 2015, Congress delayed the tax's start date until 2020 and weakened the tax by changing it from a non-deductible tax to a deductible tax.^{vi} In 2017, the initial Republican bill designed to repeal and replace the ACA sought to replace the regressive Cadillac tax with a more-properly structured cap on the value of the tax exclusion.^{vii} This provision was one of the first to be jettisoned, encountering strong political resistance from business and labor groups. In January 2018, President Trump signed legislation with another two-year delay of the Cadillac tax, moving its effective date to January 1, 2022.²⁴

CBO estimates that the thresholds will be \$11,200 for single coverage and \$30,100 in 2022, and the JCT estimates that the tax will generate \$197 billion of revenue from 2022 through 2029.²⁵ The consistent delays of the Cadillac tax and the failure of Congress to replace it with a cap on the amount of ESI excluded from taxation are testament to the deep political interests that oppose reforming this distortionary tax preference and thereby protect tax policy that inflates health care spending. On July 18, 2019, the House of Representatives overwhelmingly voted to repeal the Cadillac tax.²⁶ A common sense proposal for reforming the Cadillac tax and advancing consumer-based health reform would be to exempt HSA contributions from the Cadillac tax thresholds.²⁷

^{vi} For my view at the time of the legislation to delay and weaken the Cadillac tax, see: <https://www.forbes.com/sites/theapothecary/2015/12/16/delaying-and-weakening-obamacares-cadillac-tax-a-bad-outcome/#37511c297e21>

^{vii} The Cadillac tax applies a 40 percent excise tax to the value of ESI above a certain threshold. The tax is especially harmful to working-class or middle-class workers who are in a relatively low marginal tax rate since \$1 additional compensation that is above the threshold will have a marginal cost of \$.40, rather than the marginal tax rate they face.



HEALTH REIMBURSEMENT ARRANGEMENTS: The October 2017 Executive Order signaled that the Trump Administration would address part of the tax code problem—the bias in favor of employer-selected plans—through an expansion of Health Reimbursement Arrangements (HRAs). HRAs are tax-advantaged mechanisms for employers to reimburse employee health care expenses. In June 2019, the Departments of HHS, Labor, and the Treasury promulgated the final HRA rule, which created two new types of HRAs—the individual coverage HRA (ICHRA) and the excepted benefit HRA (EBHRA).²⁸ This rule addresses the distortion caused by the tax exclusion for ESI in perhaps the smartest possible political way—by offering employers and employees another option for utilizing the tax benefit where the employees have greater control.

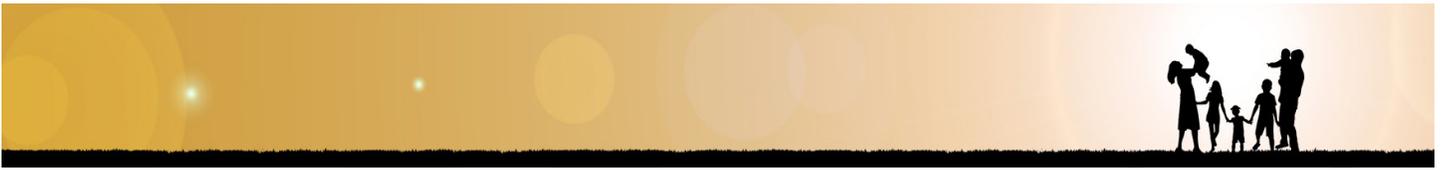
Individual Coverage HRA (ICHRA): The ICHRA effectively equalizes the tax treatment of traditional ESI and individually-selected coverage in the individual market using employer contributions.^{viii} The ICHRA was constructed to maximize employer flexibility if their employees stand to benefit from the arrangement subject to guardrails to protect the individual market from adverse selection.^{ix}

Employers will generally only offer the ICHRA if it is a more attractive option for their employees, and in the near term, this should be particularly helpful for smaller firms that would not otherwise offer coverage as well as firms that find it too costly to administer a health plan. The rule contains significant flexibilities that should make ICHRAs attractive to larger firms as well, incentivizing them to offer ICHRAs, particularly for part-time workers, hourly workers, and workers in geographic locations where the individual market contains more affordable coverage options.^x The departments also recognized that many employees with coverage are resistant to changing that coverage. The rule therefore contains a new-hire provision that permits employ-

^{viii} The employer contributions provided to the ICHRA are tax-advantaged (i.e., not subject to federal income and payroll taxes). The employee can use the ICHRA to reimburse the purchase of individual market insurance or, for enrollees aged 65 and older, Medicare. Employee premiums for traditional ESI are also tax-advantaged. Employers may offer employees a 125 Cafeteria plan so the employee share of individual market coverage purchased through an ICHRA to also be tax advantaged.

^{ix} There were three main guardrails: 1) within a class, employers cannot offer a choice of the traditional group plan and the ICHRA, 2) employers have to make the same offer on the same terms for all employees within a class, with the exception that the ICHRA can increase for older employees and for employees with more dependents, and 3) if employers offered a traditional plan to one set of employees and an ICHRA to another set of employees, a minimum class size would apply to the number of individuals offered an ICHRA for certain classes. The classes in the final rule are: full-time workers, part-time workers, salaried workers, hourly workers, seasonal employees, employees subject to a collective bargaining agreement, employees in a waiting period, employees of temporary staffing firms, employees in certain rating areas, employees who are nonresident aliens, and combinations of the classes.

