

# Affordable Care Act Under New U.S. Administration: Uncertainty Ahead for Nation, Impact on California

All significant changes are followed by times of uncertainty. The recent election is proof of that. With all the changes related to the new U.S. administration, the future of health care in America is uncertain. One thing that is certain and abundantly clear, however, is that health care and the Patient Protection and Affordable Care Act (ACA) is a top priority for the new administration. In fact, the campaign website states that on day one of the new administration, “we will ask Congress to immediately deliver a full repeal of Obamacare.”

There is no doubt that the ACA will be under attack in the coming year, either by way of a full repeal, or more likely an effort to cripple the law by repealing its funding provisions. What does this mean for California employers who need and rely upon healthy employees and a strong and able workforce?

## Affordable Care Act

The ACA was signed into law on March 23, 2010 with the intent of reforming the health care industry and giving more Americans access to quality health care. By 2014, once most of the provisions were in effect, the ACA had made significant changes to health care laws and affected how millions of Americans and Californians access health care. It built upon existing employer-based coverage and imposed new requirements on states, health insurers, employers, employees and other individuals in an effort to expand coverage to millions of uninsured Americans and control the increasing cost of health care.

## Key Provisions of ACA

- **Individual Mandate:** Mandates all U.S. citizens and legal residents (unless they qualify for an exemption) to purchase health insurance or pay a noncompliance tax penalty.

- **Employer Mandate:** Mandates employers with 50 or more full-time equivalent employees to offer affordable quality health care insurance with “Minimum Essential Coverage” to at least 95% of their full-time employees and their dependents up to age 26. If at least one full-time employee receives a premium tax credit to help pay for coverage from the ACA Exchange, then the employer will have to pay a penalty.

- **Small Group Insurance Requirements:** Subjects businesses with fewer than 50 full-time employees to small group insurance requirements, but exempts them from penalties. Small employers who choose to obtain health insurance for their employees must have plans that 1) cover 10 essential health benefits; 2) fit into the actuarial value levels defined by the ACA (platinum, gold, silver and bronze); 3) participate in the risk adjustment program and be part of a single risk pool for setting premiums; and 4) consider only age, geographic location, family composition and tobacco use in setting rates.

Businesses with fewer than 25 full-time equivalent

employees may qualify for an employer health care tax credit. Due to a repeal of an ACA provision in October 2015, states now can elect to extend the definition of small employer to include employers with up to 100 employees. Four states have chosen to do so. In California, the small group insurance requirements apply to businesses with fewer than 100 full-time equivalent employees. Thus, in California, businesses with 50 to 99 full-time equivalent employees are subject to both the employer mandate and the small group insurance requirements.

- **Health Insurance Exchanges:** Creates state-based health insurance marketplaces through which individuals not receiving employer health insurance coverage would be able to purchase private health insurance with premium and cost-sharing federal subsidies for those that qualified. If a state did not establish a state-based Marketplace (also known as the Exchange, or in California, which did establish an exchange, Covered California) a plan could be purchased through the Federal Exchange. Premium tax credit subsidies are available only to individuals/families purchasing health insurance through the exchange.

- **Guaranteed Issue—Pre-existing Condition:** Prohibits health insurers from denying coverage based on current or prior health.

- **Community Rating:** Prohibits health insurers from varying premiums within a geographic area based on factors such as gender, occupation or health status.

- **Minimum Standards—Essential Health Benefits:** Requires that all nongrandfathered, insured plans in the individual and small group markets (on and off the Exchange/Health Insurance Marketplace) meet certain minimum coverage standards, called essential health benefits (EHB). Insured Large Group plans are not required to provide EHBs under the ACA.

- **Coverage until Age 26:** Requires that all health insurance policies, including large employer plans, allow young adults to remain on their parents’ health coverage until age 26.

- **Lifetime Caps:** Prohibits insurance companies from placing annual and lifetime caps on coverage for enrollees.

## ACA Funding Provisions

Of all of the ACA provisions, the most critical to the survival of the ACA are the funding provisions (set forth below), which authorize federal subsidies for residents either purchasing health insurance through the Health Insurance Marketplace (the exchange) or receiving it through Medicaid expansion.

