A Better Way to Fix Health Care

August 24, 2016

In June, the Health Care Task Force appointed by House Speaker Paul Ryan released its "A Better Way to Fix Health Care" plan. The white paper, referred to in this report as the Plan, proposes a full repeal of the Affordable Care Act (ACA) and replaces it with an alternate coverage strategy, different tax policy, and an alternative regulatory regime. Some of the key provisions include an age adjusted tax credit available to consumers in the individual market, a cap on the tax exclusion for employer sponsored insurance, and per capita allotments for Medicaid.[1] This report details the findings of the Center for Health and Economy's (H&E) – relying heavily on its Under-65 Microsimulation Model – on the proposal's impact on health insurance coverage, provider access, medical productivity, and the federal budget. Because the Plan also includes a number of substantial Medicare reform proposals, H&E employed its Over-65 Microsimulation Model to inform its estimates of the effects that these reforms. As with all projections, the estimates are associated with some degree of uncertainty. The summary of our findings is as follows. It repeals and replace the ACA. The Plan does not include comprehensive details on all the provisions included, requiring H&E to make assumptions. In doing so, H&E relied on previous plans that have been scored by H&E. For example, the Plan prescribes age-based tax credits, yet it does not detail the amounts or the ages that would be eligible for those amounts, so a similar tax credit provision from the 2017 Project is used below.

KEY FINDINGS:

- **Coverage Impact:** The Plan is projected to lead to 1 million more insured individuals in 2018 relative to the current baseline. By 2026, this number is expected to be 4 million fewer than under current law, with the decrease concentrated in the Medicaid population.
- **Premium Impact:** The Plan is projected to decrease the premium cost of private health insurance coverage, with the largest impact on Silver, Gold, and catastrophic coverage plans.
- **Medical Productivity:** Under the Plan, medical productivity is projected to increase by 7 percent by the year 2026 relative to the current baseline.
- **Provider Access:** Provider access under the Plan is projected to increase by 4 percent by 2026 relative to the current baseline.
- **Budget Impact:** Compared to current law, the Plan is estimated to decrease the federal deficit by $481 billion between 2017 and 2026.

Analysis

The analysis utilizes two microsimulation models developed for use by H&E. Both models employ micro-data available through the Medical Expenditure Panel Survey and the Medicare Current Beneficiary Survey to analyze the effects of health policies on the health insurance plan choices of the non-disabled population and extrapolate the resulting

impact to national coverage, average insurance premiums, the federal budget, and the accessibility and efficiency of health care.[2]

The Plan would take effect on January 1, 2018. The following provisions from the Plan and subsequent assumptions are included in this score:

- The ACA is fully repealed
- Individuals and families who are not offered employer sponsored insurance are eligible for an age-adjusted premium tax credit, increased annually by 3 percent. The following table shows the tax credit values:

Table 1. Assumed Annual Premium Tax Credits Under the Plan

Age	Credit
17 and Under	$900
18 to 34	$1,200
35 to 49	$2,100
50 and Over	$3,000

- Tax credits are advanceable and refundable.
- If the premium of a plan purchased in the individual market is less than the tax credit, then the difference is deposited into an HSA.
- Premium ratio restrictions based on age are set at 5:1. Each state is given the ability to expand or narrow the ratio. All states are assumed to have a 5:1 ratio in this score.
- Continuous coverage protections so that anyone with a qualifying life event would not be medically underwritten according to pre-existing conditions.
- The tax exclusion for employer-sponsored health insurance is capped at the 90th percentile. This tax begins in 2018 and is indexed to grow at a 3 percent annual rate thereafter. It is also adjusted for regional variation in health care cost. The cap does not apply to employee contributions made on a pre-tax basis to an HSA.
- States are allowed to form interstate compacts to allow the sale of health insurance contracts across state lines.
- One-time open enrollment period for individuals entering the individual market in 2018.
- HRAs would be allowed on the individual market.
- Medicaid begins a process of returning to pre-ACA levels beginning in 2019. H&E assumes a five-year period for this transition.
- Medicaid spending would be determined using a per-capita allotment indexed to inflation. Each state would have the ability to receive Medicaid funding in the form of a block grant also. H&E assumes for this score that all states opt for the per-capita allotments.

- Medicare Advantage (MA) value-based insurance design starting in 2020. Plans are allowed to provide flexible benefits to seniors.
- Medigap plans restricted to covering no more than half of the cost sharing between the deductible and out of pocket maximum in 2020.
- Combining Medicare parts A and B starting in 2020.
- Medicare Exchange, or the Plan's premium support provision for Medicare, starts in 2024.
- Federally funded high risk insurance pools of at least $25 billion.

