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The Trumpcare Conundrum

Can Republicans repeal Obamacare without imposing the greatest costs on the older, white, blue-collar voters who put Trump into office?

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As congressional Republicans race to repeal and replace President Obama's Affordable Care Act, one of their principal challenges is finding an alternative that does not expose older and less affluent white voters at the core of Donald Trump's electoral coalition to greater costs and financial risk.

The paradox of the health-reform debate is that many of Obamacare's key elements raised costs on younger and healthier people who generally vote Democratic as a means of limiting the financial exposure of older and sicker people, even as older whites have stampeded toward the GOP. Conversely, many of the central ideas common to the Republican replacement plans would lower costs for younger and healthier adults while exposing people with greater health needs, many of them older, to the risk of much larger out-of-pocket costs, even if it reduces the health-insurance premiums they initially pay.

Even some of the most unyielding conservative critics of the ACA acknowledge that the older and blue-collar whites central to the Trump-era Republican coalition could be squeezed by the GOP alternatives that soon will surely be labeled "Trumpcare." Michael Tanner, a senior fellow at the libertarian Cato Institute, says he believes overall more people would win than lose under the replacement plans that Republicans are formulating—a view that more liberal analysts strongly reject.

But Tanner agrees that under the GOP alternatives "there are going to be winners and losers … and the losers are most likely to be older, sicker, blue-collar workers, which is a Trump constituency. The winners are going to be educated, white-collar, wealthier, and younger people who were not the Trump constituency."

This inversion is rooted in the Republican determination to unravel the sharing of risk that Obamacare aggressively mandated. While the ACA's top goal may have been reducing the number of Americans without health insurance at all, most experts agree that a close second was requiring a greater pooling of financial risk between the healthy and sick, and the young and old.

“That is part and parcel of trying to make all of the other pieces work,” said Linda Blumberg, a senior fellow in health policy at the Urban Institute.

Most of the debate over the potential impact of ACA repeal has focused on who might lose coverage if the law is revoked. As the Urban Institute has shown, the coverage expansion under the law has benefited constituencies favorable to each party: Though the number of uninsured has declined most among racial minorities, who mostly vote Democratic, whites without a college education, the cornerstone of Trump’s coalition, ranked second and also scored big gains. The choices about risk sharing affect the total level of coverage, but even more profoundly shape the cost and comprehensiveness of the coverage that the insured can obtain. And on those measures, the costs of repeal could tilt disproportionately against older working-age Americans—a mostly white age group that has become indispensable to GOP electoral fortunes.

Though few subjects may seem more arcane than health-insurance regulation, these contrasting approaches illuminate a core philosophical divide between the parties. The ACA prizes solidarity: It is an intricately interlocked mechanism for sharing the financial risks of medical needs in two respects. First, it shares risk across generations—with today’s young subsidizing today’s old. Second, it spreads risk across any individual’s lifecycle: Under the law, people pay more for health coverage when they are young so they can pay less when they are old. “In many ways under the law the young and healthy are subsidizing the older and sicker on the theory that eventually all of us get older and sicker,” said Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University. “A key policy driver of the ACA is to pool risk as much as possible on the theory that will make coverage more affordable to a greater number of people.”

By contrast, the GOP plans all prize autonomy. They would allow individuals more choice in whether to buy insurance at all or what kind to purchase, and allow the healthy to pay less unless and until they have significant health needs. The price, in policy terms, for that flexibility is accepting wider divergence between the healthy and sick in both the availability and cost of care. Under the Republican plans, “There’s a scenario where people get a cheaper premium and they have more out of pocket cost sharing and more benefit exclusions,” said Christine Eibner, a Rand Corporation senior economist who studies health care. “And if they have a healthy year they look at it and say this is better. But then they could be in for a surprise if there is a catastrophe or they get really sick and they find something is excluded and the cost sharing is really high.”

