POLICY REPORT

Health Care Challenges That States Should Prepare to Face in 2017

By Rea S. Hederman Jr. and Brian Blase, Ph.D.

Regardless of the outcome of the 2016 elections, states must prepare to deal with several health care policy challenges next year, including serious problems with the Affordable Care Act (ACA) exchanges and the large increase in Medicaid. If Republicans win the White House and retain control of Congress, several parts of the ACA may be repealed and replaced. If a Democrat wins the White House, the change may not be as dramatic, but economic realities may force Washington to revisit the workability of the law's insurance market regulations. Changes that federal policymakers make to the ACA will affect states. This paper outlines several of the challenges that states may face and the potential for reform.

Assuming the ACA is Partially Repealed

Given the ACA's significant problems thus far—including lower-than-expected exchange enrollment, risk pools disproportionately composed of older and sicker people, the exit of more than half of the health care cooperatives, and many people predictably waiting until they need medical services before purchasing health insurance—the ACA's regulatory apparatus warrants change.

In January 2016, Congress passed a partial repeal of the ACA, legislation that President Obama unsurprisingly vetoed.[1] The key components of that bill sunset the ACA's health insurance subsidies as well as its Medicaid expansion after 2017. The bill did not directly address the ACA's insurance market regulations—such as the essential health benefits mandate, actuarial value bands, or limits on premium variation[2]—because those provisions were not clearly addressable through the budget reconciliation process.

---

1. Restoring America's Health Care Freedom Reconciliation Act of 2015, H.R. 3672, 114th US Cong. (2015).
2. As an example of some of the ACA's requirements, all non-grandfathered insurance plans must cover ten essential benefits, cover preventive services without cost sharing, and meet an actuarial value band of 60 percent, 70 percent, 80 percent, or 90 percent. The ACA also prevented insurers from varying premiums based on health status of enrollees or to accurately reflect the age of enrollees. The ACA created a three-to-one age rating band, which means that insurers cannot charge the oldest members of their risk pool more than three times what they charge the youngest adults in their risk pool.

Should Republicans retain their congressional majorities and win the presidency, it is unlikely legislation that rolls back aspects of the ACA would be vetoed. If this is the case, Congress is likely to return significant regulatory authority to the states to give them the ability to increase choice and competition in their insurance markets.

If something like the 2016 reconciliation bill is signed, states that adopted the ACA's Medicaid expansion will lose the elevated federal reimbursement rate for that population. States choosing to maintain Medicaid coverage for the expanded population would receive only the standard rate—that is, the rate that states receive for the traditional Medicaid populations of lower-income children, pregnant women, the elderly, and the disabled.[3] However, a Republican replace plan is likely to provide financial assistance to lower-income individuals in a different form to help them purchase insurance.[4] Finally, states should be prepared for a new administration and Congress eliminating the ACA's 23-percentage-point increase in the matching rate for the Children's Health Insurance Program (CHIP), thus returning to the traditional CHIP reimbursement rate.

What States Should Do With Individual Health Insurance Markets

The ACA's federal regulations usurped states' traditional role in regulating health insurance. The ACA's regulations have increased health insurance premiums, burdened businesses with higher taxes and compliance costs, and created perverse incentives to delay purchasing health insurance.[5] A new Congress wishing to undo many of these ill effects may return significant regulatory power to the states, so states should be prepared.

First, states should be ready to repeal any ACA-compliant state laws or regulations. After the ACA, most states passed laws or issued regulatory guidance implementing at least some ACA policies—such as the essential health benefits or the small-business exchange. For example, North Carolina enacted almost twenty laws to conform with the ACA, while South Carolina chose to issue ACA-conforming regulations.[6] Without repealing these laws or regulations, state health insurance markets will continue to be regulated as if the ACA was still in effect.

Second, states should consider adopting protections for people with pre-existing conditions—so long as they remain continuously insured. Such policies can take many forms. Health care economist John Goodman, for example, has proposed a system of payments between insurers so that one insurer cannot dump its high-cost enrollees on another insurer.[7]

---

3. Depending on the way Congress writes the legislation, some states that wish to keep the expansion might need to submit a waiver to the Secretary of HHS.
4. Energy and Commerce Committee, "Burr, Hatch, Upton Unveil Obamacare Replacement Plan," House Energy and Commerce Committee , accessed April 28, 2016, https://energycommerce.house.gov/news-center/press-releases/burr-hatch-upton-unveil-obamacare-replacement-plan
5. National Center for Policy Analysis, "The Cost of Health Insurance Mandates," National Center for Policy Analysis, accessed April 28, 2016, http://www.ncpa.org/pub/ba237
6. Katie Keith and Kevin, W. Lucia, "Implementing the Affordable Care Act: the State of the States," The Commonwealth Foundation, accessed January 2014, http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jan/1727_keith_implementing_aca_state_of_states.pdf
7. John C. Goodman, "AEI Health Plan: Many Good Ideas, But Some Missed Opportunities," Goodman Institute for Public Policy Research, accessed April 28, 2016, http://www.goodmaninstitute.org/aei-health-plan-many-good-ideas-but-some-missed-opportunities/