^x For a fuller discussion of my view of the HRA rule, see: <https://www.cnn.com/2019/06/13/perspectives/hra-health-care-business-trump/index.html>



ers to grandfather existing employees into the traditional group plan and to offer only newly-hired employees the ICHRA.

The administration projects that it will take about five years for the ICHRA to reach an equilibrium point. At that time, the administration estimates that 800,000 employers—nearly 90 percent of them with fewer than 20 workers—will offer ICHRAs, and more than 11 million people will be enrolled in the individual market using an ICHRA.^{xi} The rule is projected to increase individual market enrollment by more than 50 percent and reduce the number of uninsured by nearly one million.²⁹

In addition to increasing employer flexibility and significantly increasing employee choice at firms that offer the ICHRA, the ICHRA should increase pressure on elected policymakers and regulators to allow a greater variety of individual market coverage at prices that more accurately reflect risk. The ICHRA will also increase the transparency of employer contributions to health insurance. A defined contribution structure for health insurance is similar to 401(k) plans and 403(b) plans for retirement savings where employers provide a set amount of funds with workers having control over the investment. The new ICHRAs will tend to produce more engaged and cost-conscious consumers. All of this will increase competitive pressure on insurers to provide better options and put downward pressure on health insurance costs.

Excepted Benefit HRA (EBHRA): Lesser publicized than the ICHRA is the EBHRA—the excepted benefit HRA. Employers can offer the EBHRA only to workers who also receive an offer of a traditional group plan. The main benefit of the EBHRA will accrue to workers who obtain a low value from the employer’s traditional group plan. For example, 27 percent of workers at firms with fewer than 200 workers turn down the offer of employer coverage.³⁰ Moreover, the Kaiser Family Foundation estimates that 3.8 million of the estimated 27.4 million who were uninsured in 2017 refused an offer of ESI.³¹ Workers can use the excepted benefit HRA, which is capped at \$1,800 in 2020 and adjusted for inflation afterward, toward the purchase of STLDI as well as other coverage, such as dental or vision plans.

HEALTH SAVINGS ACCOUNT (HSA) ENHANCEMENT: In addition to HRAs, the Trump Administration strongly supports health savings accounts (HSAs), although less can be accomplished through administrative action to expand HSAs. On July 17, 2019, the Internal Revenue Service announced that a list of preventive services could be covered by a high deductible health plan below the deductible for

^{xi} Of the 11 million employees and dependents, the administration projects that about 7 million will transition from traditional ESI, about 3 million will move from an individual market plan without an HRA to the ICHRA with individual market coverage, and about one million will gain coverage who would otherwise be uninsured.



people with chronic conditions.³² This list includes insulin for people with diabetes and statins for people with heart disease. The policy intent was to enhance the ability of insurers to offer plans that could be integrated with HSAs and to allow people with chronic conditions greater ability to save for future health care expenses. A forthcoming rule should expand consumers' ability to use HSAs and HRAs to purchase direct primary care services and potentially coverage through health sharing ministries.^{xii}

Medicaid Reform and More Sustainable Federal Health Spending

Although there are problems with the tax exclusion for ESI, it is a much cheaper way to subsidize coverage than the ACA's subsidy mechanisms. According to CBO, the average revenue loss from the exclusion equaled \$1,810 in 2019, compared to an average per enrollee federal budget cost from the ACA's premium tax credits of about \$6,490 and of \$5,500 for the Medicaid expansion.³³ Worse, despite the ACA's significant new spending, several analyses suggest that many ACA beneficiaries place little value on the coverage.

A 2015 paper estimated that enrollees in Medicaid expansion valued their coverage at much less than the cost of the coverage, with benefits accruing primarily to hospitals from a reduction in uncompensated care.³⁴ According to the study, "Across a variety of alternative specifications, we consistently find that Medicaid's value to recipients is lower than the government's costs of the program, and usually substantially below."³⁵ The economists estimated that the "welfare benefit to recipients from Medicaid per dollar of government spending range[s] from about \$0.2 to \$0.4."³⁶ The actuaries at the Centers for Medicare and Medicaid Services (CMS) also estimate that many lower-income people place extremely low value on exchange coverage. For example, the actuaries estimate that 40 percent of people with incomes between 100 percent and 138 percent of the FPL would not enroll in a heavily subsidized exchange plan if their state moved Medicaid eligibility from 138 percent of the FPL to 100 percent of the FPL.^{xiii}

^{xii} On June 24, 2019, the Secretary of the Treasury was directed by the President to further expand peoples' ability to use HSAs and HRAs by "proposing regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under section 213(d) of [the Internal Revenue Code]." See: <https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/>

^{xiii} The administration was considering a proposal to allow states to move Medicaid eligibility from 138 percent of the FPL to 100 percent of the FPL and still receive the enhanced reimbursement rate after requests from states like Arkansas and Utah. The actuaries at CMS modeled the impact of a change in administration policy that would allow states to "partially" expand their Medicaid programs. Earlier this year, the actuaries provided information that 40 percent of in-



