



The Uncertainty of Health-Care Reform and the Affordable Care Act

By Kathryn Williams

The health-care reform debate could have a substantial impact on state and local governments because of their dual roles in providing health-care services to constituents and health-care benefits to public employees.

With the 115th Congress and the Trump administration having gotten through their first 100 days, the question remains whether Republican leaders will be able to achieve one of their signature promises of the 2016 election — repealing and replacing the 2010 Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA). In general, it is not uncommon for a new administration and Congress to experience a slow start, especially on priorities where cooperation and coordination are needed from both ends of Pennsylvania Avenue. But the challenge becomes even more acute when it involves repealing and replacing a health-care law like the ACA, which is the most significant health policy since the creation of programs in the 1960s like Medicare and Medicaid.

The fact that one party controls both the White House and Congress might lead some to believe that it should be fairly simple to enact or repeal legislation. But the age-old maxim that usually holds true for federal legislation certainly applies here — the devil is in the details. And it is those details that proved to be insurmountable for Republicans in their March 2017 attempt to repeal and replace the ACA.

The setback should not be seen as a sign that health-care reform is dead. It's just on hold. In the days after the March

24 vote on a reform plan was unexpectedly cancelled, House Speaker Paul Ryan (R-WI) said the House still hopes to tackle health-care reform, but he didn't provide a specific plan or timeline. This article will discuss why the health-care debate is important for state and local governments, followed by a brief review of the current status of the health-care reform efforts that could set the stage for other major issues in the near future, like comprehensive tax reform.

WHY IT MATTERS

The ongoing debate surrounding health-care reform, and any potential outcome, could have a substantial impact on state and local governments because of their dual roles in providing health-care services to constituents and health-care benefits to public employees.

As a provider of services, state and local governments spent \$20 billion in 2013 to provide health care for low-income, uninsured, or underinsured residents — usually unreimbursed. Further, county governments invest a total of \$83 billion a year in community health systems; they support 976 hospitals and more than 1,900 local public health departments. The health-care debate has become increasingly important to GFOA's agenda in recent years because health care is the fastest-growing portion of state and local govern-

ment budgets. In 2006, GFOA adopted a policy statement expressing support for health-care reform initiatives that would expand access to quality care and control the growth of health-care costs. GFOA policy encourages a federal approach that includes: expanded health-care coverage, equal consideration for all, adequate federal funding, transparency within the health-care system, and health-care education.

As a provider of health-care benefits, state and local governments use benefits as a tool to attract and retain public employees, as well as a way to remain competitive in the job market. Therefore, any policies that negatively affect the value of employer-provided health-care benefits pose a threat to state and local government budgets. That is why GFOA adopted a 2015 policy statement that opposed the 40 percent excise tax on health-care benefits (i.e., the Cadillac tax) that was part of the ACA. While GFOA supports the expanded coverage the ACA has enabled, the Cadillac tax amounts to an unfunded mandate on state and local governments that will increase the cost of providing health-care benefits to public employees.

The flaw in the design of the Cadillac tax is that 75 percent of its estimated revenue was to come from increased taxable wages from employers reducing employee health benefits, in an attempt to avoid the tax, while simultaneously increasing wages to make up for the benefits reductions. This is a tenuous assumption at best because state and local government budgets would probably not be able to absorb the increase needed to make up that gap.

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Currently, the Middle Class Health Benefits Tax Repeal Act of 2017 has been introduced in both the House of Representatives (H.R. 173, introduced by Mike Kelly, R-PA, and Joe Courtney, D-CT) and the Senate (S. 58, introduced by Dean Heller, R-NV, and Martin Heinrich, D-NM). This legislation would only repeal the tax as implemented under the ACA; it would make no other changes to the law. Both bills are bipartisan and await potential committee action.

USING BUDGET RECONCILIATION TO DISMANTLE THE ACA

Even though Republican leaders have struggled to unite their party in an approach to replacing the ACA, having one party in control of both chambers of Congress creates a procedural advantage through the use of budget reconciliation. The reconciliation process cannot be used to repeal the ACA, but only to change key provisions. Reconciliation can be used to address legislation that affects the federal budget, so ACA provisions like tax credits for low-income individuals to purchase insurance and Medicaid expansion are examples of what can be rolled back using this method.

On January 3, 2017, Senator Michael Enzi (R-WY) introduced a budget resolution for fiscal 2017, Senate Concurrent Resolution 3. The resolution instructed the House Ways and Means, House Energy and Commerce, Senate HELP, and Senate Finance committees to produce legislation that will “achieve at least \$1 billion each in deficit reduction over ten years, fiscal years 2017 to 2026,” and to provide their respective budget committees with this legislation by January 27. After being referred to the Senate Budget Committee and sent back to the full Senate, the resolution narrowly passed on January 12 by a vote of 51 to 48. The House passed it the next day by a vote of 227 to 198.

The two House committees completed their consideration of the legislation in early March, and Republican leadership introduced the American Health Care Act (AHCA), touted as the first step in the multiphase process of repealing and replacing the ACA. The bill calls for a series of changes to ACA provisions. Changes the AHCA sought to make included: eliminating the individual mandate, which is the centerpiece of the ACA; repealing the employer mandate that requires large companies to provide affordable insurance to employees or face financial penalties; repealing tax subsidies that help some individuals pay deductibles and make co-payments; and changing Medicaid funding by giving states a per-capita amount, based on how much each state spent for the fiscal year ended September 2016. States that expanded Medicaid under the ACA would continue receiving federal funding until 2020, after which beneficiaries

would be funded at a lower level. Some components of the ACA would have been retained under the new proposal, including allowing children to stay on their parents' insurance policies until age 26 and requiring insurers to cover individuals regardless of pre-existing conditions.