Third, states should consider reinstating high-risk pools for those with pre-existing conditions. According to health policy experts, James Capretta and Tom Miller, properly designed high-risk pools can be effective.[8] They argue for high-risk pools with a cap on individual premiums to ensure affordability, a third-party entity that determines eligibility, and exempting people with continuous coverage from new risk assessments by insurance companies. Capretta and Miller also propose an "open-season enrollment period to allow people who have fallen through the cracks over the years to re-establish their rights by maintaining continuous coverage."[9]

What States Should Do About Medicaid

Medicaid enrollment and spending increases continue to challenge states and threaten their budgets. As program enrollment and spending rise, irrespective of whether states adopted the ACA Medicaid expansion, costs increasingly divert state dollars and resources from other priorities, such as education, transportation, and infrastructure.[10] Medicaid has also resulted in a large crowd-out of both private health insurance[11] and long-term care insurance while generally failing to provide services that deliver high value to enrollees. Two recent studies of Oregon's unique Medicaid expansion, for example, found that Medicaid enrollees obtain just twenty to forty cents of benefit for each dollar spent on them, and that Medicaid enrollees did not show statistically significant improvement in physical health.[12]

Federal Medicaid dollars flowing to states have increased from $77 billion in 1990 (in 2015 dollars) to $350 billion in 2015.[13] Though unfortunate, the states are increasingly reliant on federal Medicaid funding. States have taken advantage of the open-ended federal financing structure and have used accounting tricks and gimmicks to syphon as much federal funding as possible.[14] Last year, Congress's budget resolution repealed the ACA Medicaid expansion and replaced the open-ended federal funding structure with fixed allotments to states.[15] The changes were estimated to reduce federal Medicaid spending by $1.3 trillion over a decade.[16]

---

8. James C. Capretta and Tom Miller, "How to Cover Pre-Existing Conditions," National Affairs (Summer 2010: Issue 4), accessed April 28, 2016, http://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions
9. Id.
10. According to state expenditure data from the National Association of State Budget Officers, between 1990 and 2015, state spending on Medicaid has increased five times more than state spending on education and six times more than state spending on transportation.
11. Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," Journal of Health Economics 27 (2008): 201-217. Jeffrey Brown piece on LTC side.
12. Amy Finkelstein et al., "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," Massachusetts Institute of Technology, accessed May 2, 2016, http://economics.mit.edu/files/10580
13. Congressional Budget Office. "The Budget and Economic Outlook: 2016 to 2026." Congressional Budget Office. January 2016. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook_OneCol-2.pdf; National Association of State Budget Officers, State Spending and State Expenditure Report 1992: Fiscal 1990-1992 Data.
14. Brian Blase, "Medicaid Provider Taxes: The Gimmick that Exposes Flaws with Medicaid's Financing," Mercatus Center at George Mason University, accessed April 28, 2016, http://mercatus.org/publication/medicaid-provider-taxes-gimmick-exposes-flaws-medicaid-financing
15. Restoring America's Health Care Freedom Reconciliation Act of 2015, H.R. 3672, 114th US Cong. (2015).
16. Information provided by the Senate Budget Committee. The fiscal year 2016 budget resolution was estimated to save $826 billion from repealing the ACA Medicaid expansion and an additional $510 billion from changing federal payments to states from matching funds to fixed allotments.

The Supreme Court's decision in NFIB v. Sebelius made the ACA's Medicaid expansion optional for states.[17] By offering to pay 100 percent of the costs of the expansion population for the first three years (2014 to 2016) and never less than 90 percent of the expansion population costs, the federal government made expansion tempting. Thus far, thirty-one states have accepted Washington's terms, adopted the massive expansion, and watched as Medicaid costs have significantly exceeded estimates.[18] This has created additional budget pressure for state lawmakers.

In light of Medicaid's exorbitant costs, inefficiencies, and ineffectiveness, state policymakers should look for federal rules and requirements that should be streamlined or undone, as well as for ways to reform Medicaid's financing structure. These reforms could include: work requirements for non-disabled adults; implementing premiums and cost-sharing protocols to encourage enrollees to seek care at the appropriate time and place; redesigning benefit packages; restricting program eligibility to those unable to finance their care; and seeking authority to reform state Medicaid programs without using a politicized waiver process.