- **Medicaid Expansion:** Increases the Medicaid income threshold used to determine if an individual or family qualifies for the program. For states that did not opt out of the Medicaid expansion, the Medicaid coverage subsidy was extended to all adults with income at or below 138% of the federal poverty level. As enacted, the Medicaid expansion under the ACA

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was to take effect nationwide in January 2014. Under a 2012 Supreme Court ruling, however, expansion essentially became a state option. Currently 31 states, including California and Washington, D.C., have opted to expand Medicaid coverage and increase the income threshold to 138%.

- **Premium Tax Credit:** Provides federal government subsidies based on income and available to individuals making between 100% and 400% of the federal poverty level (\$24,300–\$97,200 for a family of 4 in 2016) who purchase health insurance through an exchange. The premium tax credit subsidy can either be paid directly to the health insurer in advance to lower the monthly premium of a health plan purchased through the exchange or can come in the form of an adjustment on an individual's tax return.

- **Cost Sharing Reduction:** Provides federal government subsidies to lower out-of-pocket costs such as deductibles, coinsurance and copayments to individuals and families on a silver plan purchased through the Health Insurance Marketplace. The ACA Cost Sharing Reduction Subsidy (CSR) is based on income and is available only for individuals making between 100% to 250% of the federal poverty level. CSR subsidies do not lower premiums like advanced premium tax credits, as they apply only to cost sharing amounts.

- **Cadillac Tax:** The ACA's high-cost plan tax (HCPT) is a 40% excise tax on employer plans exceeding \$10,200 in premiums per year for individuals and \$27,500 for families. The tax is scheduled to take effect in 2020.

- **Health Insurance Provider Fee:** A fee under the ACA imposed upon entities engaged in the business of providing health insurance in the United States. A moratorium suspended this fee for the 2017 calendar year in the hope that the tax reprieve will contain premium increases.

- **Medical Device Excise Tax:** The ACA imposes an excise tax on the sale of certain medical devices by the manufacturer or importer of medical devices. It is a 2.3% medical device excise tax that was to be paid starting calendar year 2013. A two-year moratorium on this tax was signed, relieving payment of the tax for the years 2016 and 2017.

## ACA Performance in U.S., California

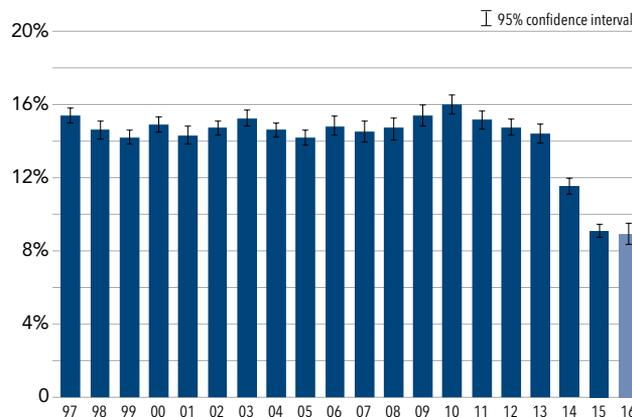
### *Decrease of Uninsured Individuals*

Although there are as many critics as there are supporters of the ACA, what cannot be denied is that the law dramatically increased the number of individuals insured in the United States and in California.

The most recent government survey, released November 2016 by the U.S. Department of Health and Human Services, revealed that the number of uninsured Americans has dropped significantly. In 2010 when the law passed, 16% of Americans were uninsured. Just before implementation of the ACA in 2013, that percentage dropped to 14.4%. As of June 2016, 8.9% were uninsured nationally.

As a result of the implementation of the ACA, more than

### Percentage of Uninsured Declining: Persons of All Ages without Health Insurance Coverage at Time of Interview



Source: National Center for Health Statistics, National Health Interview Survey, 1997–June 2016, Family Core component (Released 11/16).

11 million consumers in the United States have obtained Marketplace (Exchange) coverage as of the first quarter of 2016. Of that number, 9,389,609 ACA enrollees nationwide are receiving a premium tax credit totaling more than \$32 billion and about 6.35 million consumers are benefiting from cost-sharing reductions (CSRs) to make their coverage and covered services more affordable.

