MILLENNIAL POLICY CENTER

Policy Analysis

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Last Plan Standing *Cassidy-Graham Healthcare Proposal*

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The Cassidy-Graham Proposal

The Patient Protection and Affordable Care Act (ACA) did not increase access to quality, affordable health insurance coverage, expand coverage to the uninsured, and lower healthcare costs for Americans as promised. Unfortunately, the evidence over the past seven years clearly demonstrates that the law has failed to achieve its purported objectives and has harmed millions of Americans. The ACA must be repealed, replaced, and reformed to achieve those original goals. **The Cassidy-Graham proposal is a promising start to a step-by-step strategy to do this.**

1. ***Eliminates the individual and employer mandates.*** The ACA's individual mandate is unpopular and not effective as originally claimed. IRS records show that in 2015, 6.5 million people paid the penalty and an additional 12.7 million people claimed an exemption from the mandate.[1] The employer mandate is also a stranglehold on job creation and wage growth. To avoid the mandate's penalties and the high cost of providing employer coverage, many small businesses decided to curtail new hiring and shift full time employees into part time work. An American Action Forum study estimates that the employer mandate and other ACA regulations reduced employment among small businesses by 350,000.[2] The elimination of both mandates is a welcome relief to Americans suffering under this law.

2. ***Expands Health Savings Account opportunities for choice and competition.*** Cassidy-Graham expands Health Savings Accounts by increasing contribution limits to be equivalent to the limit on out-of-pocket cost sharing under qualified health plans ($6,550 for individual coverage, $13,100 for family coverage in 2017 dollars). HSAs are a mechanism to promote consumer-driven healthcare; they encourage patients to make informed choices based on quality and price. These accounts are owned by the individual and are portable despite employment or insurance sponsor and grow tax-free and roll over year to year. HSAs also help to decrease total healthcare spending. A study conducted prior to ACA implementation found that families who switched from traditional to consumer-directed health plans spent 21 percent less on healthcare the first year in a new plan.[3] Families and individuals need even greater control over their own healthcare decisions; therefore, the contribution limits should be even higher, such as $9,750 for individuals and $20,100 for families. In addition, Cassidy-Graham allows individuals to use HSA contributions to pay for health insurance premiums. Unlike the current plan, individuals with HSAs should also be free to pair their accounts with coverage options beyond high deductible plans – or not to purchase an insurance plan tied with their HSA at all. These changes will allow more individuals to utilize HSAs to save and shop for their healthcare as cost-conscious consumers.

3. ***Puts states in control of their own healthcare destinies.*** Perhaps the seminal part of Cassidy-Graham is that it permits states to customize healthcare systems to the unique needs of their residents. While eliminating the status quo for health insurance subsidies and Medicaid expansion, the amendment would convert much of that spending into block grants. This will open the potential for states to direct funds toward: **(1)** insurance support payments to insurers to "stabilize premiums and promote State health insurance market participation"; **(2)** establishing and maintaining high-risk pools; **(3)** "a program or mechanism to help individuals purchase health benefits coverage"; **(4)** "wrap-around" coverage for benefits or providers that are not covered by those currently enrolled in a state medical assistance program; **(5)** payments to healthcare providers directly; and/or **(6)** subsidies to reduce "out-of-pocket costs, such as copayments, coinsurance, and deductibles, of individuals enrolled in plans offered in the individual market." States would be required to put up a small percentage of the total allotment for some skin in the game (a 3% match in 2020 and 5% by 2026).

   The Framers of the Constitution established a federalist system so that the states could be the "laboratories of democracy." Offering states the flexibility to develop their own solutions and innovative strategies to lower costs, improve access, and expand coverage will produce a variety of best practices rather than forcing a failed or untested one-size-fits-all approach on the entire country. In addition, capping federal block grant payments to the states offers an incentive to control costs since the feds wouldn't be picking up so much of the tab. Onerous federal regulations currently prevent states from using funds in innovative ways. Per capita caps allow states to prioritize their populations' unique needs. States can also experiment and learn from each other on what models provide the best care at the lowest cost.

