Center for Health and Economy

2017 Project: "A Winning Alternative to Obamacare"

September 8, 2014

The 2017 Project designed an alternative to the Affordable Care Act (ACA), titled "A Winning Alternative to Obamacare."[1] The proposal, referred to in this report as the Alternative, assumes a full repeal of the ACA and replaces it with provisions to be implemented on January 1st, 2016. Key aspects of the proposal include a premium tax credit for health insurance purchased in the commercial non-group market, a cap on the tax-exempt income spent on employer sponsored health insurance, and a subsidized contribution to health savings accounts, among others. This report details the findings of the Center for Health and Economy's (H&E) Under-65 Microsimulation Model on the proposal's impact on health insurance premium prices, insurance coverage, provider access, medical productivity, and the federal budget. While our estimates are associated with some degree of uncertainty, the summary of our findings is as follows:

- **Premium Impact:** The Alternative is projected to decrease the cost of less comprehensive health insurance coverage, such as Bronze and catastrophic coverage plans.

- **Coverage Impact:** The Alternative is projected to lead to 6 million fewer insured persons by 2023. Decreased enrollment in Medicaid is the primary reason for reduced coverage.

- **Provider Access:** The Alternative is projected to result in greater patient access to providers. According to the H&E Provider Access Index, access will increase by 18 percent for the insured population by 2023.

- **Medical Productivity:** The Alternative is expected to lead greater productivity than under current law. According to the H&E Medical Productivity Index, productivity is projected to increase by 9 percent by 2023.

- **Budget Impact:** Compared to current law, the insurance coverage provisions of this proposal will decrease the federal deficit by $1.13 trillion over the next ten years.

[1] In this text, the "Affordable Care Act" refers to the Patient Protection and Affordable Care Act of 2010 and the health care provisions of the Health Care and Education Reconciliation Act of 2010.

Microsimulation Analysis

This analysis utilizes a microsimulation model developed for use by H&E. The model employs micro-data available through the Medical Expenditure Panel Survey to analyze the effects of health policies on the health insurance plan choices of the under-65 population and interpret the resulting impact on national coverage, average insurance premiums, the federal budget, and the accessibility and efficiency of health care.[2] The key policies and assumptions used by H&E to analyze the Alternative are as follows:

- The Affordable Care Act is fully repealed.
- The Alternative becomes effective on January 1, 2016.
- Individuals and families who purchase licensed health insurance in the individual market[3] are eligible for an age-adjusted premium tax credit, increased annually by 3 percent. The following table shows the credit values in 2013 dollars:

Age	Credit
0 - 17	$900
18 - 34	$1,200
35 - 49	$2,100
50 - 64	$3,000

- Employees of firms with less than 50 full time equivalent employees are eligible to receive the premium tax credit if they choose to purchase insurance through the individual market.
- Unused tax credits are deposited into a health savings account.
- The tax exclusion for employer sponsored health insurance is capped at the 75th percentile of annual employer sponsored insurance premiums. The value of ESI benefits in excess of the tax exclusion cap is subject to income and payroll taxation. These thresholds are set in 2015 and increased annually by 3 percent.
- Previously covered households cannot be dropped from their current health plan, denied coverage through a new plan, or charged higher premiums on the basis of health status in the individual market. And households with coverage through an employer can transition to the individual market with the same protections.
- Young adults, aged 18 to 25, may purchase a plan with guaranteed issue protections and without facing higher premiums because of health status for one year after turning 18 or ceasing to obtain coverage through a parent's health plan. Similarly, newborn children are eligible for the same protections for one year after birth.

[2] More information on the H&E Under-65 Microsimulation Model can be found at http://healthandeconomy.org/models/under-65-microsimulation/

[3] In this report, the individual market refers to the commercial, non-group market for health insurance.

- High risk pools, facilitated by the states, will receive $7.5B per year in federal funding, increased annually by 3 percent.
- The annual contribution limits for health savings accounts are increased to $6,250 for individuals and $12,500 for families.
- Enrollees in health savings accounts are eligible to receive a one-time, refundable tax credit of $1,000 to be deposited directly into the account.
- Health insurance can be sold across state lines.