The proposal received pushback, notably from moderate and conservative Republican members. Moderate members of Congress were concerned about the number of individuals expected to lose coverage under the AHCA, and conservative members opposed the AHCA's age and income-based tax credits, intended to replace the federal insurance subsidies in the ACA. The tax credits were panned as creating a new entitlement program. Ultimately, the vote was cancelled as the opposition to the bill increased and it became clear that House leadership didn't have the votes needed to pass the bill. Despite the AHCA setback, though, budget reconciliation appears to be the favored method for potentially enacting comprehensive tax reform later in the year.

UNDOING THE ACA THROUGH EXECUTIVE ORDER

On January 20, 2017 President Trump signed an Executive Order (EO) titled *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*. The EO calls on his administration to seek the prompt repeal of the ACA, and directs agency officials to use discretion in implementing parts of the ACA they think will cause a burden on states, people, and insurance companies. The EO does not specifically confer any new pow-

ers onto the Executive Branch; it just directs agency leaders to weaken the ACA as much as possible within the existing law, regardless of congressional action. This means it does not cause changes to tax-credit premium subsidies, the Medicaid expansion currently in place, or major rules for insurers (such as prohibiting discrimination based on gender or pre-existing conditions on premiums, or allowing adult children to remain on their parents' insurance until age 26). Essentially, the Executive Order in its current form is more of a mission statement against the ACA than a policy change.

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However, it is important to note that President Obama was aggressive in using executive authority to implement the ACA, including granting waivers and deferring burdens. He also delayed the implementation of certain components, like the employer mandate penalty, and gave his administration discretionary claim over the ACA. These actions mean that President Trump and his administration may have a precedent for making aggressive changes to the ACA, or refusing to enforce certain provisions. For example, on March 13, 2017, the U.S. Department of Health and Human Services (HHS) sent a let-

ter to governors encouraging them to apply for a new type of waiver called a Section 1332 waiver. This waiver will allow states to make changes to health insurance exchanges, qualified health plans, premium tax credits and cost-sharing subsidies.

Further, HHS and other agencies made many rules in order to implement the ACA in the absence of a Democratic House majority, and Trump's administration could begin retracting or reversing these rules in a similar use of administration authority. The Trump administration could also cease to defend the lawsuit that states President Obama did not have the authority to make cost-sharing subsidy payments, and begin to eliminate the subsidies. This would be a more dramatic action, as premiums could go up significantly, and the market could become chaotic. While the individual mandate has been upheld by the Supreme Court and would require an act of Congress to change, President Trump could specifically delay enforcement of employer mandates, allow states to sell insurance packages that are not ACA-compliant, or make the hardship exemption cover a broad group of people. However, expanding the qualification for hardship would take time, as people have to individually apply for hardship status and new rules have to be litigated.

REPEALING AND REPLACING THE ACA THROUGH LEGISLATION

On January 23, 2017, Senator Bill Cassidy (R-LA), along with senators Susan Collins (R-ME), Johnny Isakson (R-GA), and Shelley Moore Capito

(R-WV), introduced S. 191, known as the Patient Freedom Act of 2017, in an effort to selectively repeal the ACA. The bill addresses only Title 1 of the ACA and would not change Medicare or ACA-imposed taxes. Its complex suggestions involve allowing individual states to retain the ACA, utilize subsidized Roth health savings accounts, or reject reform altogether. S.191 would retain popular provisions such as section 1322 state innovation waivers, a ban on annual limits, and the prohibition against health status discrimination. While it appears that S. 191 seeks to repeal and replace the ACA in a way that could appeal to some Democrats, its complicated lan-

guage and complex provisions make it unlikely to pass by the January 2018 deadline set in the bill. S. 191 has been referred to the Senate Finance Committee, but has not seen any action to date.

Senator Rand Paul (R-KY) introduced S. 222, known as the Obamacare Replacement Act, on January 24, 2017. This legislation seeks to repeal central components of the ACA, like the individual mandate and essential health benefits that insurance plans must cover. S. 222 would also change the rules for patients with pre-existing conditions, allowing them a two-year open enrollment period to get coverage and requiring that they maintain

continuous coverage thereafter. Like S. 191, S. 222 has also been referred to the Senate Finance Committee and still awaits committee action.

S. 191 and S. 222 are only two of many proposals introduced since the beginning of the 115th Congress that seek to partially or fully repeal the ACA. But even if Congress is unable to move a massive repeal and replace bill, other must-pass health-care legislation awaits. For example, federal funding for major health programs such as the Children’s Health Insurance Program (CHIP) runs out September 20, 2017. The CHIP program is administered similarly to Medicaid and currently covers approximately 9 million children from families of modest income that is too high to qualify for Medicaid.

CONCLUSIONS

GFOA will continue to monitor the health-care reform debate, which will not be resolved anytime soon. Until then, GFOA’s Federal Liaison Center will continue its efforts to educate federal lawmakers of the importance of the health-care benefits provided to public-sector employees. GFOA members are encouraged to share data relating to their respective jurisdictions and the impact of health care-costs with their federal elected leaders. Please share any formal correspondence you send to your federal officials on this issue with GFOA’s Federal Liaison Center. |

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