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. Catastrophic coverage plans refer to health insurance plans that reimburse medical expenses only after members meet a high deductible—a maximum of $6,850 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.

Table 2. Average Annual Premiums in the Individual Market

		2017	2018	2019	2020	2021	2026
Single Coverage	Platinum	5,200	4,400	4,700	5,000	5,300	7,000
	Gold	4,100	3,500	3,700	3,900	4,100	5,500
	Silver[2]	4,800	-	-	-	-	-
	Silver	3,400	2,900	3,100	3,200	3,400	4,500
	Bronze	2,500	2,400	2,500	2,600	2,700	3,100
	Catastrophic	1,800	1,300	1,400	1,400	1,500	1,700
Family Coverage[1]	Platinum	20,500	17,200	18,200	19,300	20,500	27,300
	Gold	16,600	13,600	14,400	15,300	16,200	21,600
	Silver[2]	17,800	-	-	-	-	-
	Silver	14,100	11,300	12,000	12,700	13,500	18,000
	Bronze	10,900	10,500	10,600	10,900	11,200	12,900
	Catastrophic	6,700	4,200	4,400	4,600	4,700	5,500

[1] Family coverage estimates are based on a family size of four persons.
[2] Silver plans offered to low income households receive cost-sharing benefits that alter the effective premium relative to un-assisted silver plans.

H&E estimates that the Plan 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, the repeal of the individual mandate, and the removal of barriers to sell insurance across state lines. Under current law, health insurance plans are only able to alter prices based on three factors—geographic location, age (a maximum ratio of 3:1), and tobacco use (a maximum ratio of 1.5:1)—and are explicitly prohibited from taking into account any information on expected medical expenses.

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 those individuals to gain coverage in higher numbers. Similarly, some low-cost individuals, for whom a close-to-average premium is a bad value, may drop insurance coverage. These fluctuations in the pool of insured are likely to cause average premiums to rise. The Plan is projected to lower average premiums compared with current law by loosening these restrictions.

The ACA 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 costlier benefits in exchange for less expensive premiums. In addition, offering higher deductibles allows insurance companies to offer less generous and lower premium plans for those with low expected medical costs. H&E projects that removing the EHB requirements and deductible restrictions will lead to a decrease in average health insurance premiums relative to current law.

The Plan repeals the individual mandate that requires that all individuals who fail to obtain qualified health insurance coverage pay a tax 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. Under ACA's individual mandate, with greater numbers of healthy, low-risk individuals paying insurance premiums, insurance companies can afford to charge lower average premiums. Thus, H&E estimates that repealing the individual mandate alone would lead to an increase in average health insurance premiums. But, repealing the individual mandate is not the only change offered by the Plan.

Under the ACA, adults over the age of 30 that purchase catastrophic coverage do not meet the qualified health insurance requirements of the individual mandate and must still pay the penalty. As a result, average catastrophic coverage premiums under current law are relatively low, which is partly a reflection of a young and generally healthy population of enrollees. Average premiums for these catastrophic plans are projected to experience upward pressure absent of the individual mandate due to an influx of older, higher-risk enrollment.

Table 3. Percent Change in Premiums from Current Law

		2017	2018	2019	2020	2021	2026
Single Coverage	Platinum	0%	-20%	-19%	-18%	-18%	-19%
	Gold	0%	-19%	-20%	-20%	-21%	-20%
	Silver[2]	0%	-	-	-	-	-
	Silver	0%	-19%	-18%	-22%	-21%	-21%
	Bronze	0%	-11%	-11%	-10%	-10%	-9%
	Catastrophic	0%	-32%	-30%	-33%	-29%	-32%
Family Coverage[1]	Platinum	0%	-21%	-21%	-21%	-21%	-21%
	Gold	0%	-23%	-23%	-23%	-23%	-23%
	Silver[2]	0%	-	-	-	-	-
	Silver	0%	-24%	-24%	-24%	-24%	-24%
	Bronze	0%	-9%	-10%	-10%	-10%	-11%
	Catastrophic	0%	-36%	-35%	-34%	-35%	-35%

Coverage Impact

H&E insurance coverage estimates reflect health insurance choices for the under-65 population. The task force envisions raising the Medicare eligibility age, beginning in 2020, to ultimately match the Social Security eligibility age. The task force did not spell out the pace at which this occurs, so H&E was unable to model this provision. H&E estimates that the Plan will lead to 1 million more insured individuals in 2017 and 4 million fewer insured individuals by 2026. Under the Plan, the 2026 uninsured rate among the under-65 population will be 21 percent—up from the projected uninsured rate of 16 percent under current law.