Premium Impact

H&E health insurance premium estimates are based on five plan design categories offered in the individual market: Platinum, Gold, Silver, Bronze, and catastrophic. Under current law, the cost-sharing designs of the four metallic categories correspond to approximate actuarial values: 90 percent, 80 percent, 70 percent, and 60 percent, respectively.[4] In some cases, the less generous plans are also associated with narrower networks. Catastrophic coverage plans refer to health insurance plans that reimburse for medical expenses only after members meet high deductibles—a maximum of $6,350 for an individual under current law. When analyzing the impact of policy proposals on health insurance premiums, the particular plan designs for each category are not held constant. For example, a proposal to repeal the out-of-pocket maximum would allow insurance companies to offer catastrophic coverage plans with much higher deductibles. The plan categories are meant to roughly demarcate the range of plan options available. All premium estimates reflect health insurance prices without any financial assistance.

H&E estimates that the Alternative will lead to lower health insurance premiums in all plan categories for both single and family coverage. The primary policy mechanisms that influence health insurance premiums are the repeal of actuarial rating restrictions, the repeal of Essential Health Benefits (EHB) and deductible restrictions, and the repeal of the individual mandate.

Under current law, health insurance plans are only able to alter prices based on four factors: single or family coverage, geographic location, age (a maximum ratio of 3:1), and tobacco use (a maximum ratio of 1.5:1).[5] Since insurance companies still need to cover the cost of insured lives, these actuarial pricing restrictions lead to more people paying close to average premiums. Intuitively, high-risk individuals who would otherwise pay higher than average premiums benefit from such restrictions, leading high-risk individuals to gain coverage in higher numbers. Similarly, some low-cost individuals, for whom a close-to-average premium is not worth it, may drop insurance coverage. These

[4] Cost-sharing assistance offered to low-income households allows silver plan designs to vary in actuarial value from 70 percent for households earning over 250 percent of the federal poverty level to 94 percent for households earning less than 150 percent of the federal poverty level.

[5] States have their own set of insurance regulations that govern how health insurance companies can set rates. A minority of have regulations more strict than those implemented by the ACA.

fluctuations in the pool of insured are likely to cause average premiums to rise. The Alternative is projected to lower average premiums by repealing those restrictions.

The ACA also mandates that health insurance plans cover the EHBs and limit financial exposure to members through lower deductibles and maximum out-of-pocket spending in order to be considered qualified health plans. The EHBs include maternity care, mental health services, and other benefits that might not otherwise be included in a health insurance plan. Repealing the EHB requirements allows health insurance plans to remove more costly benefits in exchange for less expensive premiums. And allowing higher deductibles allows insurance companies to offer less generous and cheaper plans for those with low expected medical costs. H&E finds that removing the EHB requirements and deductible restrictions will lead to a decrease in health insurance premiums.

The Alternative also repeals the individual mandate which requires that all individuals who fail to obtain qualified health insurance coverage pay a penalty, as detailed by the Individual Shared Responsibility provision of the ACA. Besides raising tax revenue through the penalty, the individual mandate encourages healthy individuals who may otherwise forgo health insurance because of low medical service usage to join the pool of insured premiums. With more healthy, low-risk individuals paying insurance premiums, insurance companies can afford to charge lower premiums, on average. Thus, H&E estimates that repealing the individual mandate alone would lead to an increase in average health insurance premiums.

Table 1. Average Premiums in the Individual Market Under The Alternative

		2014	2015	2016	2017	2018	2023
Single Coverage	Platinum	5,200	5,100	4,700	5,000	5,300	6,900
	Gold	4,500	4,400	4,100	4,300	4,600	6,000
	Silver	3,700	3,500	3,300	3,500	3,700	4,800
	Bronze	2,700	2,500	2,200	2,300	2,400	2,700
	Catastrophic	1,900	1,900	1,800	1,900	1,900	2,200
Family Coverage[6]	Platinum	19,700	19,300	19,000	20,000	21,200	28,000
	Gold	17,600	18,000	17,100	18,200	19,200	25,600
	Silver	14,800	15,200	14,300	15,200	16,100	21,400
	Bronze	10,800	11,000	8,600	8,800	9,100	10,500
	Catastrophic	7,200	7,400	6,900	7,200	7,400	8,500

The individual mandate also has a specific impact for catastrophic coverage, as it discourages any person over the age of 30 from purchasing coverage without facing a penalty. The low average catastrophic coverage premiums under current law are partly a reflection of a young and healthy population of enrollees. Average premiums are projected to experience upward pressure absent the individual mandate due an influx of older, higher-risk enrollment.