The main failure of legislative efforts to replace the ACA was that these inefficient subsidy structures, particularly the extremely high Medicaid expansion reimbursement rate, remain in place. However, some progress has been made. First, some people who place very low value on the ACA coverage who would have otherwise enrolled can opt out without receiving a penalty. These individuals who decide they are better off by saving their out-of-pocket premium payment will also create social benefit from turning down the large subsidy for coverage they don't value.^{xiv} Second, the administration finalized a provision in the 2020 Notice of Benefit and Payment Parameters—the rule that governs the health insurance exchanges—to modify the way the PTC is indexed. This was important because the taxpayer share of the premium skyrocketed since the law's provisions took effect as insurers have figured out how to use the PTC structure as an open spigot to federal tax dollars. For example, between 2014 and 2019, the benchmark premium for a 49-year-old at 200 percent of the FPL increased nearly \$3,300, with taxpayers picking up about \$3,150—or 96 percent—of the increase.^{xv} The 2020 rule contained a technical fix that is estimated to reduce federal PTC outlays by about \$1 billion per year.^{xvi}

The Trump Administration has also confronted the difficult issue of “partial” Medicaid expansion over the past year. Several states requested that the administration provide the enhanced Medicaid reimbursement if states adopted expansion eligibility for

individuals enrolled in the Medicaid expansion who were made ineligible if the state adopted “partial expansion”—those with income between 100 percent and 138 percent of the FPL—would not enroll in a heavily subsidized exchange plan. This shows that lower-income enrollees tend to place extremely low value on exchange coverage because they would generally be eligible for a plan with an actuarial value of 94 percent for only about \$20 per month.

^{xiv} For example, assume a consumer valued the coverage at \$500, the coverage cost \$5,000, the mandate penalty equaled \$700, and the consumer qualified for a \$4,000 subsidy. The net social cost of this individual enrolling in the coverage equals \$4,500—the total cost subtracted by the value that the consumer places on the coverage (the benefit). With the mandate penalty in place, the consumer enrolls because they would face a cost of \$1,200 for forgoing the coverage—the mandate penalty plus the value they place on the coverage. They face a cost of \$1,000 in enrolling in the coverage (their share of the premiums) and thus enroll in the coverage. Without the mandate penalty, the individual is better off by \$200 from not enrolling and society overall is better off by about \$4,500. This is a simple example and excludes the effects of uncompensated care although uncompensated care is relatively small.

^{xv} In 2014, a 49-year old at 200 percent of the FPL would receive a \$2,923 tax credit and owe \$1,448 out-of-pocket for the purchase of a benchmark plan. In 2019, those numbers would be \$6,075 and \$1,588 respectively. See: <https://www.kff.org/interactive/subsidy-calculator/>

^{xvi} The re-indexing provision is a technical provision that was included in the ACA to account for premium growth over income growth so that the government share of the premium would not grow excessively. The Obama Administration used an index that excluded individual market premiums. The Trump Administration instituted a long overdue technical fix so that the measure fully accounted for premium growth in the private market. The index change did not affect gross premiums, but will cause a relatively small shift of the premium burden from the taxpayer to the consumer. Overall, the Trump Administration estimates that the re-indexing will reduce federal PTC outlays by about \$1 billion per year. See: <https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-2020-annual-notice-benefit-and-payment-parameters>.



people with income up to 100 percent of the FPL, rather than only for states expanding fully to 138 percent of the FPL. The Obama Administration made the decision to only allow the enhanced reimbursement for states that fully expanded.³⁷ The Trump Administration continued this policy, in large part because of estimates showing that this partial expansion would significantly increase ACA spending—the federal share of Medicaid expansion and the PTC cost. Although the Trump Administration continued the Obama Administration policy and will not allow the enhanced reimbursement rate for partial expansion, it did approve state waivers to expand eligibility to non-disabled, working-age adults at the same reimbursement rate for the traditional Medicaid populations. This decision represents a sensible middle-ground that does not create perverse incentives for states to take resources away from the traditional population and expend them on the expansion population. This decision seems even more wise given the evidence of substantial improper enrollment in the Medicaid expansion (discussed more below).

Trump Administration Improves ACA Exchanges

In addition to expanding consumer choices of coverage, the Trump Administration has taken actions to shore up the ACA exchanges. These actions prove that the administration has not engaged in sabotaging the ACA, though some opponents of the President repeat this falsehood.^{xvii} Overall, the Trump Administration's actions have improved the individual market despite the fact that the ACA's rules and pricing restrictions have generally caused premiums to surge and choices to dwindle. As evidence of the improved markets, more insurers will likely participate in the individual market in 2020 than participated in 2017.^{xviii} The Trump Administration's actions to improve the market include:

- In April 2017, HHS issued a final rule aimed at stabilizing the exchanges. Among other provisions, this rule made it more difficult for consumers to

^{xvii} For example, some cite the Trump Administration's decision to stop paying insurers Cost Sharing Reduction (CSR) payments as evidence of sabotage. However, the administration's decision was after a thorough legal analysis that concluded there was an absence of an appropriation. And the administration has sought a congressional appropriation for CSRs to make the payments, including this policy in both the president's fiscal year 2019 and fiscal year 2020 budget proposals. Congressional Democrats tend not to be supportive of efforts to fund CSRs, preferring instead the silver-loading workaround developed by insurers. Relative to funded CSRs, silver-loading has likely increased total subsidization (the increase in PTCs minus the reduction in CSR funding) by about \$5 billion a year.