The essence of risk-sharing is to require more payment into the insurance pool from people when they are healthy so that there is more money available to limit the cost to people when they are sick and must use more medical care. Historically, health insurance obtained through employers has shared risk most robustly because it brings together large pools of people of widely varying health status, and typically charges them the same premium regardless of age or medical condition. The ACA changed the rules for those plans only at the margins, for instance by requiring insurers to cover preventive care and barring them from imposing annual or lifetime limits on benefits.

By contrast, the ACA transformed the individual insurance market in myriad ways—and always in the direction of requiring greater sharing of risk.

Before the ACA, the individual insurance market, used by consumers who did not obtain coverage through an employer or a government program such as Medicaid, provided almost no risk sharing. Prior to the ACA, people with significant health needs were either charged much higher premiums for coverage in the individual market, or denied coverage altogether because they had a preexisting condition. In other instances, people obtained insurance through the individual market only to find that it provided very little coverage once they actually needed it, whether because of limits on annual or lifetime benefits or very high copayments and deductibles. Insurers could also effectively segment out people with greater health needs from their plans by excluding benefits like hospitalization that sicker people were likely to use.

Under these rules, healthier people in the individual market benefited because it was so difficult for people with greater health needs to purchase insurance there. With sicker people systematically excluded from coverage, insurers had to cover fewer claims—which allowed them to hold down premiums for the relatively healthier people who could buy coverage in that market. That's one critical reason why costs have increased under the ACA for people who had coverage before the law in the individual market: Today their premiums are determined in part by the costs of a much broader risk pool that includes many more people with health needs who had been previously excluded from coverage.

The core trade-off in the ACA upended this arrangement. It required all adults to purchase health insurance while mandating that insurers sell to all consumers at comparable prices, regardless of their health status. That compelled insurers to cover the people with greater health needs who had been largely excluded from the market before, but also in theory required previously uninsured younger and healthier people to purchase coverage, in the hope of maintaining a balanced risk pool.

The law followed that core decision with a series of other reforms with the same goal. It prevented insurers from varying premiums based on gender or any other health factor except for tobacco use and age. (Even on age, the law said insurers could only charge older consumers three times as much for insurance as younger ones—a far more restrictive age "band" than existed before.) The law's prohibition on annual or lifetime benefit caps operated with similar intent: to ensure that the costs of the sickest are shared through the entire risk pool.

Equally important, the law mandated that all insurance policies sold in either the individual market or to small groups provided a robust menu of 10 "essential health benefits" including hospitalization, mental-health needs, and maternity and newborn care. Requiring all of the insured to purchase plans with comprehensive benefits is a critical component of risk sharing because otherwise only those with greater health needs buy the more expensive services—meaning their costs are funded by a much smaller pool of beneficiaries. "The broader the benefits that are covered in the [insurance] package, the greater and broader the pooling," notes Blumberg.

Critics, and even some sympathetic observers, say Obamacare may have gone too far in demanding the pooling of risk—in a way that ultimately proved counterproductive. The law has not only required healthier and younger people to buy coverage, but also to purchase coverage that is more expensive (partly because of the limits on the premium variation between young and

old) and comprehensive (including components such maternity benefits) than many would prefer. Those costs have been somewhat offset by the fact that young people, who mostly have relatively lower incomes, have been big beneficiaries of the law's subsidies for buying coverage.

But overall, fewer younger and healthier people than the administration hoped have purchased coverage—producing an older and sicker risk pool than expected. That's at the root of the recent cost increases for plans offered under the law. The law, with its many risk-sharing provisions, "in some ways has worked too well in terms of people with preexisting conditions getting insurance but not enough healthy people signing up," said Larry Leavitt, senior vice president of the Kaiser Family Foundation, which studies health-care trends. "The more you force cross-subsidies based on age, the harder it is to keep the insurance pool stable."