[6] Family coverage estimates are based on a family size of four persons.

Table 2. Percent Change in Premiums From Current Law

		2014	2015	2016	2017	2018	2023
Single Coverage	Platinum	0%	0%	-6%	-4%	-4%	-4%
	Gold	0%	0%	-7%	-9%	-6%	-8%
	Silver	0%	0%	-6%	-5%	-8%	-8%
	Bronze	0%	0%	-8%	-12%	-11%	-10%
	Catastrophic	0%	0%	-10%	-14%	-17%	-15%
Family Coverage[7]	Platinum	0%	0%	-5%	-6%	-6%	-7%
	Gold	0%	0%	-9%	-9%	-9%	-9%
	Silver	0%	0%	-10%	-10%	-10%	-10%
	Bronze	0%	0%	-23%	-25%	-25%	-25%
	Catastrophic	0%	0%	-10%	-5%	-5%	-6%

The net effect of these provisions is to decrease the average insurance premiums between 4 and 25 percent in all categories. The largest effects are in Bronze and catastrophic plans for single coverage, and Silver and Bronze plans for family coverage.

Coverage Impact

H&E insurance coverage estimates reflect health insurance choices for the under-65 population as estimated by the H&E Under-65 Model.[8] H&E estimates that the Alternative will lead to 6 million fewer insured individuals in 2016, a difference that remains constant—within rounding error—throughout the analysis period. Under the Alternative, the 2023 uninsured rate among the under-65 population will be 15 percent—up from the projected uninsured rate of 13 percent under current law.

The sharp increase in individual market enrollment in 2016 relative to current law is a result of a one-time tax credit for enrollees in health savings accounts (HSA). Any enrollee in a health savings account is eligible to receive a single direct contribution of $1,000 into the HSA from the federal government. In 2016, H&E predicts that not only will most HSA enrollees claim this one-time contribution, but many uninsured and enrollees in other plans will be incentivized to enroll in an HSA for the first time. After 2016, there continue to be new enrollees in HSAs that will claim the subsidized contribution. However, some of the households that already received the credit will return to their previously preferred insurance plan or choose to again forgo insurance coverage. The one-time HSA contribution policy is likely to cause an aberrant increase of insured persons during the first year of its implementation before falling to a steady state benefit for new enrollees in HSAs associated with a moderate increase in insured persons.

[7] Family coverage estimates are based on a family size of four persons.
[8] Parente, S.T., Feldman, R. "Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act." Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.

Table 3. Health Insurance Coverage Under The Alternative (millions)[9]

	2014	2015	2016	2017	2018	2023
Individual Market	35	42	58	52	51	51
Employer Sponsored Insurance	151	149	145	149	150	149
Medicaid	42	46	35	36	36	37
Other Public Insurance	2	2	3	3	3	6
Total Population[10]	**275**	**276**	**277**	**279**	**280**	**287**
Total Insured[9]	**230**	**239**	**241**	**240**	**240**	**243**
Uninsured	**45**	**37**	**36**	**39**	**40**	**44**

Table 4. Change in Insurance Coverage Under The Alternative (millions)[9]

	2014	2015	2016	2017	2018	2023
Individual Market	0	0	8	3	3	4
Employer Sponsored Insurance	0	0	-2	2	2	2
Medicaid	0	0	-11	-11	-12	-12
Other Public Insurance	0	0	0	0	0	0
Total Insured[10]	**0**	**0**	**-6**	**-6**	**-6**	**-6**

Beyond 2016, the Alternative is estimated to result in greater individual market insurance coverage than under current law. Premium subsidies declining with income are available under the ACA to households that earn between 100 and 400 percent of the Federal Poverty Level (FPL) and purchase substantial health insurance through state-based exchanges. The subsidies are based on a formula that allows a household to purchase a medium PPO plan—a Silver plan—for a certain percent of their income. The Alternative prescribes lower subsidies that vary only by age but allows any household that purchases licensed health insurance to claim the subsidy, regardless of income. The Alternative also repeals the provisions of the ACA that provide extra cost-sharing benefits to low-income enrollees.