The principle reason for reduced coverage is a decline in the Medicaid population. In 2019 the Plan begins the process of moving the states' federal medical assistance percentage (FMAP) for Medicaid back to pre-ACA levels. H&E assumes a five-year window for this transition. By 2026, H&E expects Medicaid enrollment to decrease by 18 million relative to current law. The decrease in Medicaid enrollment is partially offset by an increase of coverage in the individual market, supported by tax credits available to all individuals that are not offered insurance through an employer. Under the Plan, anyone that is not offered ESI is eligible to receive an age-adjusted tax credit.

Table 4. Health Insurance Coverage (millions)

	2017	2018	2019	2020	2021	2026
Individual Market	36	35	42	41	41	40
Health Insurance Marketplace	16	0	0	0	0	0
Other Non-group Insurance	19	35	42	41	41	40
Employer Sponsored Insurance	145	144	145	145	145	144
Medicaid	50	50	41	40	38	35
Other Public Insurance[2]	10	10	10	11	12	17
Total Non-Elderly Population	**273**	**274**	**275**	**277**	**278**	**285**
Total Insured[1]	**241**	**241**	**237**	**237**	**236**	**236**
Uninsured[1]	**32**	**33**	**38**	**40**	**42**	**49**

[1] All insurance coverage estimates refer only to the under-65 population.

[2] Other Public Insurance includes under-65 Medicare enrollment.

By 2026, 40 million people are expected to have insurance in the individual market—13 million more than expected under current law. As Medicaid eligibility is tightened more individuals are expected to use the tax credit to purchase private insurance. Since the EHBs of the ACA are repealed under the Plan, the tax credits provided by the Plan may be used to purchase a wider range of health plans that leads to an increase in coverage. For example, under the Plan, the tax credits may be used to purchase catastrophic and plan designs with tailored benefits, whereas the tax credits under the ACA can only be used on plans that meet the EHBs prescribed.

H&E estimates that the Plan will lead to a slight decrease in enrollment through employer sponsored insurance. While the Plan raises the threshold for a tax on high-cost employer sponsored health insurance, the repeal of the employer mandate and lower average prices in the individual market lead to a slight increase in households that either forgo employer sponsored insurance for individual market insurance or are no longer offered insurance by their employer.

Table 5. Change in Coverage Estimates (millions)

	2017	2018	2019	2020	2021	2026
Individual Market	0	2	10	10	12	13
Health Insurance Marketplace	0	-17	-16	-15	-14	-12
Other Non-group Insurance	0	19	26	26	26	25
Employer Sponsored Insurance	0	-1	0	0	0	0
Medicaid	0	-1	-10	-12	-14	-18
Other Public Insurance	0	-1	-2	-1	-1	1
March 2016 Baseline[1]	241	240	240	239	239	240
A Better Way	241	241	237	237	236	236

[1] All insurance coverage estimates refer only to the under-65 population.
* Difference between baseline estimates is between 0 and 1 billion.

In addition to premium tax credits, the Plan also allows households to use tax-exempt medical savings in Health Savings Accounts (HSA) to pay for HSA-qualified health insurance premiums. It is not common for HSAs to be large enough to be able to pay for a significant amount of annual health insurance premiums, even those of relatively low-cost HSA-qualified plans, in part due to a cap on tax-exempt contributions. H&E estimates that this provision will lead to a small amount of savings on health insurance premiums for those who have the available funds, but this effect is small compared to other factors affecting premium prices and insurance coverage.

Productivity and Access

In an 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 uses the changes in plan choices to project the evolution of health care quality. In tables 8 and 9, there is some seemingly irregular changes from year to year. Most of that is due to the interaction between provisions of our most recent baseline and the Plan, as the Plan has many different provisions being enacted over the ten-year window.

Table 6. Medical Productivity Index

	2017	2018	2019	2020	2021	2026
Individual Market	2.4	2.4	2.5	2.6	2.6	3.0
Employer Sponsored Insurance	2.3	2.4	2.4	2.4	2.4	2.6
Private Insurance	**2.3**	**2.4**	**2.4**	**2.4**	**2.5**	**2.6**
Medicaid	1.5	1.5	1.5	1.5	1.5	1.5
Over-65 Medicare	3.0	3.0	3.0	3.2	3.2	3.4
Total Insured[1]	**2.2**	**2.3**	**2.3**	**2.4**	**2.4**	**2.6**