All of the Republican alternatives would careen in the other direction. To varying degrees, the plans proposed by Representative Tom Price, Trump's choice as Health and Human Services Secretary, the House Republican leadership (through the "Better Way" document released last summer), and Senator Lamar Alexander, chair of the relevant Senate committee, in a floor statement last week would all dilute or eliminate the ACA's major risk-sharing components. These proposals would eliminate the mandate on individuals to buy coverage, roll back or eliminate the comprehensive federally mandated benefit packages, free states to again allow insurers to vary prices more by age or health status, and drop other ACA rules that require more risk-sharing. Alexander, framing his proposal as a transition from the ACA, succinctly summarized the GOP's direction: "In general, the goal is to get as close as possible to allowing any state-approved plan to count as health insurance under Obamacare rules, while we are transitioning to new systems."

After repealing those ACA provisions, Price, House Republicans, and Trump in his campaign proposal would then move to further unravel risk sharing by allowing any insurance policy licensed in any state to be sold in every state. (Alexander, focusing on transition issues, did not address the subject.) Experts across the ideological spectrum agree that such interstate insurance sale would threaten the risk pool in states that require comprehensive benefits because it would encourage younger and healthier people to buy bare-bones packages from states with little regulation. Since older and sicker consumers would be most likely to remain in the comprehensive plans, premiums would rise, further driving away young people in what insurance actuaries call a "death spiral."

"Truly allowing insurance to be sold across state lines would make it impossible for any one state to preserve the kind of risk pooling in the ACA if it choose to," says Leavitt. "An insurer operating in a less regulatory state could always undercut an insurer operating in a more highly regulated state."

When the Rand Corporation modeled the impact of interstate insurance sale combined with repealing the ACA, it found that the combination would induce some young people to purchase insurance. But it also projected that relative to continuing the ACA, this approach would increase out of pocket costs for insurance consumers by nearly 80 percent—with older and sicker consumers experiencing even greater increases.

That prospect captures the core challenge facing the GOP. Deregulating insurance to allow the sale of less comprehensive plans than the ACA requires would likely produce lower initial premiums both for younger and healthier and older and sicker consumers. That would also save the federal government money because it could provide smaller tax credits for the uninsured to buy those less expensive plans.

Those with fewer health needs may find that system acceptable, which is why Tanner argues, "the people who have very little health-care costs will be winners." But inevitably those skimpier plans would cover fewer services and demand more out of pocket costs from those with greater health needs—if they can buy coverage at all. "They are going to have less comprehensive coverage," said Tanner flatly.

That might prove a very unpleasant surprise for Obamacare recipients whose principal complaint has been that the coverage already costs them too much not only in premiums, but also co-payments and deductibles. "What people really want out of the health-care system is to pay less for health care," said Leavitt. "And it's not at all clear that the replacement plans on the table now would have that result." That's especially true for older people with typically greater medical expenses. Since seniors are protected by Medicare, the most vulnerable group in a system with less risk sharing may be older adults aged 45-64. And today, over two-thirds of people in that age group are white, compared to only about 55 percent of younger adults aged 20-34, according to calculations provided by the Brookings Institution demographer William Frey. In November, Trump won just over three-fifths of all whites aged 45-64, and together with white seniors, they provided nearly three-fifths of all of his votes, according to exit polls. In particular, Trump carried a remarkable 71 percent of 45-64 year-old whites without a college degree—his best showing among those blue-collar whites in any age group.

The prospect that the principal Republican replacement plans would shift costs toward older and in many instances blue-collar consumers with greater health needs could not only complicate the calculation for congressional Republicans. It could also make it tougher for them to recruit support from the Democrats they will need to pass replacement plans through the Senate. The Democratic Senators most likely to support Trump initiatives are the 10 facing 2018 reelection contests in states Trump carried, but almost all of them represent graying, blue-collar places like Michigan, Ohio, Pennsylvania, and Missouri. In places with so many older and working-class voters, abandoning the ACA's risk-sharing may prove a formidable risk itself as the cost becomes more apparent over time.