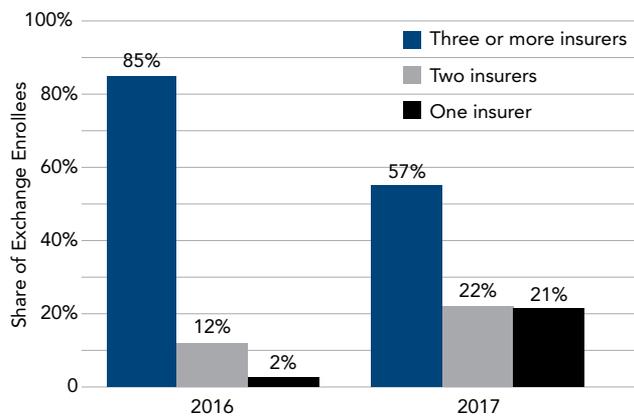
In California, as of the first quarter of 2016, a little more than 1.4 million individuals obtained Marketplace coverage with 1,239,893 receiving a premium tax credit and 707,671 individuals receiving CSR subsidies.

Data released by the Kaiser Family Foundation revealed that as of March 31, 2016, the average monthly premium tax credit subsidy per individual receiving health coverage through the ACA Exchange in the United States was \$291. In California, the average monthly premium tax credit subsidy was \$309. Of the \$32.8 billion the federal government provides under the ACA premium tax credit subsidy nationwide, almost \$4.6 billion goes to California enrollees. In fact, in 2016, California received the second highest amount of ACA premium tax credit subsidies from the federal government of any state in the U.S.

Before the ACA was implemented, the average U.S. monthly Medicaid/Children's Health Insurance Program (CHIP) enrollment was at 56,392,477 individuals. As of September 2016, that number increased by 28% to 73,141,300. In California, the average monthly Medicaid/CHIP enrollment was 7,755,381 individuals before ACA implementation and had increased as of September 2016 by 52% to 11,787,879. In fact, Medicaid enrollment has increased by greater than 50% in more than 10 states as a result of the ACA Medicaid expansion.

Thus, the most dramatic growth in health care coverage in both the United States and California has been due to the Medicaid

## Fewer Exchange Enrollees Will Have Choice of Insurers in 2017



Source: Kaiser Family Foundation

expansion, mostly because the coverage threshold was increased to 138% of the federal poverty level. The ACA and the attention it has brought to health insurance, however, also has led to enrollment and Medicaid coverage for individuals who previously would have been eligible and covered but were unaware or simply had not enrolled. Since 2013, Medicaid enrollment has grown by 13.7 million individuals in the United States.

Of the federal ACA subsidies received in California, the largest share comes from the Medicaid expansion. As noted above, the premium tax credit provides subsidies of almost \$4.6 billion to 1,239,893 Californians. Since the Medicaid expansion, however, California has enrolled almost 5 million individuals in Medi-Cal (California's Medicaid welfare program). Of that number, 3,666,877 are adults ages 19–64 enrolled due to the ACA expansion. In July 2013, before implementation of the ACA, the number of individuals enrolled in Medi-Cal was 8,468,988. In July 2016, that number increased to 13,467,939.

California currently receives approximately \$14.3 billion annually from the federal government to support services for Californians who are newly eligible for Medi-Cal under the program expansion and the amount is expected to increase to \$17.3 billion in the coming year. The federal government is paying the full cost for this group through 2016, phasing down to 90% of the cost by 2020. Therefore, although repeal of the premium tax credit would cripple the law in California, the biggest hit would come from defunding or doing away with the Medicaid expansion in California, which is where the largest share of the ACA federal funds go in the state.

### ***Rise of Premiums/Costs and Loss of Competition***

Although most would not refute that the ACA has decreased the uninsured rate in the United States and in California, there is significant debate on whether the ACA has accomplished its purpose of providing quality affordable health care. California

is an example of a state where the ACA seems to be functioning better than elsewhere. However, the ACA is a federal law and program and needs to function properly in all states; otherwise the impact will be felt eventually in other states.