How States Should Free the Supply Side of Their Health Care Markets

Despite federal infringement on state insurance markets, states still retain a great deal of control over the rules surrounding the delivery of health care services. States should pursue policies that improve consumer price and choice through supply-side reforms that will encourage and increase the efficient supply of affordable, quality health care services. Unfortunately, many states have taken the opposite approach, imposing laws and regulations that reduce competition in health care markets, driving up prices, and limiting consumer choice.[19]

Two common types of state regulations ripe for reform are "certificate of need" (CON) laws and scope of practice regulations. More than two-thirds of states have some version of CON laws that require health care suppliers to obtain permission from government regulators before expanding services or building new facilities.[20] The Mercatus Center at George Mason University found that these laws can dramatically reduce the available amount of medical care and equipment.[21] Similarly, scope of practice regulations limit the services that a health care professional may legally provide. These regulations are unique to each state, with some states enforcing more stringent rules than others. For example, some states allow nurses to conduct routine examinations—well within their skill sets—only with the oversight of an on-site physician. These types of restrictions spur higher prices for medical services with little, if any, benefit to patients.[22]

---

17. National Federation of Independent Business v. Sebelius, 567 U.S. ___ (2012), 183 L. Ed. 2d 450, 132 S.Ct. 2566.
18. "Where the states stand on Medicaid expansion," The Advisory Board Company, January 13, 2016, https://www.advisory.com/daily-briefing/resources/primers/medicaidmap
19. Martin Gaynor and Robert J. Town, "Competition in Health Care Markets," National Bureau of Economic Research Working Paper (July 2011), accessed May 2, 2016, http://www.nber.org/papers/w17208.pdf
20. Matthew Mitchell, Anna Mills, and Dana Williams, "Three Prescriptions for States to Improve Health Care," Mercatus Center at George Mason University (2015), accessed May 2, 2016, http://mercatus.org/sites/default/files/Mitchell-Prescriptions-MOP.pdf
21. Thomas Stratman and Jacob W. Russ, "Do Certificate of Need Laws Increase Indigent Care," Mercatus Working Paper, Mercatus Center at George Mason University, accessed April 28, 2016, http://mercatus.org/publication/do-certificate-need-laws-increase-indigent-care
22. Morris M. Kleiner et al., "Relaxing Occupational Licenses Requirements: Analyzing Wages and Prices for a Medical Service," NBER working Paper #19906 (February 2014), accessed April 28, 2016, http://www.nber.org/papers/w19906

State bans on charity care are another common but unnecessary constraint on access to medical care. Licensed doctors and other medical professionals are often prohibited from providing free, charity medical services in states other than where they are licensed. Some states, including Ohio, are drafting legislation that would increase charity care by removing artificial boundaries preventing medical providers from caring for people most in need and least able to afford care.[23] States can further encourage charity care by allowing health care professionals to provide free care in poor or rural areas in lieu of some continuing education credits.

In addition to lowering government-imposed barriers to health care services, state policymakers should also look for ways to encourage medical innovation. New products and inventions tend to improve quality and reduce prices. For example, computers and other electronic devices now allow patients to "visit" their doctors virtually through "telemedicine." Lawmakers should encourage telemedicine as a means of increasing access to health care services, particularly in rural and isolated areas, and connecting patients to medical professionals for diagnosing minor illnesses and prescribing medication.[24] With parity laws that treat telemedicine like personal visits, states can encourage further innovation in this groundbreaking area and add choices and services for patients.

A Pro-ACA Administration

If Democrats retain control of the White House next year, they will likely aim to keep the ACA as intact as possible. Economic realities, however, may force a Democratic administration to address problems inflicted by the ACA on the individual insurance market. The ACA's individual mandate and generous federal subsidies have not induced enough young and healthy people into the health insurance market to create a stable risk pool. A recent Mercatus Center working paper details how insurers have suffered large losses selling ACA plans despite significant government subsidies through the law's reinsurance program.[25] These subsidies expire after 2016, which means that, for the first time, health insurance premiums in 2017 must be sufficient to cover insurers' expenses. With the phase-out of the reinsurance program and large insurer losses to date, premiums will likely rise considerably in 2017, which will exacerbate adverse selection pressures in the exchanges.[26]

Although it may be tempting for lawmakers to promulgate additional regulations to deal with the adverse effects of the ACA, negotiations in Washington ultimately may restore significant insurance market control to states—so long as the states develop plans to ensure coverage for people with pre-existing conditions. If this is the case, regardless of who wins in November's election, the steps for states to take described in the previous section will be relevant.

