Center for Health and Economy

Health and Economy Baseline Estimates

March 6, 2018

Entering the 2018 plan year, the health insurance market continues to see increasing and unpredictable costs, large numbers of uninsured individuals, and inadequate access to care. The Center for Health and Economy (H&E) is dedicated to assessing the impact of proposed reforms that attempt to address these issues. The following report details the most recent updates to the H&E baseline estimates of insurance coverage, federal budgetary impact, plan choice, and the premium landscape of health insurance for Americans under the age of 65.

KEY FINDINGS:

- It is estimated that the individual market includes 18 million members in 2018, with 10 million lives covered through the Affordable Care Act's (ACA) Health Insurance Marketplace. The total size of the individual market is estimated to decline throughout the budget window—dropping to 11 million in 2028.
- It is estimated that the uninsured rate will rise from 11 percent in 2018 to 13 percent in 2028
- As premiums and health care costs rise, plans chosen in the individual market are expected to shift toward lower-cost options. Highly subsidized enrollment in Silver plans is projected to fade as a percentage of enrollment on the individual market, while enrollment in Bronze plans will grow among both subsidized and unsubsidized consumers.
- The health insurance coverage provisions under current law for the non-elderly are estimated to increase Federal outlays by $5.02 trillion, and Federal health-related revenue is expected to decrease as the individual mandate penalty is set to $0 beginning in 2019.

INSURANCE COVERAGE

H&E estimates there were 246 million non-elderly U.S. residents with health insurance in 2017—90 percent of the total non-elderly population. Estimates of health insurance coverage encompass four primary categories: the individual market, employer-sponsored insurance, Medicaid, and other public insurance. The individual market is divided into two subsets: subsidized and unsubsidized coverage. Subsidized coverage is purchased through the Health Insurance Marketplace, and unsubsidized coverage is comprised of similar insurance plans purchased either directly from the insurer (represented in Other Non-Group Insurance) or through the Marketplace without financial assistance. H&E makes no distinction between unsubsidized enrollees through the Marketplace and households that purchase individual market insurance directly from an insurer. Estimates

concerning Medicaid also include beneficiaries of the Children's Health Insurance Program. Other public insurance is primarily comprised of Medicare coverage for disabled persons, but also includes Tricare, the Indian Health Service, and other federal health care programs for specific populations.

Table 1. Health Insurance Coverage (Millions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Individual Market*	18	16	16	15	15	14	14	14	13	12	12	11
Health Insurance Marketplace	10	11	10	10	10	9	9	9	8	8	8	7
Other Non-Group Insurance	8	6	5	5	5	5	5	5	5	5	4	4
Employer-Sponsored Insurance	155	155	156	156	157	157	158	158	159	159	159	160
Medicaid	67	68	68	68	68	68	68	69	69	69	69	69
Other Public Insurance[1]	5	5	5	5	5	5	5	5	5	5	5	5
Total Non-Elderly Population	**275**	**276**	**276**	**277**	**278**	**279**	**280**	**280**	**281**	**282**	**283**	**284**
Total Insured[2]	**246**	**245**	**245**	**245**	**245**	**245**	**245**	**246**	**246**	**246**	**246**	**246**
Uninsured[2]	**29**	**31**	**32**	**32**	**33**	**33**	**34**	**35**	**35**	**36**	**37**	**37**
Percent Uninsured	**10%**	**11%**	**11%**	**12%**	**12%**	**12%**	**12%**	**12%**	**13%**	**13%**	**13%**	**13%**

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

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

* Individual Market and Total Insured numbers may not equal the sum of other sub-categories due to rounding.

The enrollment for the Health Insurance Marketplace in 2017 is benchmarked to the effectuated enrollment reported by the Centers for Medicare and Medicaid Service for the first half of 2017.[1] By 2019, the number of uninsured, non-elderly Americans is projected to increase to 32 million—11 percent of the total non-elderly population. This increase in the number of uninsured Americans is primarily the result of 2018 premium increases in the individual market. The average population of non-elderly Medicaid beneficiaries is estimated to be 67 million in 2017 and will rise to 69 million by 2028.[2]

These estimates are subject to the uncertainty of each state's decision regarding Medicaid expansion. H&E does not make any assumptions about future state take-up of the Medicaid expansion, due to the many variables involved in projecting the magnitude of the effects of potential future expansions. Because of this limitation, the Medicaid enrollment and spending reflected in this baseline only reflect the projected costs and enrollment of the Medicaid program if it were to remain as it currently is.

