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what lies ahead for healthcare reform?

With the midterm election over, predicting what the next Congress will do to or for healthcare reform has become one of Washington's favorite indoor sports.

Most observers expect that one or both houses of Congress will pass what has become the obligatory Affordable Care Act (ACA) repeal bill. However, the president would veto such a bill, and the Senate would be unlikely to produce the 67 votes needed to override a veto.

There has been some discussion of using the budget reconciliation process, which requires only a simple majority of votes, to repeal the ACA, but using this type of legislative vehicle poses several problems. First, because the Congressional Budget Office (CBO) has scored the ACA as a budget savings, Congress cannot use the budget reconciliation process to implement any modifications that would result in an increase in mandatory spending and the deficit. Second, the Byrd rule prohibits the budget reconciliation process from including any "extraneous" matter that is not germane to the deficit reduction goals of reconciliation. If any such matter is included, the legislation is subject to a 60-vote point of order. Both of these obstacles make the successful use of the reconciliation process unlikely.

Although total repeal cannot occur as long as Barack Obama is president, Republicans can propose incremental changes to the existing legislation with the goal of improving some of its perceived shortcomings. Republicans also will want to lay the groundwork for the type of legislation they would like to see replace the ACA after 2016, such as that presented by Senators

Richard Burr (R-N.C.), Tom Coburn (R-Okla.), and Orrin Hatch (R-Utah) in their proposed Patient Choice, Affordability, Responsibility, and Empowerment (Patient CARE) Act.^a

Potential Legislative "Fixes"

Several important measures could be passed over the next two years, some more incremental than others.

Tax repeals. The most popular candidate is a repeal of the tax on medical devices—one of several excise-type taxes levied to raise revenue to help cover the cost of expanding coverage under the ACA. Another candidate for repeal is the tax on health insurers and pharmaceutical companies. These taxes never had a clear policy rationale behind them aside from simply raising revenue. The device tax, however, has raised the strongest objections because of the concern it will act as a tax on innovation. Proponents of repealing the tax have included not only Republicans but also a number of Democrats, including Senators Elizabeth Warren (D-Mass.), Amy Klobuchar (D-Minn.), and Al Franken (D-Minn). Although the actual impact on the industry is a matter of some debate, the major constraint to its removal is finding a way to replace almost \$30 billion in lost revenue.

Revision of definition of worker under the employer mandate. Much attention has been given to how the ACA defines *workers* with respect to the penalty for employers that do not provide the required minimum package of benefits. The

a. See Capretta, J., and Antos, J., "A Senate GOP Health Reform Proposal: The Burr-Coburn-Hatch Plan," *Health Affairs*, Feb. 12, 2014.

existing legislation applies to all employers that employ more than 50 workers, with *workers* defined as those who work at least 30 hours per week. The most frequently proposed change has been to revise the definition to 40 hours per week. Some employers and their advocates have expressed concerns that the ACA will pressure them to reduce the work hours for part-time employees to below the 30-hour minimum or to refrain from hiring additional workers if they are near the 50-employee threshold. Some have questioned the rationale for having an employer mandate at all, citing a 2014 Urban Institute analysis, which suggested eliminating the employer mandate would have a minimal impact.^b Again the problem is offsetting the revenue loss, which the Urban Institute estimates to be a fraction of the \$130 billion that the CBO has scored as revenue from the employer mandate.

Removal of the Independent Payment Advisory Board (IPAB). A significant measure being proposed is to remove the widely criticized IPAB, which is charged with proposing reductions in payments to providers of Medicare services in the event that spending on Medicare grows faster than GDP plus 1 percent. No changes in benefits can be considered. If Congress overrides the recommendations of the IPAB, it must act quickly to produce a comparable amount of savings. The board was scheduled to be appointed in 2014 and to first meet in 2015, with limits for the first few years on areas in which it could propose reductions. No members have been confirmed, however. Estimates of the cost of eliminating the IPAB have been quite small—about \$3 billion—due to the current slow growth in Medicare spending.

Allowance of health insurance exchanges as an option versus Medicaid. An occasionally proposed change is to allow individuals at or near the poverty line to use subsidies to purchase insurance in the exchanges rather than participate in an expanded Medicaid program (in expansion states).

b. Blumberg, L.J., Holahan, J., and Buettgens, M., “Why Not Just Eliminate the Employer Mandate?” Robert Wood Johnson Foundation and Urban Institute, May 2014.

Although the benefits are broader in Medicaid, access is frequently more challenging, and this provision would allow individuals to make the trade-off that suits them best. The Senate had considered this option in early versions of the ACA legislation, but the option was not included in the final bill.

Deferment of the individual mandate. Finally, the much-maligned individual mandate could be tabled for a few years while the strategy the Centers for Medicare & Medicaid Services (CMS) uses to incentivize seniors to purchase Medicare coverage is tried with the under-65 population. In Medicare, seniors are allowed to purchase the voluntary parts of Medicare within the first year after they turn 65 and are no longer covered by group insurance, and they face a penalty equal to 1 percent of the national average premium for every month they delay purchasing such coverage. Using this strategy, Medicare has successfully covered almost all seniors for Part B (physician) coverage and 90 percent of seniors for Part D (outpatient prescription drug) coverage. As other industry experts have noted, because seniors are more risk-averse, they are more likely to recognize the need for coverage than are some of the younger uninsured. But two steps—reducing the cross-subsidies from the youngest to the oldest individuals not yet qualifying for Medicare and making the penalties for delaying coverage reflect the cost of the adverse selection being imposed—could effectively bring in as many or almost as many individuals to healthcare coverage as does the mandate, with less national trauma.

Significant Change Without Repeal

Taken together, these potential changes could significantly change the ACA without getting into the repeal battle—changes that may be less satisfying politically for some, but that could actually have a profound impact. ■

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