One state having difficulty is Tennessee, which did not participate in the ACA Medicaid expansion. Although the U.S. Department of Health and Human Services shows a 28% decrease in the number of uninsured Tennessee residents, Tennessee seems to be experiencing significant difficulty providing those residents with affordable health insurance.

In late 2016, the Tennessee state insurance commissioner approved premium increases of up to 62% in an effort to save Tennessee's ACA Health Insurance Exchange. In doing so, she stated, "I would characterize the exchange market in Tennessee as very near collapse... and that all of our efforts are really focused on making sure we have as many writers in the areas as possible, knowing that might be one. I'm doing everything I can to prevent a situation whether that turns to zero." Within weeks of this approval, a large health insurer announced it would leave three of the state's largest exchange markets—Nashville, Memphis and Knoxville. Two other insurers also are leaving the Tennessee Exchange due to significant losses. The majority of Tennessee's counties will be left with only one insurer on the exchange, which leads to even higher premiums due to lack of competition.

Tennessee is just one example, among many, where premiums are increasing and insurers are leaving due to suffering significant losses in the hundreds of millions of dollars. These losses will not simply go away. Instead, those insurers will have to make up their losses in other states, which will have an impact on premium costs and the overall success of the ACA in those states.

An October 2016 report on Insurer Participation in the ACA Health Insurance Marketplaces revealed that 57% of exchange enrollees will have a choice of three or more insurers in 2017, down from 85% of exchange enrollees in 2016. Even more troubling, in 2016 only 2% of enrollees had a choice of only one insurer in the ACA Exchange, but in 2017 that number has increased to 21% of enrollees essentially having no choice on who their Exchange insurer will be.

Even on lower premium plans in the ACA, such as the silver and bronze plans, the cost of health care is high due to high deductibles. The ACA created actuarial value tiers of platinum, gold, silver and bronze for all nongrandfathered plans sold in the small-group and individual markets. Platinum has the highest premium and lowest deductible. This changes as you go down the tiers, with bronze having the lowest premium and the highest deductible. A provision in the ACA ties the premium tax credits to the silver plan, thus providing an incentive for individuals to obtain High Deductible Health Plans (HDHP).

In the individual market, as of 2015, almost 90% of ACA Exchange enrollees are in a plan with a high deductible, meaning a plan with a deductible greater than \$1,300 for an individual and \$2,600 for a family (not including cost-sharing reductions). Although these plans keep premium costs down,

they can get very expensive for families and individuals when one gets sick or needs medical care.

The HDHPs also raise another important issue. If the deductible is so high that an individual or family cannot afford to pay the deductible to seek care, important medical care will be delayed or avoided entirely. In that situation, access to health insurance will not equate to access to health care. The goal of the ACA was to ensure access to affordable, quality health care, not simply health insurance.

Even with the use of these HDHPs and even in states that have significant competition and insurer involvement in the Marketplace, health insurance premiums in the ACA continue to increase. California has been deemed a successful ACA state mainly due to the large number of Californians who enrolled in Covered California and Medi-Cal and the number of insurers in the Exchange (11 as of mid-2016). Even with this success, however, in July 2016, Covered California announced double-digit rate increases of 13.2%, compared to an increase of approximately 4% in the two previous years. Critics of the ACA argue that the purpose of the ACA was not simply to provide insurance to more Americans. Rather it was meant to provide affordable quality insurance, and even in California, premiums continue to increase.

#### ***Premium Cost Drivers***

This rise in premiums in the health insurance market can be attributed to several factors, including the following:

- **Increase In Health Care Costs:** There has been an increase in the cost of medical services and prescription and specialty drugs. Costs for prescription drugs continue to outpace costs for other medical services. This trend will most likely continue because more high-cost specialty drugs are expected to come to market. Prescription drug costs are expected to rise 7.3% in 2017, and specialty drugs are projected to increase by 16.8%.

- **Sunset of Reinsurance and Risk Corridors Program Funds:** 2016 is the end of a transitional and temporary funding mechanism in the ACA known as the reinsurance program, which was designed to help stabilize premiums for coverage in the individual market during 2014 through 2016, the first three years when exchanges were being established. The reinsurance statute requires all health insurance issuers and third-party administrators on behalf of self-insured group health plans to make contributions under the program to support payments to individual market issuers that cover high-cost individuals. If an enrollee's cost exceeds a certain threshold (called an attachment point), the plan is eligible for payment up to the insurance cap. By offsetting a portion of claims, the reinsurance program lowered premiums, and each year the gradual reduction in reinsurance funding resulted in a corresponding increase in premiums.

