Patient Freedom, S.191, 2017 – A Complex Approach to Replace the Affordable Care Act (ACA)

Senator Bill Cassidy (R-LA), joined by colleagues Susan Collins (R-ME), Johnny Isakson (R-GA), and Shelly Moore Capito (R-WV) introduced the Patient Freedom Act, S.191, in the U.S. Senate on January 24, 2017. The bill is unique from other Republican proposals in that it retains some provisions of the Affordable Care Ac, while other Republican proposals have advocated for swift and thorough ACA repeal. Some ACA features that S.191 would retain include:

- Allowing children to remain on their parents' health insurance plans until age 26.
- Prohibiting coverage denial based on health-status/pre-existing conditions.
- Prohibiting annual and lifetime limits on health insurance coverage.
- State innovation waivers.
- Black lung benefits for coal miners.
- Disallowing cost-sharing for employer coverage for preventive services.
- Bans discrimination on the basis of age, race, gender, disability, or national origin.

Despite the ACA provisions that S.191 retains, the bill would repeal the individual mandate and requirements that employers offer coverage to employees working more than 30 hours per week.

There are a two other standout issues with the S191: first, it offers no estimates on potential coverage gains or losses; second, it leaves low-income individuals and people with pre-existing conditions especially vulnerable. In its current form, S.191 expands the group of people eligible for tax credits, while contracting the size of tax credits available. It is likely that this approach would result in coverage losses, and/or growth in the numbers of people who are uninsured or underinsured. In states that have expanded Medicaid, S.191 creates new Roth HSAs, accounts funded by federal government deposits allowing individuals to purchase healthcare. Under S.191, HSA accounts would replace ACA subsidies; further, S.191 states that expanded Medicaid to opt-out of expansion. Individuals who gained health insurance coverage through Medicaid expansion would be left without insurance, without a comprehensive plan, or left with coverage gaps or high-cost sharing. In this regard, S.191 neither improves patient choices nor ensures access, nor does it offer other consumer protections. While S.191 suggests that any coverage an individual purchases would include a high deductible plan, such a plan would require that a person pay more for their healthcare costs, and would be of little value to an individual with low-income.

The Patient Freedom Act is a radical departure from ACA repeal and replacement plans previously put forward by Republicans. The proposed plan offers an option to keep the ACA or portions of it intact, while previous Republicans proposals have advocated ACA repeal. As of February 28, 2017, there is still no consensus about whether or not S.191 would serve as a model for ACA replacement. The healthcare reform landscape is quickly and continually evolving as multiple plans and proposals continue to emerge.

As new plans surface and discussions about ACA repeal advance, it is imperative to continue examining how proposed models would affect ACA health insurance coverage gains, their impact on a trajectory leading to universal access to healthcare, provisions for high quality services, and a sufficient supply of a highly skilled healthcare labor force.

The following are four tables, each showing the different options states could choose if the Patient Freedom Act is voted into law. Each option is briefly outlined with a side-by-side comparison to ANA's principles for health system transformation.

Option 1:

States could keep the ACA intact, including its market place subsidies, mandates, and consumer protections with less federal funding. States would receive 95 percent less funding previously available under the ACA. The newly appointed Secretary of Health and Human Services, Dr. Tom Price, former Republican Member from Georgia would set the amount of funding states would receive. In its current form, S.191 is unclear about how the capped amount would adjust for higher than expected enrollment or growth in premiums.

Table 1 Side-by-Side Comparison of ANA Principles Patient Freedom Act, 2017

ANA Principles	Draft Patient Freedom Act, Option 1
I. Ensure universal access to standard package of essential healthcare services for all citizens and residents.	• Dependent coverage until age 26 • Prohibits discrimination based on health status. • Mental health coverage and parity, but individual must be diagnosed with serious mental health illness. (Serious is undefined.)
II. Optimize primary, community based preventive services while supporting the cost effective use of innovative, technology driven acute hospital based services.	• Preventive services are available if the employer does not contribute to the individuals Roth HSA • Unclear about how non-employer based coverage would ensure or address access to preventive health services.
III. Ensure mechanisms to stimulate economic use of health care services while supporting those who do not have the means to share in costs.	• Retains certain portions of the ACA including certain taxes and fees.
IV. Ensure sufficient supply of a skilled workforce to providing high quality healthcare services.	• No employer requirements to provide insurance to anyone working at least 30 hours per week.