4. ***Ends the disastrous Medicaid expansion in January 2020 and shifts to block grants.*** Cassidy-Graham gives states block grants to manage the healthcare of low-income people, including those on Medicaid. Since the ACA, Medicaid expansion has exploded enrollment by 29% nationally, with increases as high as 106% (in Kentucky). Current enrollment is 74.5 million people, up from 56.8 million pre-ACA.[4] Many of these new enrollees are able-bodied individuals with no dependents who can work. This expansion is nothing more than a new entitlement, as few enrollees ever come off the Medicaid rolls, and at the current rate, this expansion will put a tremendous financial strain on the nation. Furthermore, expansion has caused states to prioritize the working-age adults over the truly vulnerable because they get more funding for the expansion population. This causes wait lists for necessary services for *traditional* Medicaid patients. The block grants are *not* a Medicaid cut but rather an equalization of funding so that the truly vulnerable get as much federal funding as able-bodied adults.

   According to the CBO, in 2016 total entitlement outlays (Social Security, Medicare, and Medicaid) totaled $1.866 trillion. At $368 billion, Medicaid makes up a whopping 20% of this number.[5] The CBO reports that federal spending for major healthcare programs like Medicare and Medicaid, together with Social Security, will reach 14 percent of GDP by 2038, twice the average of the past 40 years.[6] This is unsustainable. Let the states, who have traditionally administered their own Medicaid populations effectively, do so again. Now they would have the assistance of block grants, while caring for their low-income people who need the state's assistance. In addition, block grants may give individual states the authority to negotiate directly with drug manufacturers to control drug costs within their own Medicaid populations, which would foster competition and control of drug prices from state to state.

Additional Recommendations for Reform

There are several more provisions that should be included in the Cassidy-Graham legislation and/or included in separate simultaneous or subsequent bills. The Cassidy-Graham proposal should repeal *all* ACA taxes, not just the ones provided for in the bill as proposed. These represent an economic burden that constrains investment, which must be injected into the American economy at a crucial time when wages are stagnant and the labor force participation rate remains low.

This legislation should also provide a seventh option for how states direct their market-based healthcare grants. States should be able to provide tax credits directly into tax-free HSAs, based on criteria determined by an individual state. These could in turn be used to pay premiums or offset other healthcare costs as discussed above. This would create a market for healthcare centered more on the individual consumer, which would help to lower costs and promote high quality medical care by putting consumers in charge of their own healthcare spending.

The reforms contained in the Cassidy-Graham plan, as well as those suggested above, would be beneficial yet insufficient on their own. Additional legislation will be necessary and will require bipartisan collaboration. One bill should permit insurance sales across state lines. Another would unleash Association Health Plans, allowing community organizations like churches and small businesses to pool their resources to affordably insure members and employees. Finally, subsequent legislation should expand the existing 1332 waivers to permit the sale of plans that do *not* meet the essential health benefits, community rating, and age rating rules, while not segmenting the risk pool. These changes will stabilize insurance markets by encouraging young people to buy coverage by offering access to more affordable plans.

Contact the Millennial Policy Center [7]

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Endnotes

[1] Koskinen, John. "IRS Commissioner John Koskinen Updated Members of Congress regarding 2016 Tax Filings Related to Affordable Care Act Provisions." Letter to Congress. Internal Revenue Service, 9 Jan. 2017.
[2] Gitis, Ben. *To Buy or Not to Buy: Uninsured Young Adults and the Perverse Economic Incentives of the ACA.* American Action Forum, 9 Sept. 2014.
[3] *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care.* Rand Corporation, 2012.
[4] "Total Monthly Medicaid and CHIP Enrollment." KFF.org. The Henry J. Kaiser Family Foundation, 2 Aug. 2017.
[5] "The Federal Budget in 2016: An Infographic." CBO.gov. Congressional Budget Office, 8 Feb. 2017.
[6] Quora. "What Share Of The Federal Budget Goes To Health Care Versus Other Spending?" Forbes.com. *Forbes Magazine*, 6 Mar. 2014.
[7] The **Millennial Policy Center** is a policy research, development, and education program (a think tank) whose mission is to address public policy issues that affect the Millennial Generation (born between and including the years 1981 to 1998) and to develop and present policy solutions that advance the constitutional values of freedom, opportunity, and economic vitality for Millennials throughout the United States. Our website is www.MillennialPolicyCenter.org.