Similarly, the Risk Corridors program limited the losses and gains of ACA-qualified health plans, thus stabilizing premiums and protecting against inaccurate premium setting during the initial years of reform. The U.S. Department of

Health and Human Services collected funds from plans with lower-than-expected claims and made payments to plans with higher-than-expected claims. In 2016, the federal government paid only 1.9% of the reinsurance costs, which resulted in an increase in 2017 premiums. This year will be the first in which there is no reinsurance and no risk corridors in the individual market under the ACA. Thus, the final impact of the programs on insurance premiums will occur in 2017, when projected claims are expected to increase by 4% to 7%.

- **Enrollment and Demand by High-Cost Individuals:**

Special enrollment by some consumers subsequent to getting sick or needing care has affected the composition of the risk pool. Also, due to the laws in place before the ACA, individuals with pre-existing health conditions were not able to obtain affordable or any health insurance. Because of the ACA, those very individuals can finally obtain health care insurance and have been enrolling. In fact, these previously uninsured individuals have been enrolling first, resulting in much more health services spending than projected. The hope was that with time there would be an increase in enrollment of healthier people to stabilize the risk pool and premiums. Time, however, is a luxury that the ACA no longer has.

#### **Repeal and/or Replace?**

##### ***Repeal***

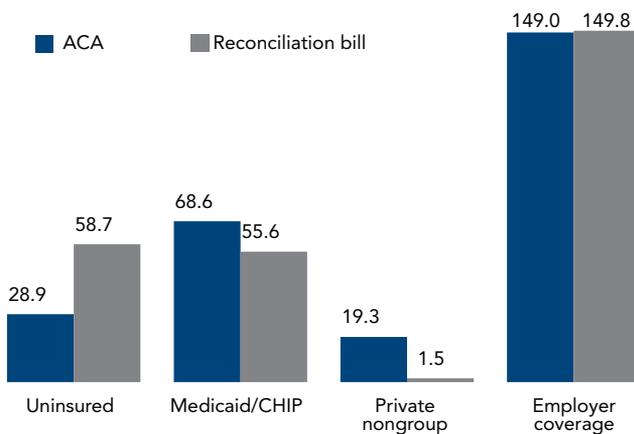
The ACA is the primary target of the new U.S. administration and repealing seems to be priority No. 1. There is a difference, however, between repealing the market reforms within the law, and simply defunding the ACA. An attempt by Republicans to repeal the market reforms could result in a filibuster by the Democrats. For Republicans to overcome this filibuster, they would need a 60-seat supermajority in the Senate, which they do not have, unless eight Democrats join in support. This is why defunding may become the GOP's only immediate option if the new administration's goal remains doing away with the ACA.

##### ***Reconciliation***

The alternative to the full repeal would be a partial repeal through a budget process called reconciliation. Reconciliation is a powerful legislative mechanism because it allows consideration of a budget reconciliation bill with debate on the bill limited to 20 hours. When a bill is highly contested, legislators use a stalling or obstructive tactic (a filibuster), usually in the form of continuous debate on a bill in the U.S. Senate to prevent voting on a certain bill. The delay tactics can be stopped by a vote of 60 senators, which no one party has in the Senate. Because of the Senate rule limiting the debate on reconciliation bills to 20 hours, such bills are not subject to filibuster in the Senate. A simple majority vote, which the Republicans do have in the U.S. Senate, will suffice on a budget reconciliation bill.

Additionally, only sections of the law with federal budget implications (related to taxes and spending) can be changed through reconciliation. This would include elimination of the individual and employer mandates, the Medicaid expansion, the

## Health Insurance of Nonelderly in 2019 Under ACA, Anticipated Reconciliation Bill



\*CHIP: Children's Health Insurance Program

Source: Urban Institute analysis using Health Insurance Policy Simulation Model 2016.

premium tax credit and cost-sharing reduction subsidies, and the Cadillac tax, as well as any other ACA funding provisions. The portions of the law that would not be subject to partial repeal under reconciliation are the prohibition against denials based on current or prior health status, the essential health benefits requirements, coverage of young dependent adults up to age 26, and the actuarial value standards, as well as other insurance market reforms under the ACA.