Option 2

States could establish a new market based alternative, depositing federal dollars into newly created, Roth Health Savings Accounts (HSAs). These Roth HSAs would be capped at 95 percent of ACA funding, and would be offered to U.S. citizens or lawful residents enrolled in a health plan, including employer sponsored coverage, but not otherwise covered by a federal health program such as Medicare, Medicaid, or VA. Roth HSAs would be extended to individuals with incomes up to $190,000 or couples with incomes up to $250,000. Enrollees could use the money in the accounts to pay for healthcare costs and out of pocket spending. States would auto-enroll any individuals not signed up for coverage, and enrollees not wishing to participate would have to actively unenroll.

The new Roth HSA deposits would be capped at 95 percent of the funds ACA would have provided for subsidies under Medicaid expansion, states that did not expand Medicaid would still receive federal funding equaling 95 percent of the marketplace subsides, plus federal Medicaid funding as if the state had adopted Medicaid expansion. In addition, states that selected Option 2 would also receive 2 percent of the total federal Roth HSA deposit amount to help cover population level health initiatives.

Table 2 Side-By-Side Comparison of ANA Principles and Patient Freedom Act, 2017

ANA Principles		Draft Patient Freedom Act, Option 2
I.	**Ensure universal access to standard package of essential healthcare services for all citizens and residents.**	• Auto-enrollment for anyone uninsured. • Expands coverage to a wider pool, including anyone who is a legal resident, or Citizen, and is not participating in a federal health program, but may be participating in employer sponsored insurance and/or annually earns up to $190,000 for individuals, and $250 per couples.
II.	**Optimize primary, community based preventive services while supporting the cost effective use of innovative, technology driven acute hospital based services.**	• Provides some preventive services. • Free immunizations. • States can provide high deductible standard health plans to uninsured.
III.	**Ensure mechanisms to stimulate economic use of health care services while supporting those who do not have the means to share in costs.**	• Individuals would receive tax credits to fund Roth HSA accounts and utilize those dollars to pay for healthcare costs. • Offers high deductible healthcare plans. • Unclear about how individuals with low-incomes would be eligible for tax credits or could afford to pay for high deductible health plans.
IV.	**Ensure sufficient supply of a skilled workforce to provide high quality healthcare services.**	• Provides no details about healthcare workforce development.

Option 3

States could reject any federal assistance, but would still be required to abide by ACA guidelines such as no annual lifetime limits, required coverage for people up to age 26 on their parents' insurance plans, and no exclusions based on health status.

Table 3 Side-by-Side Comparison of ANA Principles and Patient Freedom Act, 2017

ANA Principles	Draft Patient Freedom Act, Option 3
I. Ensure universal access to standard package of essential healthcare services for all citizens and residents.	• No federal assistance to individuals ineligible for Medicaid or other federal health provisions. • ACA provides subsidies for low-income individuals to purchase healthcare.
II. Optimize primary, community based preventive services while supporting the cost effective use of innovative, technology driven acute hospital based services.	• No consumer protections except for those already included in S.191.
III. Ensure mechanisms to stimulate economic use of health care services while supporting those who do not have the means to share in costs.	• No details provided.
IV. Ensure sufficient supply of a skilled workforce to provide high quality healthcare services.	• No details provided.

Option 4

States could design their own innovative alternative models, but must retain ACA provisions. It is unclear how funding would work if states innovate. States that do not choose an option would automatically default to Option 2.

Table 4 Side-by-Side Comparison of ANA Principles and Patient Freedom Act, 2017

ANA Principles		Draft Patient Freedom Act, Option 4
I.	**Ensure universal access to standard package of essential healthcare services for all citizens and residents.**	• No details provided. • States would develop their own plans.
II.	**Optimize primary, community based preventive services while supporting the cost effective use of innovative, technology driven acute hospital based services.**	• No details provided. • States would develop their own plans.
III.	**Ensure mechanisms to stimulate economic use of health care services while supporting those who do not have the means to share in costs.**	• No details provided. • States would develop their own plans.
IV.	**Ensure sufficient supply of a skilled workforce to provide high quality healthcare services.**	• No details provided. • States would develop their own plans.