^{xviii} In 2017, an average of 4.3 insurers were offering coverage in each state. In 2018, this number declined to 3.5 but it rebounded last year to 4.0. Based on initial reports of insurer profitability and insurers expanding market presence, it is likely that the average will exceed 4.3 in 2020. Of note, this number is still well below pre-ACA levels of insurer participation. See: <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/>



wait until they needed medical services to enter the exchanges. This limits gaming of the program and driving up premiums for those who maintain continuous coverage.³⁸

- In 2017 and 2018, the administration approved seven State Innovation waivers under Section 1332 of the ACA for state-based risk mitigation programs. Under a typical waiver, the state sets up a fund to subsidize insurers for a certain amount of the expense of people who experience high cost claims. This back-end subsidy leads to lower ACA plan premiums and thus lowers associated PTC costs. These seven states had an average premium decline of nearly eight percent relative to an increase in non-waiver states of three percent.³⁹^{xix} This has likely caused somewhat higher enrollment in these states than otherwise would have occurred. Based on the experience so far, states receive roughly 60 percent of their initial contribution back in the form of federal pass through savings.
- The HRA rule is expected to cause a significant increase in individual market enrollment, which should be a welcome development across the political spectrum. The rule is projected to do so through additional choice and market competition and without any new government mandates or new spending. Since younger and healthier employees are more likely to prefer the typical individual market coverage of relatively high deductibles and more limited provider networks, it is possible, if not likely, that the HRA rule could lead to an improved individual market risk pool.

Sensibly Addressing the Remaining Challenges With the ACA's Coverage Provisions

THE ACA'S MEDICAID EXPANSION: The open-ended federal reimbursement of a large share of state Medicaid spending has always created perverse incentives for states, encouraging states to develop financing gimmicks to maximize federal money and leading to significant waste and low-value spending. The ACA's Medicaid expansion made the program's structural problems substantially worse since Washington pays for nearly the full cost of the expansion population of non-disabled, childless,

^{xix} For an overview of the benefit of 1332 waivers for state reinsurance programs, see: <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>



single adults.^{xx} Moreover, the ACA upended basic safety-net norms and moral sensibilities by creating a greater federal reimbursement rate for able-bodied adults than for the traditional Medicaid populations of the disabled and low-income children, pregnant women, and seniors. Unfortunately, the last Congress was unable to end this inequity, protect Medicaid for the truly vulnerable, and put the program on more sustainable footing.

Congress should equalize the federal reimbursement rate between the expansion population and the traditional Medicaid population. This would rectify the immorality of the enhanced reimbursement rate for the expansion. It would also reduce the incentive for states to engage in creative financing gimmicks since they have a greater return the higher the reimbursement rate. Such a reform should be done in a way that puts the overall program on more sustainable footing. A model for this type of reform—the so-called blended rate proposal—was advanced by the Obama Administration in President Obama’s 2013 budget.^{xxi 40}

The federal bureaucracy faces significant challenges overseeing the expansion, but it needs to make proper oversight a top priority. The extremely high reimbursement rate for the expansion population is a recipe for abuse and misspending. The Obama Administration’s top priority was maximizing enrollment in the expansion, and as a result, program integrity efforts, of enormous importance given the incentives facing states, were virtually abandoned. The Trump Administration needs to do more to address these problems.

Millions of people enrolled as a result of Medicaid expansion were almost certainly ineligible for the program—either because their incomes were too high or because they were not lawful residents. The Inspector General at HHS estimated that one-quarter of newly-eligible enrollees in California and New York did not meet eligibility requirements.⁴¹

An August 2019 paper published in the National Bureau of Economic Research utilized reliable data from U.S. Census Bureau surveys to assess coverage changes from 2012 to 2017 in nine states that expanded Medicaid versus 12 states that did not.^{42-xxii}

^{xx} For a detailed discussion of problems with the ACA’s Medicaid expansion, see: <https://www.mercatus.org/publications/aca-worsened-medicaid-structural-problems>

^{xxi} President Obama’s 2013 budget proposal included a provision to apply a single reimbursement rate, by state, for populations on Medicaid and CHIP. The administration and CBO estimated that the proposal would reduce federal Medicaid spending by \$18 billion between Fiscal Years 2017 and 2022.

^{xxii} I wrote a piece about this study for *The Wall Street Journal*, along with Aaron Yelowitz, one of the paper’s authors. See: <https://www.wsj.com/articles/obamacares-medicaid-deception-11565822360>



(The nine states represent just under 20 percent of the population that resides in Medicaid expansion states.) The authors found that in the nine states that expanded Medicaid, “around 800,000 individuals appeared to gain Medicaid coverage for which they were seemingly income-ineligible.”⁴³ In these states, the authors found that 78 percent of the population with incomes between 138 percent (the maximum for Medicaid eligibility) and 250 percent of the poverty line (about \$65,000 for a family of four) who gained coverage were enrolled in Medicaid.⁴⁴ Worse, 65 percent of the population who gained coverage with incomes above 250 percent of the poverty line were enrolled in Medicaid.⁴⁵ The improper enrollment grew over time and was two or three times as prevalent in 2017 as in 2014.⁴⁶ The cost of this misspending to federal taxpayers almost certainly exceeds \$10 billion per year and may actually be two times that level.^{xxiii}