So even if the strict and complex rules of reconciliation do not prevent a partial repeal of the ACA, the outcome of a partial repeal would not be ideal for anyone. It would leave a country without funding for health care and leave health insurers scrambling. Forcing insurers to continue to insure young dependent adults up to age 26 and individuals with pre-existing conditions, but not mandating that all individuals buy in would leave health insurers with an imbalanced risk pool. The healthy individuals who are not required to buy coverage would have no reason to buy it and would most likely stop paying premiums; the unhealthy individuals would buy and could buy health insurance because insurers would be prohibited from denying them coverage under the nonrepealed portions of the ACA. There would be significant market disruption and severe and substantial financial losses to health insurers. A partial repeal could result in financial failure for health insurers, or more likely, lead them to drop out of or decide not to participate in the Exchange.

### **Repeal and Replace vs. Repeal and Delay**

Repealing the ACA without a replacement could have dire implications. If the ACA is defunded or fully repealed, the majority of the newly eligible Medicare and Medi-Cal enrollees, as well as those who purchased through the Exchange would go without coverage, unless some form of a replacement is enacted. Data from the Urban Institute dated December 6, 2016, showed that a partial repeal of the ACA without replacement

would result in 30 million uninsured individuals by 2019. Specifically, the data revealed that the number of uninsured individuals would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people.

Of the 29.8 million newly uninsured, 22.5 million would be as a direct result of eliminating the premium tax credits, the Medicaid expansion and the individual mandate. The additional 7.3 million individuals would become uninsured as a result of the near-collapse of the nongroup insurance market.

Even the ACA's harshest critics are cognizant of the devastating effects an immediately effective repeal of the ACA would have on the state of health care in America and the percentage of uninsured in the country. The consensus amongst critics seems to be that even if there is a full or partial repeal, an effective date of repeal extending 2–3 years is necessary to come up with a replacement plan. The problem with this "repeal and delay" strategy is similar to the problems with an immediately effective repeal: severe market disruption and loss of coverage due to insurers leaving the market.

## Replacement Plans

Most supporters and even some ACA critics agree that if a repeal is to occur, the only way to minimize disruption and provide some stability to the market is to provide an immediate replacement plan upon which health insurers and the public can rely. The incoming President has said he wants congressional Republicans to simultaneously repeal and replace the ACA. Although an ACA replacement plan has not been introduced, there are two main proposals.

### **Empower Patients First Act**

The only ACA replacement plan with legislative language already prepared is Congressman Tom Price's Empower Patients First Act, proposed in 2015. He first introduced the bill in 2009, and has introduced it with modifications in every congressional session since. Representative Price is a Republican from Georgia, a leading critic of the ACA, the House Budget Committee chairman and an orthopedic surgeon. He also is the nominee for Secretary of Health and Human Services.

Price's replacement plan would fully repeal the ACA. It does not mandate employers to provide health insurance to employees. It is a combination of tax credits and regulatory reforms. For individual coverage, the plan provides refundable tax credits based on age: \$900 per child up to age 18; \$1,200 for ages 18 to 35; \$2,100 for ages 35 to 50; \$3,000 for those over 50.

There is a one-time \$1,000 tax credit to put into a health savings account. The credit is not available to individuals covered through employer-subsidized group plans or receiving federal/other benefits, including: Medicare, Medicaid, State Children's Health Insurance Program, TRICARE, Veterans Administration benefits or Federal Employees Health Benefit Program. The plan prohibits an individual who is not a citizen or lawful permanent resident from receiving a credit.

**Employer coverage:** Although not mandated, if employer coverage is provided, the employer tax exclusion or health care premium deduction is limited to \$8,000 for individuals, \$20,000 for families. This would be a source for funding to offset the above individual tax credits. Small business owners would be able to band together across state lines to buy insurance through trade associations; insurers licensed in one state would be able to sell insurance in any state.

