VIEWPOINT

Improving and Refining the Affordable Care Act

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Neither Republicans nor Democrats have spent much time, at least not in public, discussing changes to the Affordable Care Act (ACA) that could refine or improve the legislation. Republicans have mostly focused on strategies to repeal the ACA, which, even with their control of the House and Senate, appears highly unlikely because they could not muster the 67 votes needed to override a presidential veto. Democrats, while privately acknowledging there are changes that could improve the legislation, have publicly devoted most of their energies to defending the ACA.

The history of complex legislation is that it usually produces follow-on legislation that refines or modifies the original legislation because of unintended consequences or unanticipated political pushback following the bill's implementation. Several rounds of such legislation followed the Balanced Budget Act, for example.[1,2] Although it could be argued that major portions of the ACA were not implemented until 2014 so that not having introduced modifying or corrective legislation by mid-2015 is not unusual, it is clear that the acrimonious and partisan passage of the legislation has made corrective legislation in the near term highly unlikely, although the overwhelming passage of the sustainable growth rate reform by both houses of congress in the spring suggests that corrective legislation is not impossible.[3] However, sustainable growth rate reform appears to be a special case, reflecting the strong interest of Congress to dispose of what had become a festering annoyance, and was able to happen only because Congress ignored the most contentious aspect of the legislation—funding its cost. The only comparable situation would have been the need to replace the current system of subsidies in the federal exchanges had the Supreme Court ruled against the government. Even that would have been as likely to result in a bill that continued the current system of subsidies until after the 2016 election.

Near-term Changes

Despite the challenges, several near-term and more difficult (and therefore probably mid-term) reforms would improve the program. Near term refers to after the 2016 election and assumes Republican control of the White House and at least 1 house of Congress or of both houses of Congress but not the White House. If Republicans only control 1 of the 3, the willingness of Democrats to compromise on what they regard as important components of the ACA is not likely to be high. If Republicans were to control all 3, less compromise would be needed but still important, assuming Republicans would have fewer than 60 Senate votes. Also, bipartisan reform has a better chance of prevailing over the long term. The near-term political changes should focus on the following.

Making Insurance in the Exchanges an Option for Medicaid Coverage

An earlier version of the ACA that had been considered by the Senate allowed individuals at or above the poverty line to be able to use their Medicaid subsidies to purchase insurance in the exchanges. This is also consistent with the request by some states for waivers to convert their Medicaid expansion to private insurance but allows individuals to make the choice between Medicaid and private insurance rather than the state. The benefits under Medicaid are generally broader and include more complete coverage that may remain a dominant factor, but Medicaid's access to physicians, especially specialists, has been problematic in many states.

Eliminating the Independent Payment Advisory Board

The Independent Payment Advisory Board (IPAB) has been charged with proposing reductions in reimbursements to clinicians and health care entities that provide Medicare services if Medicare spending grows faster than the gross domestic product plus 1%. The areas of Medicare that could be reduced were initially limited (primarily limited to home health and skilled nursing facilities) but not similarly constrained after 2020. Congress can override the recommendations if it produces savings of an equal amount but has a limited period in which to act. To date, no members have been confirmed for the IPAB, and, because of the slow growth in Medicare spending, no reductions would have resulted if it had been in place. The current cost of eliminating the IPAB is small because Centers for Medicare & Medicaid Services actuaries are predicting a continued slow growth in Medicare spending over the next several years, but eliminating the IPAB will become more difficult if Medicare spending starts to increase. Many in Congress dislike this provision, because the executive branch is seen as usurping congressional authority, and would like to see the provision eliminated.

Deferment of the Individual Mandate

The rationale behind the mandate is clear: to minimize adverse selection and reduce the likelihood of "free riders." However, this feature has managed to produce a hostile response from the public at the same time that its effectiveness has been questioned.[4] It is also unclear how many people will actually be required to pay a penalty, at least initially, because the administration has broadened the number of conditions that qualify for a hardship exemption over the few initially included in the legislation and will rely on self-attestation regarding both coverage and the rationale for the hardship exemption. In view of this, the next administration should defer the mandate in favor of

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the heavily incentivized strategy that Medicare uses for its voluntary areas of coverage—Part B physician coverage and Part D outpatient prescription drug coverage.

Under Medicare, individuals who turn 65 and no longer have comparable group coverage for these services have the remainder of the year to sign up for Parts B and D. Otherwise, they face a penalty of 1% for every month they delay purchase of such insurance whenever they purchase these coverages. Using this strategy, which has never been regarded as a "mandate," 98% of older adults sign up for Part B and 90% for Part D. A similar option could be tried for the under-65 population, who at some point will want coverage. Although some industry experts have warned that older adults may be much more risk averse than the under-65 population and that this strategy would not work, it should be attempted before implementing a mandate. If a mandate is to be used, it needs to be at a level that will be effective.

Mid-term Reforms

At least 2 areas need to be addressed, if not immediately after a new administration is in place, as soon thereafter as possible.

Unify "Old" and Expanded" Match Rates for Medicaid and the Children's Health Insurance Program

Under current legislation, the base Medicaid program that existed before the ACA has Federal match rates that vary between 50% and 90% depending on the income of the state, although some components have higher match rates. The expanded Medicaid program is currently being reimbursed at 100%, but reimbursement is scheduled to decrease to 90% as of 2017. The Children's Health Insurance Program (CHIP) is also reimbursed at 90%. Having different match rates and especially having a lower match rate for the poorest Medicaid population makes no sense. If CHIP is extended beyond the current 2 years, all 3 rates for a state should be replaced by a single rate, although not necessarily the same rate across all states.

Unify the Insurance Subsidies for People With the Same Income

People with employer-sponsored insurance receive a federal subsidy because their employer contribution is not counted as taxable income to the employee and because it is not subject to social security tax. Lower-income people who pay little or no federal income tax mainly benefit from the social security tax exclusion. The income tax exclusion primarily benefits higher-income people because of their higher marginal tax rates. People buying insurance in the exchanges receive a subsidy that varies with their incomes and with the cost of the lowest silver plan in their area. This means that people in the same area with the same income potentially (and probably) receive very different subsidies depending on where they get their insurance, and people with the same incomes who live in different areas have even greater differences. These types of differences are both unfair and likely to lead people to seek the choice by which they will receive the highest subsidy. Substituting the current exclusion for a sliding scale refundable tax credit, as several Republican plans have proposed, would solve this problem but will be politically challenging.[5]

Over time the ACA will be modified, as complex legislation always is. When that will happen is unclear, but hopefully it will begin in 2017. Whether the resulting legislation is a refined version of the ACA or a replaced version of the ACA is a matter best left to the political process.

ARTICLE INFORMATION

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