The individual market is estimated to decline from 18 million covered lives in 2017 to 11 million in 2028, driven by premium increases in the Marketplace. By 2028, roughly 2.5 million of the 7 million decrease in the individual market's size is a result of a 2019

premium increases from the individual mandate penalty being set to $0 in 2019, while the rest can be attributed general premium growth relative to income.

As seen in Table 1, the number of individuals with unsubsidized, individual market insurance is expected to decrease substantially in 2018. Unsubsidized enrollment will continue to slide throughout the budget window with 4 million enrolled in unsubsidized insurance in 2028. Rising costs and higher income contributions for subsidized enrollees are estimated to lead to higher uninsured numbers later in the analysis period.

PREMIUMS

Estimates of the subsidy-eligible premiums available in the Marketplace are calculated using publicly available data on plans offered in the 36 Federally Facilitated Marketplaces. Premium estimates for unsubsidized health insurance are calculated from a sample of plans available through the Robert Wood Johnson Foundation.[3] In both cases, H&E uses the default age rating curve put forth by the Department of Health and Human Services and by individual states to compute the applicable premium for a household. For simplification and comparability, H&E uses a standard family size of four (two adults and two children) when estimating family premiums. Subsidy payments and tax revenue are adjusted for the appropriate average family size in budget impact estimates. Premium increases in the tables below represent average premiums for plans selected in the individual market.

Table 2. Average Premiums in the Individual Market

		2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Single Coverage	Platinum	6,000	7,600	8,200	8,500	8,800	9,100	9,500	9,800	10,200	10,500	10,900	11,300
	Gold	5,200	6,800	7,300	7,600	8,000	8,300	8,600	9,000	9,400	9,700	10,100	10,500
	Silver[2]	4,900	6,500	7,100	7,400	7,800	8,200	8,500	8,900	9,300	9,700	10,100	10,500
	Bronze	3,900	5,200	5,600	5,900	6,100	6,400	6,700	7,000	7,200	7,500	7,800	8,100
	Catastrophic	2,000	2,700	3,000	3,100	3,200	3,400	3,600	3,700	3,900	4,100	4,300	4,500
Family Coverage [1]	Platinum	12,700	15,700	16,600	17,100	17,700	18,300	19,000	19,700	20,300	21,000	21,800	22,600
	Gold	11,800	15,100	16,100	16,600	17,300	17,900	18,600	19,300	20,000	20,700	21,600	22,500
	Silver[2]	11,000	14,500	15,800	16,400	17,200	17,900	18,700	19,500	20,300	21,200	22,100	23,100
	Bronze	9,600	12,600	13,500	13,900	14,300	14,800	15,200	15,700	16,200	16,600	17,300	17,900
	Catastrophic	4,500	5,900	6,400	6,700	7,100	7,400	7,800	8,100	8,500	8,900	9,200	9,600

[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 unassisted Silver plans.

Subsidized insurance plans offered in the Marketplace are divided into four categories—Platinum, Gold, Silver, and Bronze—that correspond to four approximate actuarial values—90 percent, 80 percent, 70 percent, and 60 percent. The actuarial value refers to the expected percentage of annual medical expenses covered by the insurance plan.