Table 7. Provider Access Index

	2017	2018	2019	2020	2021	2026
Individual Market	3.0	2.3	2.2	2.2	2.2	2.1
Employer Sponsored Insurance	3.8	3.8	3.7	3.7	3.7	3.7
Private Insurance	**3.7**	**3.6**	**3.5**	**3.5**	**3.5**	**3.4**
Medicaid	1.0	1.0	1.0	1.0	1.0	1.0
Over-65 Medicare	3.7	3.7	3.7	3.6	3.6	3.6
Total Insured[1]	**3.1**	**3.1**	**3.1**	**3.1**	**3.1**	**3.0**

H&E expects medical productivity to increase under the Plan. The shift of consumers from public plans to the individual market leads to a net increase in efficiency, as individual market plans typically require more cost-sharing, which encourages price-conscious decision making among consumers. Lower enrollment in traditional Medicaid also leads to higher medical productivity. For Medicare, Specifically, we expect movement to narrow network plans from the Medicaid market which is expected to increase productivity. Value Based Insurance Design, Medigap reform, and the creation of the Medicare exchange in 2024 leads to an increase in MA enrollment. Because MA's managed care plans typically have higher productivity than fee-for-service, as the MA enrollment increases, Medicare's productivity increases from 2017 to 2026. These gains are partially offset by lower productivity in the employer market, as the weaker tax of high-cost insurance mitigates the trend towards more consumer-driven insurance products.

Under the Plan, average provider access is projected to increase relative to current law due to large enrollment in catastrophic and high deductible plans that commonly offer a wide choice of providers assuming these plans continue to offer large regional and national provider networks. The structure of the Plan's premium credits encourage catastrophic coverage enrollment, as many households can purchase catastrophic for less than the value of the subsidy. H&E also projects an increase in average provider access for the total insured population starting in 2020 as individuals currently in the "expansion

population" are moved out of traditional Medicaid—which generally offers poor access to physicians—and begin to buy insurance using the subsidy, access is expected to increase H&E expects that the Plan will lead to less provider access in Medicare. Under the Value-Based Insurance Design provision of the plan, it is expected that MA plans would provide incentives that could restrict providers that are not optimal under such a system.

Table 8. Change in Medical Productivity Index

	2017	2018	2019	2020	2021	2026
Individual Market	1%	9%	15%	12%	15%	23%
Employer Sponsored Insurance	1%	2%	-1%	0%	1%	-2%
Private Insurance	**2%**	**3%**	**4%**	**1%**	**2%**	**5%**
Medicaid	0%	0%	0%	0%	0%	0%
Over-65 Medicare	0%	0%	0%	8%	8%	11%
Total Insured[1]	**0%**	**1%**	**3%**	**4%**	**4%**	**7%**

Table 9. Change in Provider Access

	2017	2018	2019	2020	2021	2026
Individual Market	0%	-15%	-14%	-16%	-14%	2%
Employer Sponsored Insurance	0%	-1%	-1%	1%	1%	2%
Private Insurance	**-1%**	**-2%**	**-3%**	**-4%**	**-4%**	**-3%**
Medicaid	0%	0%	0%	0%	0%	0%
Over-65 Medicare	0%	0%	0%	-3%	-3%	-4%
Total Insured[1]	**0%**	**-2%**	**0%**	**1%**	**1%**	**4%**

Budget Impact

H&E projects that the insurance coverage provisions of the Plan will lead to a net budget surplus of $481 billion dollars relative to the current H&E baseline over the next decade. In its analysis of the Plan's impact on the federal budget, H&E looks only at provisions directly related to health insurance coverage. For plans that repeal the ACA—such as the Plan—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. Taxes like the medical device tax and the health insurers fee are examples of these types of tax policies that would be repealed along with the ACA, but are not directly related to health insurance coverage.

H&E estimates that the Plan will lead to a gross reduction in source funds of $218 billion. The Plan repeals both the individual and employer mandates without replacing them without any similar tax penalty, which H&E estimates will cost $208 billion over the next decade. The Plan also repeals the excise tax on high cost employer sponsored insurance under the ACA that begins in 2020 and replaces it with a slightly weaker cap on the employer exclusion beginning in 2018. In 2018 and 2019, the Plan raises revenue as the cap on the employer tax exclusion would be implemented earlier than the excise tax. Despite the two-year head start, H&E expects the Plan's cap to raise less money relative to the ACA's excise tax because the Plan's tax threshold begins at a higher dollar value and is indexed annually at a higher rate than the threshold under current law. H&E estimates that the Plan will lead to a decrease in revenue of $10 billion through taxes on employer sponsored health insurance.