The subsidies available under the Alternative are not advanceable; eligible enrollees will receive the subsidy in the form of a tax refund or health insurance rebate. Unlike current law, enrollees will have to pay the full health insurance premium and receive the subsidy in a bulk sum later in the year. This type of discount leads to lower coverage in two ways: not all eligible enrollees will apply for the credit, and many consumers may be unable to pay for expensive insurance premiums before receiving the subsidy payment. H&E uses research on Earned Income Tax Credit (EITC) take-up to benchmark assumptions regarding how many eligible households will claim the health insurance tax-credits under

[9] All insurance coverage estimates refer only to the under-65 population.
[10] Total enrollment estimates may not equal the sum of all other enrollment due to rounding.

the Alternative. For a closer examination of this assumption and plausible alternatives, see the Uncertainty in H&E Projections section. In aggregate, lower individual market enrollment as a result of a less generous subsidy design and the non-advanceable nature of subsidy payments is marginally over-shadowed by increased enrollment through wider subsidy eligibility, the one-time HSA credit, and lower insurance premiums.

The Alternative also eliminates the federal funds for Medicaid expansion made available by the ACA. Under current law, states can expand Medicaid eligibility to include individuals and families earning up to 138 percent of FPL. The narrowing of Medicaid eligibility under the Alternative is softened by newly available premium credits to households that earn below 100 percent of FPL. Some of the households that lose Medicaid coverage will gain low-cost coverage through less expensive narrow network or high deductible plans.

Productivity and Access

In attempt to evaluate access and productivity in the health care system, H&E estimates: the Medical Productivity Index (MPI) and the Provider Access Index (PAI). Health insurance plan designs are associated with varying degrees of access to desired physicians and facilities as well as incentives that promote or discourage efficient use of resources. H&E estimates each index by attributing productivity and access scores to the range of plan designs available and exploits changing plan choices to project the evolution of health care quality.

Table 5. Provider Access Index Under the Alternative[11]

	2014	2015	2016	2017	2018	2023
Individual Market	3.4	3.2	3.6	3.7	3.6	3.3
Employer Sponsored Insurance	3.9	3.8	3.9	3.9	3.9	3.9
Private Insurance	**3.8**	**3.7**	**3.9**	**3.9**	**3.9**	**3.9**
Medicaid	1.0	1.0	1.0	1.0	1.0	1.0
Total Insured	**3.2**	**3.2**	**3.4**	**3.4**	**3.4**	**3.3**

Under the Alternative, average provider access is projected to increase relative to current law due to large enrollment in catastrophic coverage plans that commonly offer a wide choice of providers. The structure of the Alternative's premium credits encourage catastrophic coverage enrollment, as many households can purchase catastrophic for less than the value of the subsidy. Decreased enrollment in Medicaid, which offers poor access to physicians, also leads to an increase in average provider access in the total insured population.

[11] Productivity and access estimates refer only to the under-65 population.

Table 6. Change in Provider Access Under the Alternative[12]

	2014	2015	2016	2017	2018	2023
Individual Market	0%	0%	19%	33%	36%	57%
Employer Sponsored Insurance	0%	0%	3%	3%	3%	4%
Private Insurance	**0%**	**0%**	**7%**	**9%**	**10%**	**14%**
Medicaid	0%	0%	0%	0%	0%	0%
Total Insured	**0%**	**0%**	**11%**	**12%**	**13%**	**18%**

Table 7. Medical Productivity Index Under the Alternative[12]

	2014	2015	2016	2017	2018	2023
Individual Market	2.7	2.5	2.7	2.6	2.7	2.9
Employer Sponsored Insurance	2.3	2.3	2.4	2.4	2.4	2.5
Private Insurance	**2.3**	**2.3**	**2.6**	**2.5**	**2.6**	**2.7**
Medicaid	1.5	1.5	1.5	1.5	1.5	1.5
Total Insured	**2.2**	**2.2**	**2.4**	**2.4**	**2.4**	**2.5**

Table 8. Change in Medical Productivity Under the Alternative[12]

	2014	2015	2016	2017	2018	2023
Individual Market	0%	0%	9%	9%	8%	6%
Employer Sponsored Insurance	0%	0%	3%	1%	1%	1%
Private Insurance	**0%**	**0%**	**9%**	**7%**	**7%**	**7%**
Medicaid	0%	0%	0%	0%	0%	0%
Total Insured	**0%**	**0%**	**10%**	**8%**	**8%**	**9%**

Budget Impact

In its analysis of a proposal's impact on the federal budget, H&E looks only at provisions directly related to health insurance coverage. For proposals that repeal the ACA—such as the Alternative—there are a number of tax policy changes that are not directly related to health insurance coverage and are thus not included in our budget impact analysis. In July 2012, the Congressional Budget Office (CBO) estimated that the net effect on the budget of repealing the non-coverage provisions of the ACA is a deficit increase of $1.03

[12] Productivity and access estimates refer only to the under-65 population.

trillion over the next ten years.[13] The Alternative also includes a cut of 0.75 percent of discretionary, non-defense spending, which is not included in this analysis.