The principal area where the administration can pursue greater program reform is by enhancing program integrity efforts. Given the stunning size of the problem with Medicaid expansion ineligibility, HHS must do more. HHS currently has two important rules on its regulatory agenda that, if prioritized by the administration and well-designed, could significantly improve the Medicaid program. These rules would help limit state financial gimmicks and help ensure that states only receive the enhanced reimbursement rate for people who meet the eligibility criteria. The rule must end the outrageous problem that several states permit people who apply for coverage on the exchange and enter zero or low income to be automatically enrolled in the state’s Medicaid program without proper checks against the state’s income and wage databases. The rules should also end the problem of states significantly overpaying public providers for treating Medicaid enrollees in order to obtain additional federal funds to use for other purposes.⁴⁷ HHS also needs to make appropriate recoveries for the federal taxpayer for payments made on behalf of enrollees who do not meet the eligibility criteria. This is the best way to ensure that states make the proper investment, so the law is followed, particularly around eligibility.

Additionally, while HHS has sought to give states greater ability to manage their programs through more flexible Medicaid 1115 waivers,^{xxiv} particularly for community engagement requirements for non-disabled, working-age adults, these efforts have had limited effect thus far. A federal judge struck down the community engagement re-

^{xxiii} Assuming a 20 percent error rate means that roughly 2.5 million Medicaid expansion enrollees nationally are improperly enrolled in the program. Using a \$5,500 average federal cost and 2.5 million ineligible enrollees amounts to \$13.75 billion annually. The total budgetary cost is less than this since some of the 2.5 million people would enroll in the exchanges with a PTC or in their employer’s plan and receive the benefit of the exclusion. Importantly, the Yelowitz et al. study suggests that a 20 percent error rate is likely low.

^{xxiv} 1115 Medicaid waivers refers to the section of the Social Security Act where the waivers are authorized.



quirements in two states (Arkansas and Kentucky) as inconsistent with the Medicaid statute.⁴⁸ However, seven other states have received waivers to implement community engagement requirements, and an additional seven states have waiver applications pending with HHS.⁴⁹

INDIVIDUAL MARKET REFORM: As a result of the ACA, the individual market for health insurance remains in significant trouble in many parts of the country. Choices are severely limited, and premiums are too high, driving millions of relatively healthy people in the middle-class out of the market. In fact, individual market enrollment of people who do not receive PTCs declined by 2.5 million people, or 40 percent, between 2016 and 2018.⁵⁰

The most creative policy proposal during the 2017 legislative effort to reform the individual market was Senator Ted Cruz’s (R-TX) “freedom option,” which would have allowed insurers selling ACA-compliant policies to also sell non-compliant policies.⁵¹ HHS had a version of the proposal modeled, with results showing that Senator Cruz’s plan would improve the individual market with lower average premiums and more enrollees.⁵² In practice, the STLDI rule accomplishes even more of what Senator Cruz was intending with the freedom option since issuers of STLDI policies are not under the obligation to sell ACA-compliant policies. This should expand consumer choices and bring more insurers into the market, including many who exited as a result of losses incurred in the first several years of the ACA’s implementation. Congress should codify the administration’s STLDI rule. Federal and state policymakers should also ensure that other types of innovative coverage arrangements, such as health sharing ministries and indemnity plans, can continue to meet individuals’ variety of preferences and coverage needs.

With respect to the individual market, reforms should be centered on allowing premiums to more accurately reflect risk—the principal feature of any well-functioning insurance market—and allowing consumers greater ability to pick insurance that works them. Potential bipartisan reforms could include stretching the ACA’s age-rating band to more appropriately reflect differences in age and also relaxing the EHBs. These reforms are essential for the HRA rule to be maximally attractive to employers and employees. Congress should also address the perverse incentive, caused by the ACA’s guaranteed issue and modified community rating provisions,^{xxv} for people to delay purchasing insurance until medical care is needed. They could, for example, replace these provisions with a high-risk pool program that guarantees government payment for people without access to affordable coverage who have uninsurable conditions.

^{xxv} In the ACA-compliant individual market, insurers must offer coverage to all applicants (guarantee issue) and cannot vary the premium based on applicants’ health status (modified community rating).



Optimally, there would not be a surcharge for people who maintained continuous coverage.

The last legislative effort to reform the ACA in the early fall of 2017 centered on a federalist approach led by Senators Lindsey Graham (SC), Bill Cassidy (LA), Ron Johnson (WI), and Dean Heller (NV). The legislation would have replaced the ACA's primary funding mechanisms—the PTCs and the Medicaid expansion—with a federal grant for states to help finance medical expenses of high-cost individuals and to subsidize coverage for citizens needing help in purchasing coverage. The approach recognized that the ACA's subsidy structures were highly inefficient, and that federal money could be better targeted to address the narrow problem of uninsured individuals unable to get coverage. In a 2002 paper, economists Mark Pauly and Len Nichols reported that “the fraction of nonelderly uninsured persons who are not institutionalized and who would be rated as actuarially uninsurable is generally estimated to be very small, less than one percent of the population.”⁵³ As part of any reform going forward, Congress should reallocate a portion of ACA funding to state-designed risk mitigation programs, such as high-risk pool arrangements that 35 states maintained prior to 2014 and that worked reasonably well.⁵⁴

The main concern with these high-risk pools was inadequate funding, but the ACA deposited so much additional federal money into the health care system that there is enough money to generously fund state high-risk pools and other risk-mitigation programs. Doing so will spread the cost of uninsurable populations across the general tax base rather than on unsubsidized consumers purchasing in the individual market, as the ACA required. Effective state risk mitigation programs, along with common-sense deregulation, will improve the individual market and enable the HRA rule to be as effective as possible by creating a more attractive market for employees.

