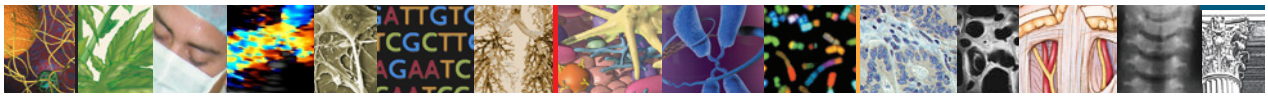

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Perspective

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Strengthening the ACA for the Long Term

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Most complaints about the Affordable Care Act (ACA) (e.g., high and rising insurance premiums, large deductibles, and insurer exits) relate to nongroup insurance markets. These markets, the ones that were the most dysfunctional before the ACA, provide coverage to just 7% of the nonelderly population (under 65 years of age) and 6% of the full U.S. population. The ACA's changes to employer-sponsored insurance plans, Medicare, and Medicaid were more limited, and enrollees are generally satisfied with those coverage options. The problems with the nongroup market, though significant, are fixable, and correcting them does not necessitate disruption of coverage for the remaining 94% of the population.

These problems spring from two central sources: initial underfunding of the ACA and consolidated insurer and provider markets. The first has meant that insurance remains unaffordable for some people, even while others have received substantial financial assistance, so enrollment levels are lower than desired. The second has led to high and escalating premiums in many geographic areas. In addition, administrative policy changes initiated by the Trump administration all exacerbate the other problems.

We propose two sets of policies — the first is needed to stabilize nongroup insurance markets as quickly as possible and the second to improve consumers' buying power, increase the size of nongroup markets, and thereby make the markets more attractive for insurers. We believe that these proposals would ensure the long-term strength and stability of the ACA, but we are under no illusions about the current political challenges to enacting them.

Immediate stabilizing policies include long-term federal commitment to reimbursing insurers for the cost-sharing subsidies they are legally required to provide to low-income marketplace enrollees, continued enforcement of individual-mandate penalties, additional funds invested in outreach and enrollment assistance, creation of a permanent nongroup-market reinsurance program, and reversal of recent administrative policies impeding enrollment.

Cost-sharing subsidies reduce deductibles, copayments, coinsurance, and out-of-pocket maximums for a large percentage of marketplace enrollees, providing them with effective access to medical care. Uncertainty surrounding their reimbursement is the most common reason that insurers have cited for their requests for large premium increases for 2018, and such uncertainty probably prompted a number of insurers to exit from these markets. President Donald Trump has just announced that he will cease reimbursements of these subsidies, a move likely

to lead to more insurer exits. Although some insurers incorporated these costs into their 2018 premiums, not all did. Congress could explicitly appropriate funds to finance these subsidies. Without an individual mandate, the nongroup insurance pools will shrink, with healthy people being most likely to disenroll, increasing average premiums, but the Trump administration has suggested that it may not enforce the mandate penalties. More outreach and enrollment assistance would increase enrollment and would probably attract disproportionate numbers of new healthy enrollees — but increased spending is needed, and the administration has severely cut that assistance for 2018.

In addition, the administration has shortened the open-enrollment period and reduced the hours when consumers can access the healthcare.gov enrollment system, making it even more difficult for consumers to enroll in marketplace coverage. These changes will certainly reduce the size of nongroup markets, lower insurer participation, and increase premiums for people who are ineligible for premium tax credits. They also will result in more uninsured people, increase demand for uncompensated care, and lead to higher levels of unmet need, so reversing them should be a high priority.

Making the ACA's temporary reinsurance program permanent would spread the financing of high-cost medical claims to the broader tax-paying population, reducing nongroup premiums and insurers' risk. Reinsurance is a permanent and uncontroversial component of Medicare Part D and was included in most of the proposals to "repeal and replace" the ACA put forth by Republican lawmakers this year.

These strategies would stabilize ACA marketplaces, generally at current levels of coverage and affordability. However, more needs to be done to increase coverage, improve affordability, and make the markets more attractive for insurers.

Three concrete steps would increase enrollment in marketplace plans, thereby attracting more insurers to the market, reducing the uninsured population, and increasing access to care. Step one is lowering patients' premiums and out-of-pocket costs, since many Americans still face premiums that are high relative to their incomes as well as high cost-sharing obligations. The tax-credit schedule that determines what premiums people pay could be revised so that enrollees would contribute lower percentages of their income, and the large premium "cliff" for people with incomes over 400% of the poverty level could be eliminated.[1] As things stand in 2017, a single 64-year-old purchasing an average-priced silver plan would face a jump in his or her own payment contribution of about $6,200 per year (from about $4,680 to about $10,920) when moving from an income of 399% of the poverty level (tax-credit–eligible) to 401% (not tax-credit–eligible). Larger cost-sharing subsidies should also be offered, in part by tying tax credits to more generous gold insurance plans instead of silver plans.