H&E projects that the insurance coverage provisions of the Alternative will decrease the budget deficit by $1.13 trillion over the next decade. The budget impact table is divided into two sections: Sources of Funds refers to changes in dollars raised by the federal government and Uses of Funds refers to changes of dollars spent by the federal government. Many of the insurance coverage provisions of both current law and the Alternative disseminate financial benefits through tax credits. Technically, these provisions reduce the effective tax rate and would lead to less money raised—except in cases where the tax credit exceeds a households total tax obligation. However, in the interest of simplicity and clarity, these "tax expenditures" are categorized as Uses of Funds in H&E budget estimates.

Table 9. Budgetary Impact of the Alternative (billions)[14]

	2014	2015	2016	2017	2018	2023	10-Year Total
Sources of Funds[15]							
Tax on Employer Sponsored Health Insurance	0	0	34	36	10	9	130
Individual and Employer Mandate Taxes	0	0	-10	-11	-13	-24	-129
Subtotal	**0**	**0**	**24**	**25**	**-2**	**-15**	**1**
Uses of Funds[16]							
Cost Sharing Benefits	0	0	-23	-23	-22	-14	-160
Health Savings Account Credits	0	0	29	6	6	6	70
Premium Tax Credits	0	0	-54	-60	-65	-89	-572
High Risk Pools	0	0	8	8	8	9	67
Medicaid	0	0	-63	-62	-64	-74	-533
Subtotal	**0**	**0**	**-103**	**-132**	**-138**	**-161**	**-1,128**
Net Budgetary Impact	**0**	**0**	**-127**	**-157**	**-135**	**-147**	**-1,130**

[13] Elmendorf, Douglas W., "Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act," Congressional Budget Office, July 24, 2012, available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf

[14] Cost estimates refer only to coverage provisions for the under-65 population.

[15] Positive values denote increases in revenue; negative values denote decreases in revenue. Due to rounding, totals may not add to the sum of each year.

[16] Positive values denote increases in spending; negative values denote decreases in spending. Due to rounding, totals may not add to the sum of each year.

H&E estimates that the Alternative will lead to a small net revenue increase of $1 billion. The Alternative repeals the individual and employer mandate without replacing it with any similar tax penalty, which H&E estimates will cost $129 billion over the next ten years. The Alternative also repeals a tax on high cost employer sponsored insurance under the ACA that begins in 2018 and replaces it with a stricter cap on the value of employer sponsored insurance that can be designated as pre-tax income, beginning in 2015. Under the Alternative, enrollees in employer sponsored insurance with total premium values exceeding the cap will owe income and payroll taxes on the value of premiums that exceed the cap. Because the tax exclusion cap is defined as the 75th percentile of all employer sponsored insurance premiums, only 25 percent of those enrolled through an employer will pay additional taxes in the first year of implementation. After the first year, more beneficiaries are estimated to be subject to the tax as employer sponsored insurance premiums rise more quickly than the exclusion cap. The Alternative generates significant revenue relative to current law by implementing the tax on employer sponsored insurance 2 years before it will be implemented under current law and smaller amounts of revenue after 2018 by taxing more benefits than under current law. H&E estimates that the Alternative will lead to a net increase of $130 billion through taxes on employer sponsored health insurance.

H&E estimates that the Alternative will lead to a net decrease in uses of funds of $1.13 trillion. The Alternative includes two new sources of spending: contributions to HSAs and funding for high risk pools. The subsidized contributions to HSAs—detailed in the previous section—are estimated to cost $70 billion over the next ten years. While the ACA appropriated funding for high risk pools, there is no requirement for annual funding to help states facilitate and cover the costs of insuring high risk individuals. The Alternative dedicates $7.5 billion to fund high risk pools, increasing annually by 3 percent. Over the next ten years, the Alternative dedicates $67 billion to high risk pool funding. The Alternative also repeals the Medicaid expansion funded by the ACA, which H&E estimates will save $533 billion over the next ten years.