These policies would do a better job of protecting those with pre-existing conditions and high health costs than the ACA did, while providing more affordable insurance options to those currently being shut out of the market for insurance because of high costs.

Broader Health System Reform

It is stunning that so many Democratic candidates running for President have essentially abandoned the ACA and now endorse Medicare for All proposals. As Americans overwhelmingly say high costs are their top health care concern, this is largely a recognition that the ACA failed to address this core problem. While Medicare for All is unlikely to be achieved in the foreseeable future given political resistance and general concern about rapid disruption in existing health care arrangements, the question is



whether our policy will move toward greater government control or toward greater consumer choices in a more competitive market.

In December 2018, after a year's worth of work, the Trump Administration released a report, *Reforming America's Health Care System Through Choice and Competition*.⁵⁵ The comprehensive report recognized that existing government policies—which promote centralized decision-making and third-party payers and that tend to protect incumbents from competition—often serve as barriers to a radically improved health sector. There are essentially two ways to lower costs while preserving quality: 1) enhancing consumer choice and improving incentives for consumers to obtain value from their health care decisions, and 2) maximizing competition between providers of health care to provide the lowest cost and highest quality services.

To address the first way, the Trump Administration's report recommended expanding affordable coverage options, enhancing consumers' abilities to utilize HRAs and HSAs, and reforming Medicare payments so they are based on outcomes and not on site of service. And, as this paper has discussed, the elimination of the individual mandate penalty combined with the affordable coverage options expanded by the Trump Administration have already given small businesses and consumers greater choices of coverage. President Trump's budget contains a legislative proposal that would create an alternative pathway for an insurance plan to be integrated with an HSA—thus addressing the problem that too few plans can be integrated with HSAs.^{xxxvi} The administration is now embarking on an aggressive effort to expand the availability of price and quality information so consumers and employers have more resources to smartly navigate the health care sector.

To address the second approach, the report recommended that states repeal or scale back measures like Certificate of Need (CON) laws, narrow scope of practice requirements, and restrictive supervisory requirements. It also recommends that the Federal Trade Commission and the Anti-trust Division at the Department of Justice combat anticompetitive mergers. A promising recent development is several successful state-level efforts to eliminate or reduce anticompetitive state rules. For example, Arizona reformed its occupational licensing laws, and Florida limited its hospital CON law.⁵⁶ The administration is pursuing innovative efforts on this front as well, such as its vision to transform the nation's market for kidneys.⁵⁷

^{xxxvi} About 60 percent of people who have deductibles exceeding the required minimum deductibles for a high deductible health plan do not have HSAs. President Trump's fiscal year 2020 budget contained a legislative proposal for Congress to create an alternative standard for what can be considered an HSA-qualified plan, using a plan's actuarial value. The administration proposed that all plans, regardless of their design, could be integrated with an HSA so long as their actuarial value was below 70 percent.



Conclusion

The American health care sector needs fundamental reform. The ACA further restricted consumer choices, empowered third-party payers, and contained subsidies that put upward pressure on prices and caused low-value health care spending to ratchet up. The Trump Administration took aggressive action to help Americans harmed by the ACA, to expand choice and transparency, and to lay out a pathway for fundamental reform driven by empowered consumers and greater competitive forces throughout the market. The administration's record is a superior alternative to the Left's call for more centralized control over Americans' health care.

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ENDNOTES

- ¹Blase, Brian, “Learning From CBO’s History Of Incorrect ObamaCare Projections,” *Forbes*, Jan. 2, 2017. <https://www.forbes.com/sites/theapothecary/2017/01/02/learning-from-cbos-history-of-incorrect-obamacare-projections/#7e6065c146a7>; Short, Marc and Blase, Brian, “The fundamental error in the CBO’s health-care projections,” *The Washington Post*, https://www.washingtonpost.com/opinions/the-fundamental-error-in-the-cbos-health-care-projections/2017/07/14/25f0d8a4-67ee-11e7-a1d7-9a32c91c6f40_story.html?noredirect=on&utm_term=.39012b560b19
- ²King, Robert, “Deadline for fast track Obamacare repeal bill expires Sept. 30,” *Washington Examiner*, Sept. 1, 2017. <https://www.washingtonexaminer.com/deadline-for-fast-track-obamacare-repeal-bill-expires-sept-30>
- ³Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, Oct. 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>
- ⁴Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First, The White House, June 24, 2019. <https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/>
- ⁵National Federation of Independent Business v. Sebelius, Secretary of Health and Human Services (NFIB v Sebelius). <https://www.law.cornell.edu/supremecourt/text/11-393>
- ⁶Distribution of individual mandate penalties: 2015, IRS data. <https://infogram.com/mandate-penalty-1gv02gkyzj5lm1x>
- ⁷H.R.1 - An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, 115th Congress. <https://www.congress.gov/bill/115th-congress/house-bill/1/text>
- ⁸Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans, A Rule by the Employee Benefits Security Administration, June 21, 2018. <https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans>
- ⁹U.S. Department of Labor Statement Relating to the U.S. District Court Ruling in State of New York v. United States Department of Labor, Employee Benefits Security Administration, April 29, 2019. <https://www.dol.gov/newsroom/releases/ebsa/ebsa20190429>
- ¹⁰Short-Term, Limited-Duration Insurance, A Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department, Office of the Federal Register, August 3, 2018. <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>
- ¹¹Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, A Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department, Office of the Federal Register, Oct. 31, 2016. <https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance>
- ¹²How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans, Congressional Budget Office, Jan. 2019. https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
- ¹³Ibid.
- ¹⁴Blase, Brian, Mulligan, Casey, and Philipson, Tomas J, “President Trump’s Health Care Actions Are Improving the Lives of Americans,” *Real Clear Policy*, Feb. 13, 2019. https://www.realclearpolicy.com/articles/2019/02/13/president_trumps_health_care_actions_are_improving_the_lives_of_americans.html