Table 10. Change in Budgetary Impact Estimates (billions)[1]

	2017	2018	2019	2020	2021	2026	2017-2026
Change in Sources of Funds Baseline Estimates[2]							
Tax on Employer Sponsored Health Insurance	0	11	12	-6	-7	-1	-10
Individual and Employer Mandate Taxes	0	-13	-15	-17	-19	-37	-208
Subtotal	**0**	**-2**	**-3**	**-23**	**-26**	**-38**	**-218**
Change in Uses of Funds Baseline Estimates[3]							
Cost Sharing Benefits	0	-14	-14	-13	-12	-5	-90
Premium Tax Credits	0	2	44	45	45	43	360
Medicaid	0	-18	-55	-60	-67	-95	-636
Other Public Insurance	0	-7	-15	-10	-2	17	26
Over-65 Medicare (see Table 11)	0	0	0	-29	-33	-61	-306
Medical Malpractice Reform	0	-6	-7	-8	-8	-10	-77
High Risk Pools	0	2	3	3	3	3	25
Subtotal	**0**	**-41**	**-45**	**-81**	**-78**	**-88**	**-699**
Net Budgetary Impact[4]	**0**	**39**	**42**	**49**	**49**	**71**	**481**

[1] Cost estimates refer only for the under-65 population.

[2] Positive values denote increases in revenue; negative values denote decreases in revenue.

[3] Positive values denote increases in spending; negative values denote decreases in spending.

[4] Positive values denote surplus; negative values denote deficit.

* Difference between baseline estimates is between 0 and 1 billion.

H&E estimates that the Plan will lead to a gross decrease in uses of funds of $733 billion. The Plan includes only one new source of spending—funding for high risk pools of at least $25 billion. While the ACA initially 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 Plan repeals the Medicaid expansion funded by the ACA and institutes a funding system of per-capita caps, which H&E estimates will save $636 billion over ten years. The Plan is also expected to save $77 billion over ten years on federal health care expenditures through medical malpractice reforms.

The Plan and the ACA both implement premium tax credits to help insure people in the Individual Market. The Plan's tax credits are available to all who are not offered employer sponsored insurance, therefore H&E expects a wider take up of the Plan's tax credits to lead to an increase in spending of $360 billion relative to current law. This is partially offset by the Plan's repeal of the cost sharing benefits available through the ACA, which is expected to save $90 billion from 2017 to 2026.

Table 11. Medicare Expenditure Change
(Billions of Dollars)

Plan Choice	2017	2018	2019	2020	2021	2026	2017-2026
FFS & RX	0	0	0	11	12	13	84
FFS & SUPP	0	0	0	-16	-18	-37	-178
FFS & SUPP & RX	0	0	0	-53	-59	-111	-553
FFS Only	0	0	0	3	3	-1	9
MA & RX	0	0	0	27	30	75	331
TOTAL	**0**	**0**	**0**	**-29**	**-33**	**-61**	**-306**

H&E expects a net decrease in Medicare expenditures under the Plan. The Plan's major Medicare reforms start in 2020 with the implementation of Value-Based Insurance Design and combining Part A and Part B cost sharing. As coverage is switched from traditional fee-for-service to managed care, H&E expects costs to be managed as well. H&E expects by 2024, the addition of the Medicare Exchange will yield additional savings. By 2026, H&E expects that the Medigap population will be reduced by 43 percent relative to current law while the MA population is projected to have a net increase of 33 percent. Because of the shift to managed care, H&E projects that the ten-year budget impact of the Plan will result in a net savings of $306 billion.

Uncertainty in H&E Projections

As with all policy projections, 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. H&E attempts to depict an unbiased, middle -ground representation of the future should the policy and economic environment remain constant. While the goal is to quantitatively describe the most likely scenario, actual events may differ significantly from published predictions.

Aside from the details assumed by H&E in order to make the Plan scoreable, one point of uncertainty that applies to this analysis is the unpredictability of state behavior when it comes to several key provisions. The Plan gives the states a high degree of flexibility with regards to premium ratio restrictions based on age and Medicaid provisions.

The Plan sets the age-based premium ratio restrictions at 5:1 while states are given the option to either constrict or relax the ratio. Depending on how states react to their ability to tweak this ratio this provision could have effects on average premiums and enrollment in the individual market. For each state that might decide to adjust this ratio, the greater the population of the state, the more impact that the adjustment would have on premiums and enrollment. A similar scenario is created in relation to the Medicaid provisions with regards to the ability for states to choose to block grant, the flexible benefit package option for state Medicaid programs, and the use state tax dollars to fund Medicaid.

---

[1] The text of the "A Better Way" can be found at http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

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