The most significant spending provisions in both the ACA and the Alternative are those relating to health insurance premium credits. However, H&E estimates that the total spending under the Alternative is substantially less than spending under current law. Over the next ten years, H&E projects that replacing the premium tax credits under the ACA with those specified by the Alternative would save $572 billion. The decrease in spending under the Alternative is due to smaller average premium subsidies and lower take-up of subsidies distributed through refunds or rebates relative to the advanceable credits available through current law.

Uncertainty in H&E Projections

As with all economic forecasting, H&E estimates are associated with substantial uncertainty. While our estimates provide good indication on the nation's health care outlook, it is not likely that the policy environment will remain unchanged throughout our ten-year analysis period. And even if no major legislative action occurs, there still exists a wide range of possible future scenarios. For instance, the uncertainty surrounding the implementation of the ACA and similar obstacles facing the implementation of new

health care overhauls affect the accuracy of short-term coverage estimates. In analyzing the Alternative, we assume that the subsidized health insurance exchanges will be fully functional and stable by 2016, but it is difficult to approximate the costs associated with the new implementation of health reform in 2016.

One dimension of the analysis that is particularly sensitive to uncertainty is our assumption on the take-up of non-advanceable health insurance premium credits available under the Alternative. In the baseline analysis, H&E assumes that 75 percent of eligible households will claim the credits—the same rate of take-up found in research on the EITC.[17] While the EITC is similar in magnitude to the premium credits available under the Alternative, there are several key differences that may impact take-up. The EITC is offered only to low-income households, many of which don't have access to tax preparers that might notify filers of the available credit. However, premium tax credits may also benefit from ad campaigns, similar to those pursued by the Obama Administration in the Health Insurance Marketplace rollout. Eligibility for the EITC is also based on income, rather than a purchasing decision. Tax credit take-up may be higher when a household makes a conscious choice to become eligible.

Table 10. Robustness of Tax Credit Take-up Assumptions

	2014	2015	2016	2017	2018	2023	10-Year Total
Coverage Impact (millions)[18]							
Lower Bound	0	0	-6	-7	-7	-8	
Baseline	0	0	-6	-6	-6	-6	
Upper Bound	0	0	-5	-6	-6	-6	
Budgetary Impact (billions)[19]							
Lower Bound	0	0	-133	-162	-141	-154	-1,180
Baseline	0	0	-127	-157	-135	-147	-1,130
Upper Bound	0	0	-124	-155	-133	-143	-1,105

In an effort to test the robustness of our assumption, H&E also examines the broad impacts of the proposal under two alternate assumptions. Take-up of the EITC varies among the population of households eligible for the credit. As a lower bound, H&E assumes that take-up of the health insurance premium credit will be equal to take-up of the EITC among the "phase-in" population, low-income households for which the credit increases with earned income. In this population, take-up is 65 percent. As an upper bound, H&E assumes that take-up of the health insurance premium credit will be equal to take-up of the EITC among the "max benefit" population. The full EITC benefit varies

[17] Plueger, Dean, "Earned Income Tax Credit Participation Rate for Tax Year 2005," Internal Revenue Service, available at: http://www.irs.gov/pub/irs-soi/09resconeitcpart.pdf
[18] Coverage estimates refer only to the under-65 population.
[19] Positive values denote increases in the deficit; negative values decreases in the deficit.

among households according to the number of qualifying children, but the benefit does not change with marginal changes in income. EITC take-up is 80 percent among this population.

The H&E health insurance coverage and federal budget forecasts respond relatively simply to changes in the premium credit take-up assumption. Lower premium credit take-up leads to fewer households obtaining health insurance coverage and less spending on premium tax credits, and the converse is true for higher take-up. Under the lower-bound assumption, H&E estimates that the Alternative will lead to 8 million fewer insured individuals than under current law in 2023, and the upper-bound projection is within rounding error of the baseline estimate of 6 million fewer covered individuals. The lower- and upper-bound assumptions create a $75 billion error bracket around the baseline budgetary savings estimate—a high of $1.18 trillion and a low of $1.105 trillion in savings.