¹⁵ Case 1:18-cv-02133-RJL, United States District Court for the District of Columbia, July 19, 2019. <https://affordablecareactlitigation.files.wordpress.com/2019/07/stld-memorandum-opinion.pdf>

¹⁶ Ibid.

¹⁷ Deregulating Health Insurance Markets: Value to Market Participants, The White House, Feb. 2019. <https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf>

¹⁸ Blase, Brian, Mulligan, Casey, and Philipson, Tomas J, “President Trump’s Health Care Actions Are Improving the Lives of Americans,” *Real Clear Policy*, Feb. 13, 2019. https://www.realclearpolicy.com/articles/2019/02/13/president_trumps_health_care_actions_are_improving_the_lives_of_americans.html

¹⁹ Waivers for State Innovation, A Rule by the Treasury Department and the Health and Human Services Department, Office of the Federal Register, Dec. 16, 2015. <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>

²⁰ Section 1332 State Relief and Empowerment Waiver Concepts, Discussion Paper, Centers for Medicare & Medicaid Services, Nov. 29, 2018. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>

²¹ Horpedahl, Jeremy and Searles, Harrison, “The Tax Exemption of Employer-Provided Health Insurance,” Mercatus Center, Sept. 10, 2013. <https://www.mercatus.org/publication/tax-exemption-employer-provided-health-insurance>

²² Burtless, Gary and Milusheva, Sveta, Research Summary: Effects of Employer-Sponsored Health Insurance Costs on Social Security Taxable Wages, Social Security Office of Retirement and Disability Policy, 2013. <https://www.ssa.gov/policy/docs/ssb/v73n1/v73n1p83.html>

²³ Figure 4.1, Employer Health Benefits Annual Survey, Kaiser Family Foundation, 2018. <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

²⁴ H.R. 195: Extension of Continuing Appropriations Act, 115th Congress, Jan. 22, 2018. <https://www.govtrack.us/congress/votes/115-2018/h44>

²⁵ Estimated Revenue Effects of H.R. 748, The “Middle Class Health Benefits Tax Repeal Act of 2019,” Joint Committee on Taxation, July 17, 2019. <http://src.bna.com/JYw>

²⁶ Rubin, Richard and Armour, Stephanie, “Bipartisan House Coalition Votes to Repeal Health Law’s Cadillac Tax,” *The Wall Street Journal*, July 17, 2019. <https://www.wsj.com/articles/bipartisan-house-coalition-strikes-against-health-laws-cadillac-tax-11563357600>

²⁷ Blase, Brian, “Improve, Don’t Repeal, ObamaCare’s Cadillac Tax,” *The Wall Street Journal*, July 24, 2019. <https://www.wsj.com/articles/improve-dont-repeal-obamacares-cadillac-tax-11564007975>

²⁸ Health Reimbursement Arrangements and Other Account-Based Group Health Plans, A Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department, Office of the Federal Register, June 20, 2019. <https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

²⁹ U.S. Departments of Health and Human Services, Labor, and the Treasury Expand Access to Quality, Affordable Health Coverage Through Health Reimbursement Arrangements, June 13, 2019. <https://www.hhs.gov/about/news/2019/06/13/hhs-labor-treasury-expand-access-quality-affordable-health-coverage.html>

³⁰ Figure 3.3, Employer Health Benefits Annual Survey, Kaiser Family Foundation, 2018. <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.





³¹ Garfield, Rachel and Kendal, Orgera, Figure 5, The Uninsured and the ACA: A Primer, Kaiser Family Foundation, Jan. 2019.

<http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act>

³² IRS expands list of preventive care for HSA participants to include certain care for chronic conditions, Internal Revenue Service, July 17, 2019. <https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>

³³ Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029, Congressional Budget Office, May 2019. https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf

³⁴ Finkelstein, Amy, Hendren, Nathaniel, and Luttmer, Erzo F.P., “The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment” NBER working paper, Massachusetts Institute of Technology, June 2015. <https://www.nber.org/papers/w21308>

³⁵ Ibid.

³⁶ Ibid.