Second, fixing the family "glitch" would increase enrollment in marketplaces by an estimated 3.6 million people while reducing financial burdens for low-income families.[2] According to current interpretation, the ACA prohibits otherwise eligible family members from obtaining marketplace subsidies if even one family member is offered affordable worker-only employer insurance. Creating a family affordability standard would enable more people to enroll in marketplaces.

Third, prohibiting the sale of non–ACA-compliant health plans (e.g., short-term policies) would also increase nongroup insurance enrollment, adding relatively healthy people to the pool. President Trump's recent executive order would instead loosen restrictions on these plans, degrading the health of the pool.

Other measures would increase insurer participation and marketplace competition. Currently, with premium tax credits determined on the basis of the second-lowest-cost silver plan available, many enrollees are driven to the two lowest-priced plans — which are frequently offered by the same insurer. Other insurers, therefore, have difficulty getting sufficient market share to remain.

Three policies could lower premiums and increase insurer participation. First, if each insurer were limited to one standardized cost-sharing and benefit design at each level, the two lowest-cost plans would be offered by different insurers. Standardizing plan designs would also make plans more comparable, simplifying consumer decision making and spurring greater competition between insurers. Second, tax credits could be set on the basis of the greater of the median or second-lowest-cost premiums, which would increase insurer participation.

Finally, insurer and provider consolidation appears to be a central source of high-priced insur-

ance markets. Monopoly health systems negate insurers' negotiating power over payment rates. Meanwhile, a very dominant insurer makes it extremely difficult for new insurers to enter these markets and negotiate favorable rates with providers. In order to address both types of consolidation, providers could be prohibited from charging more than traditional Medicare payment rates plus a percentage.[3] Medicare Advantage uses a similar policy. Such a policy would counteract the monopoly pricing power of a health system, and insurers could more easily enter new markets, knowing that they would be able to compete using reasonable provider payment rates. As competition increases, premium growth would slow.

An audio interview with Dr. Blumberg is available at NEJM.org

Taken together, these strategies would have significant positive ramifications for patients. Additional outreach and enrollment assistance, reversal of recent administrative impediments to enrollment, and standardization of plans would simplify the enrollment process, facilitating patients' ability to get coverage. Affordability as well as access and continuity of care would be increased through guaranteed and improved premium and cost-sharing assistance. Reduced costs in currently high-priced markets, achieved through a permanent reinsurance program, caps on provider payment rates, and standardized plans, would lead to greater affordability for people who are not eligible for subsidies, and they could increase insurer participation and thus patient choice of insurers and provider networks.

For physicians, more insurance coverage would mean access to more patients who can afford necessary medical care. Lowering premiums, improving cost-sharing subsidies, instituting reinsurance, and increasing outreach and enrollment efforts would lead to large decreases in the uninsured population, with a consequent decrease in the number of people unable to pay doctor bills. The proposed caps on provider payment rates could reduce payments to some providers, but these rates could be set above Medicare rates and still have the desired effect, and they would apply to a market representing just 6% of the population.

Disclosure forms provided by the authors are available at NEJM.org.

From the Urban Institute, Washington, DC.

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Lessons from the Latest ACA Battle

Jeanne M. Lambrew, Ph.D.

At the end of the 2017 Obamacare repeal-and-replace legislative battle (and before the next one begins), it is worth taking stock of why — defying the odds — the Affordable Care Act (ACA) still stands. From my perspective as an Obama administration veteran of every near-death experience of the law to date, this one is notable for its unlikely heroes.

Pundits primarily attribute the end of the latest attempt to repeal and replace the ACA to a political failure. With the Republicans in charge of both the White House and Congress, voting to keep the promise of repealing the ACA was, in the words of Senator Chuck Grassley (R-IA), "as much of a reason as the substance of the bill."[1]

The press has also credited the handful of Republican senators who bucked political pressure to oppose four successive repeal-and-replace bills. Senator Susan Collins (R-ME) opposed all the versions, and Senator Lisa Murkowski (R-AK) opposed nearly all of them. Their opposition, unlike the process-oriented objections of Senator John McCain (R-AZ), was grounded in concerns about reducing health insurance coverage, undermining Medicaid, increasing what people pay for health care, and failing to lower underlying health care costs.

But in my experience, "no"