• **Medicare, Medicaid and Veterans Administration:** The Price plan would allow individuals to opt out of these programs and instead use credits to purchase private insurance. Other than opting out, Price's plan is silent on Medicaid alternatives, which, as discussed above, is where the majority of the newly insured individuals were enrolled under the ACA. More than 15 million Americans who gained coverage through Medicaid expansion would suddenly find themselves uninsured under Price's plan due to their financial inability to afford a private plan even if tax credits are provided.

• **Pre-existing conditions:** Price's plan would uphold this feature of the ACA, but only for people who have continuous coverage for 18 months. If there was any break in that coverage, for example due to loss of a job or inability to pay due to illness, insurers could deny coverage completely or raise premiums dramatically. Instead, Price would provide grants to states to offer coverage to individuals with such conditions, using high-risk pools to spread risk.

• **Medical malpractice liability reforms:** The plan would change the burden of proof based on physicians following clinical guidelines. The guidelines would be issued by the Secretary of Health and Human Services in consultation with medical societies.

• **Limitation on abortion funding and discrimination:** The plan requires that no federal funds such as credits or deductions authorized under the bill be used to pay for abortion (with minor exceptions) or cover any part of the costs of any health plan that includes coverage of abortion. Prohibits discrimination against any individual or health care entity that does not provide, cover, or pay for abortions and provides for private right of action with actual or threatened violation of that section.

### ***'A Better Way to Fix Health Care' Plan***

In mid-2016, House Speaker Paul D. Ryan (R-Wisconsin) unveiled "A Better Way to Fix Health Care"—a broad set of proposals without a legislative mechanism (a "blueprint") to repeal the ACA and replace it with a system wherein tax credits are provided to individuals who choose to buy health insurance plans in markets regulated by the states, not the federal government.

The plan does not say how much the credits will be but says that the credits will increase with age and time. Ryan's plan would do away with the ACA's individual and employer mandate, as well as the federal and state exchanges, and would institute expansions to health savings accounts.

Like Price's plan, Ryan's would cap the employer tax exclusion or deduction of health care premiums, but the amount is unspecified. The "blueprint" says only the most

generous plans would be affected and that most Americans' plans would not be. As such, it would do away with the ACA Cadillac tax, which has yet to go into effect.

As for Medicaid, the Ryan plan would give states the option of taking Medicaid funding in a block grant, a lump sum without federal requirements on how to run state Medicaid programs for nondisabled, nonelderly adults and children. This approach would give states the ability to put conditions on receiving Medicaid benefits. However, the federal government would offer states a "per capita cap" in which federal support would depend on how many individuals were enrolled.

Federal medical liability reform also would be part of the plan in the form of caps on noneconomic damages. Of the more popular provisions of the ACA, allowing young adults to stay on their parents' plans until age 26 would remain, but the prohibition on insurers denying coverage to individuals with pre-existing conditions would be loosened. Like the Price plan, Ryan's plan would prohibit insurers from denying coverage based on pre-existing health conditions, but only if the individuals have continuous coverage. A lapse in coverage could lead to denial or higher rates in premiums.

Under the ACA, the age rating ratio limits the cost of an older individual's plan to no more than 3 times what a younger person pays in premiums. Critics complain that this has resulted in high premiums for younger and healthier individuals, leading them to avoid buying health insurance and accept the penalty instead. Under Speaker Ryan's plan, the premiums would have a default ratio of 5 to 1, which would lead to higher premiums for older individuals and lower premiums for younger individuals. States would have discretion and the final say on whether they would like to expand or narrow the ratio.

The Ryan plan also would allow consumers to purchase coverage across state lines, provide \$25 billion in federal funding for high-risk pool programs, and prohibit the use of federal funds to flow toward any plans that cover abortions. The plan also would create a private right of action for individuals or entities who do not wish to provide, pay or cover such services. The plan "blueprint" references specific California law that requires health plans to cover basic health care services, which encompasses maternity services and legal termination of pregnancies, as the reason for needing this private right of action.