³⁷ Carey, Mary Agnes, and Galewitz, Phil, “HHS Tells States It Will Not Fund Partial Medicaid Expansion,” *Kaiser Health News*, Dec. 10, 2012. <https://khn.org/news/hhs-states-medicaid-expansion/>

³⁸ Patient Protection and Affordable Care Act; Market Stabilization A Rule by the Health and Human Services Department, Office of the Federal Register, April 18, 2017. <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>

³⁹ Badger, Doug, “How Health Care Premiums Are Declining in States That Seek Relief from Obamacare’s Mandates,” The Heritage Foundation, Aug. 13, 2019. <https://www.heritage.org/health-care-reform/report/how-health-care-premiums-are-declining-states-seek-relief-obamacares>

⁴⁰ Proposals to Reduce Federal Medicaid Expenditures, Congressional Research Service, Jan. 10, 2013. <https://www.everycrsreport.com/reports/R42893.html>

⁴¹ California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements, Department of Health & Human Services Office of the Inspector General, Feb. 20, 2018. <https://oig.hhs.gov/oas/reports/region9/91602023.asp>;

California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements, Department of Health & Human Services Office of the Inspector General, Dec. 2018. <https://oig.hhs.gov/oas/reports/region9/91702002.pdf>;

New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries, Department of Health & Human Services Office of the Inspector General, Jan. 5, 2018. <https://oig.hhs.gov/oas/reports/region2/21501015.asp>

⁴² Courtemanche, Charles J., Marton, James, and Yelowitz, Aaron, “Medicaid Coverage across the Income Distribution under the Affordable Care Act” working paper, National Bureau of Economic Research, Aug. 2019. <https://www.nber.org/papers/w26145>

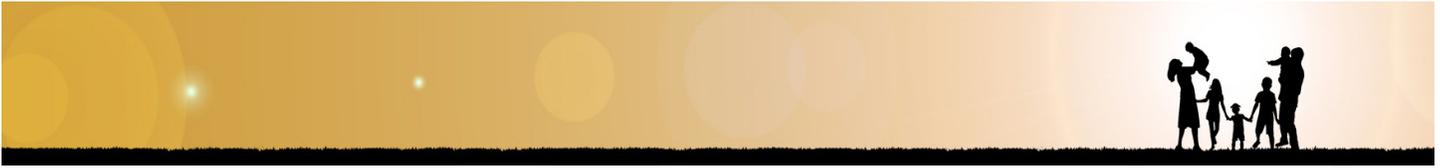
⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.





⁴⁷ States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection, U.S. Government Accountability Office, March 13, 2015. <https://www.gao.gov/products/GAO-14-627>;

Billions of Federal Tax Dollars Wasted Annually by New York's Medicaid Program, Committee Report U.S. House of Representatives, 113th Congress, Committee on Oversight and Government Reform, Feb. 5, 2013. <https://docs.house.gov/meetings/go/go00/20130205/100224/hrpt-113-x.pdf>

⁴⁸ Hackman, Michelle, "Federal Judge Blocks Medicaid Work Requirements," *The Wall Street Journal*, March 27, 2019. <https://www.wsj.com/articles/federal-judge-scrap-requirements-11553724923>

⁴⁹ Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, Kaiser Family Foundation, Aug. 21, 2019. <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>

⁵⁰ Trends in Subsidized and Unsubsidized Enrollment, Centers for Medicare & Medicaid Services, Aug. 12, 2019. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf>

⁵¹ The Consumer Freedom Option, Sen. Ted Cruz (R-TX), <https://www.politico.com/f/?id=0000015d-1c70-d61c-a77f-1ef382af0000>

⁵² Ferrechio, Susan, "HHS analysis finds Cruz amendment lowers premiums, boosts enrollment," *Washington Examiner*, July 19, 2017. <https://www.washingtonexaminer.com/hhs-analysis-finds-cruz-amendment-lowers-premiums-boosts-enrollment>

⁵³ Pauly, Mark V. and Nichols, Len M., "The Nongroup Health Insurance Market: Short On Facts, Long On Opinions And Policy Disputes," *Health Affairs*, Oct. 23, 2002. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.w2.325>

⁵⁴ Goodman, John C., "High Risk Pools Worked Just Fine Before Obamacare," *Forbes*, May 2, 2017. <https://www.forbes.com/sites/johngoodman/2017/05/02/high-risk-pools-worked-just-fine-before-obamacare/>

⁵⁵ Reforming America's Healthcare System Through Choice and Competition, U.S. Department of Health & Human Services, U.S. Department of the Treasury, U.S. Department of Labor, Dec. 3, 2018. <https://www.hhs.gov/about/news/2018/12/03/reforming-america-healthcare-system-through-choice-and-competition.html>

⁵⁶ Mitchell, Matthew D. and Philpot, Anne, "Arizona Makes the Right Move on Occupational Licensing," Mercatus Center, April 30, 2019. <https://www.mercatus.org/bridge/commentary/arizona-makes-right-move-occupational-licensing>;

Davis, Gary Scott and Rogers, Adam J., "Florida Repeals Significant Portions Of Certificate Of Need Law," *The National Law Review*, July 1, 2019. <https://www.natlawreview.com/article/florida-repeals-significant-portions-certificate-need-law>

⁵⁷ Abelson, Reed and Thomas, Katie. "Trump Proposes Ways to Improve Care for Kidney Disease and Increase Transplants," *The New York Times*, July 10, 2019. <https://www.nytimes.com/2019/07/10/health/trump-kidney-disease-transplant.html>