---

23. Tom Lampman, "Expanding Access to Healthcare in Ohio," The Buckeye Institute, November 30, 2015, http://www.buckeyeinstitute.org/uploads/files/Expanding_Access_to_Healthcare_in_Ohio.pdf
24. Matthew Mitchell, Anna Mills, and Dana Williams, "Three Prescriptions for States to Improve Health Care," Mercatus Center at George Mason University (2015), accessed May 2, 2016, http://mercatus.org/sites/default/files/Mitchell-Prescriptions-MOP.pdf
25. Brian Blase, Doug Badger, and Edmund Haislmaier, "The Affordable Care Act in 2014: Significant Insurer Losses despite Substantial Subsidies," Mercatus Center at George Mason University, http://mercatus.org/publication/affordable-care-act-2014-significant-insurer-losses-despite-substantial-subsidies
26. Id.

In addition to problems in the individual insurance market that Washington may be forced to confront in 2017, Medicaid represents the fastest-growing component of the federal budget, and a bipartisan consensus among policy experts recommends that federal deficit reduction should be a priority.[27] For example, in 2011, the Obama administration signaled that the federal commitment to finance the ACA expansion was unsustainable and proposed more than $100 billion in federal Medicaid savings over a decade.[28] These proposed savings would largely occur by equalizing the federal reimbursement rates for the various Medicaid eligibility groups.[29] Cost-saving reform measures like this, of course, can dramatically alter the terms and benefits of the ACA's Medicaid expansion deal between Washington and the states. This means that states that have yet to sign on to Medicaid's expansion should proceed with caution as states risk losing a considerable amount of federal support for their programs in the near future.

Section 1332 Waivers and a Divided Federal Government

If political control in Washington remains divided between Republicans and Democrats after the 2016 election, state policymakers may look to Section 1332 of the ACA as a path forward. But even then, Section 1332's promise for relief is limited.

Section 1332 allows states to ask the Secretary of the Department of Health and Human Services (HHS) to waive key provisions of the law in their state. These provisions include: the individual mandate; the employer mandate; many of the law's insurance market regulations; and the law's subsidies that reduce out-of-pocket premiums and cost-sharing requirements.[30]

In order to receive a waiver, Section 1332 requires that a state plan meets four requirements:

> 1) the state must provide coverage to at least a "comparable" number of people as the ACA would cover without the waiver;
>
> 2) the state must provide coverage that is at least as "comprehensive" as ACA coverage obtained through an exchange;
>
> 3) the state must provide "coverage and cost sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as exchange coverage; and
>
> 4) the plan cannot increase the federal deficit.

A state with a waiver can obtain the estimated value of financial assistance that its residents would have received from the law's subsidies in the absence of the waiver.

---

27. The White House, "The National Commission of Fiscal Responsibility and Reform: The Moment of Truth," The White House December 2010, accessed April 27, 2016, http://momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf#page=40
28. The White House, "The President's Framework for Shared Prosperity and Shared Fiscal Responsibility," The White House, accessed May 2, 2016, https://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp
29. Id.
30. 42 United States Code, Section 18052 at https://www.gpo.gov/fdsys/granule/USCODE-2010-title42/USCODE-2010-title42-chap157-subchapIII-partD-sec18052

As written and interpreted by HHS, Section 1332 does not offer states much help against many of the ACA's harmful effects or allow them latitude to create innovative policy solutions. The waiver provisions rely on the dubious assumption that the ACA's objectives, dials on benefits design, coverage goals, and affordability estimates are all correct. Thus, they allow the federal bureaucracy broad power and discretion to reject state approaches deemed inconsistent with the prevailing wisdom of Washington. Nevertheless, state legislators should consider how Section 1332 might be amended to be more useful in the future.

Conclusion

More than six years after enactment of the Affordable Care Act, the law's fate, particularly its health insurance market regulations, remains vulnerable to significant change. States must be ready to retake control of their health insurance markets if Congress repeals parts of the ACA in 2017. Even without repeal, fiscal realities at the state and federal levels will likely prompt changes to Medicaid, a program in dire need of fundamental reform. In the interim, states should work to repeal their own regulations that reduce competition and innovation in their health care markets and look for ways to increase consumer choice and lower costs.

About the Authors

Brian Blase is a Senior Research Fellow focusing on health care policy with the Spending and Budget Initiative at the Mercatus Center. Previously, Brian was with the Senate Republican Policy Committee where he served as a health care policy analyst, and before that worked as senior professional staffer for the House Committee on Oversight and Government Reform. Brian received his Ph.D. from GMU in 2013 in economics, with his dissertation on Medicaid.

Rea S. Hederman Jr. is Executive Vice President and Chief Operating Officer of The Buckeye Institute. Previously, Hederman was Director of the Center for Data Analysis (CDA) at The Heritage Foundation. He graduated from Georgetown Public Policy Institute with a Master of Public Policy degree and holds a Bachelor of Arts degree from the University of Virginia.

Founded in 1989, The Buckeye Institute is an independent research and educational institution—a think tank—whose mission is to advance free-market public policy in the states.
.

88 East Broad Street, Suite 1120 · Columbus, Ohio 43215 · 614-224-4422 · BuckeyeInstitute.org