The ACA replacement alternatives are similar. If there is a full repeal of the ACA, however, regardless of which plan is chosen, it will most likely be modified or altered as both parties will have to compromise and come to an agreement on how best to continue to decrease the uninsured rate as seen under the ACA, but also find a way to decrease the premiums and keep insurers in the Marketplace, which has been difficult under the ACA.

### **Effect of ACA Repeal on California**

The majority of the provisions of the Affordable Care Act were codified into California state law during implementation of the ACA. Therefore, even with repeal of the ACA federal provisions,

California's ACA-related provisions would be controlling. The majority of the significant ACA-related provisions in California code sections, however, contain tie-back language to the ACA.

An example of that tie-back language is contained in Health and Safety Code Section 1399.849(k), in relevant part, as follows: "If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA is repealed or amended to no longer apply to the individual market... subdivisions (a), (b), and (g) shall become inoperative 12 months after that repeal or amendment." Thus, a repeal of the ACA at the federal level would mean a repeal of the California ACA-related provisions within 12 months of the federal repeal.

Where the effect of congressional action pertaining to the ACA becomes murky is with a defunding or partial repeal. If Congress uses the budget reconciliation process to defund certain provisions of the ACA, such as the individual mandate, it is unclear whether that would trigger the tie-back language because the individual mandate technically wouldn't be repealed. The tie-back language specifically states that if a repeal or amendment occurred, the California statutes would become inoperative within 12 months. Whether defunding would fall under this definition is unclear.

This scenario creates even more uncertainty in the California Exchange because insurers would have difficulty creating and pricing new products without knowing what the market reforms will allow. In addition, losing the Medicaid expansion funds without knowing what the Medicaid reforms are and what funds will be available creates uncertainty around who will be uninsured and how that cost shift will affect the private market.

## Conclusion

Relative to the other states, California has had success in implementing the Affordable Care Act. It has a competitive Health Insurance Marketplace with a large number of insurers. As a direct result of the ACA, California has enrolled 3,666,877 Californians into Medi-Cal and a little more than 1.4 million individuals obtained Marketplace coverage. Nationwide, more than 11 million consumers have obtained Marketplace coverage and 13.7 million individuals have enrolled in Medicaid. There is no doubt that the majority of these newly insured individuals would become uninsured nationwide, and also in California, if the ACA was fully and immediately repealed with no replacement plan. There also is no question that California and the rest of the country still have work to do in decreasing premiums and providing quality affordable and accessible health care.

Without action at the federal level, California's policymakers must continue to focus on reducing costs to health care consumers in California. With health care and the ACA being a priority for the new U.S. administration it is likely that action, either in the form of a simultaneous repeal and replace, or a defunding through budget reconciliation with a delayed replacement, will take place early on in the new presidential term. At that time, it is imperative

that policymakers put California's health care consumers first by continuing to assess and contain the cost drivers of health care and premiums, as well as determining what path to take as a state, possibly without the ACA, to deliver affordable and accessible health care to Californians.

## CalChamber Position

- Promote efforts to contain health care costs and improve access to high-quality health care by supporting a health care system that is affordable and improves the overall health of California citizens.
- Work to avoid unnecessary, expensive regulatory controls and the imposition of new coverage mandates, by allowing market forces to continue playing a predominant role in driving innovation and transforming health care delivery.
- Continue to support managed care legislation and regulatory action that promotes quality care and cost containment.
- Encourage personal responsibility for individual health care, including coverage, wellness and education, in order to enhance quality of life and achieve long-term health care cost savings.
- Oppose policies and initiatives that shift the cost of health care programs and coverage of the uninsured and underinsured to employers.
- Support opportunities to gain efficiencies and optimal outcomes by coordinating the fragmented health care delivery systems.
- Support efforts to streamline government regulations in order to increase efficiency and reduce overall administrative burdens.
- Support innovative solutions to improve access, quality and cost of health care delivery, including inter-operable e-prescribing with the appropriate assistance for developing infrastructure.
- Support policies that encourage continued Medi-Cal discoveries and innovations that improve quality of care.
- Support the development of a public database with independent governance and clearly defined requirements related to data collection and submission to provide information to purchasers about the quality and value of health care services, providers, and coverage in the state.
- Support efforts to ensure Medi-Cal is fully funded.



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