Table 3. Average Premium Growth in the Individual Market

		2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Single Coverage	Platinum	26.7%	7.9%	3.7%	3.5%	3.4%	4.4%	3.2%	4.1%	2.9%	3.8%	3.7%
	Gold	30.8%	7.4%	4.1%	5.3%	3.8%	3.6%	4.7%	4.4%	3.2%	4.1%	4.0%
	Silver[2]	32.7%	9.2%	4.2%	5.4%	5.1%	3.7%	4.7%	4.5%	4.3%	4.1%	4.0%
	Bronze	33.3%	7.7%	5.4%	3.4%	4.9%	4.7%	4.5%	2.9%	4.2%	4.0%	3.8%
	Catastrophic	35.0%	11.1%	3.3%	3.2%	6.3%	5.9%	2.8%	5.4%	5.1%	4.9%	4.7%
Family Coverage[1]	Platinum	23.6%	5.7%	3.0%	3.5%	3.4%	3.8%	3.7%	3.0%	3.4%	3.8%	3.7%
	Gold	28.0%	6.6%	3.1%	4.2%	3.5%	3.9%	3.8%	3.6%	3.5%	4.3%	4.2%
	Silver[2]	31.8%	9.0%	3.8%	4.9%	4.1%	4.5%	4.3%	4.1%	4.4%	4.2%	4.5%
	Bronze	31.3%	7.1%	3.0%	2.9%	3.5%	2.7%	3.3%	3.2%	2.5%	4.2%	3.5%
	Catastrophic	31.1%	8.5%	4.7%	6.0%	4.2%	5.4%	3.8%	4.9%	4.7%	3.4%	4.3%

[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 unassisted Silver plans.

Eligible households may purchase subsidized coverage for a specified percentage of household income that ranges from 2.01 to 9.56 percent in 2018, depending on income. A federal subsidy pays the remaining portion of the premium that is not covered by the household's specified income contribution. This specified income contribution is also subject to annual increases if the annual increase in health insurance costs exceeds a measure of household income growth. H&E also projects an additional cost control measure, which prescribes further increases in the income contribution if total subsidy spending exceeds 0.504 percent of GDP. 2018 is the first year this adjustment is eligible to take effect; however, H&E does not project it to take place during the budget window.

Table 4. Average Subsidized Premiums in the Individual Market

		2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Single Coverage	Platinum	2,000	2,500	2,700	2,800	2,900	3,000	3,100	3,100	3,200	3,300	3,400	3,400
	Gold	1,600	2,000	2,100	2,100	2,200	2,300	2,300	2,300	2,400	2,400	2,400	2,400
	Silver[2]	700	800	800	800	900	900	900	900	900	900	900	900
	Bronze	600	600	600	600	600	600	500	500	500	500	500	500
Family Coverage[1]	Platinum	8,300	6,200	5,800	5,700	5,600	5,100	5,000	5,100	5,100	5,100	4,900	4,900
	Gold	4,200	3,200	2,900	2,900	2,800	2,500	2,500	2,400	2,400	2,400	2,300	2,300
	Silver[2]	2,700	2,400	2,400	2,400	2,300	2,300	2,300	2,200	2,100	2,100	2,100	2,100
	Bronze	2,400	1,600	1,400	1,300	1,200	1,000	1,000	900	800	800	700	700

[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 unassisted Silver plans.

It is important to note that, because of additional cost-sharing assistance, the plan designs categorized as Silver vary significantly in actuarial value across different income categories. For enrollees in the marketplace that earn between 100 and 150 percent of the Federal Poverty Level (FPL), Silver plans have an actuarial value of 94 percent, the highest of any plan offered in the Marketplace. For enrollees earning between 150 and 200 percent of FPL, Silver plans have an actuarial value of 87 percent, and for enrollees earning between 200 and 250 percent of FPL, Silver plans have a 73 percent actuarial value. H&E estimates the unsubsidized premiums for these high-value Silver plans using the true actuarial value of the plan, rather than the Silver plan price.

Unsubsidized insurance plans, purchased in the Marketplace or directly from an insurer, are similar in design and price to those eligible for subsidies. The ACA requires that all health insurance plans meet certain requirements to certify as qualified coverage.

Paid premiums for Silver plans are project to increase by an average of 33 percent in 2018 as federal payments to insurers that covered the additional cost-sharing requirements were discontinued at the end of 2017. As a result, in many areas Silver premiums are higher than Gold premiums. Table 2 illustrates this disparity, as average Gold premiums for families are lower than average paid Silver premiums beginning in 2023. As seen in Table 3, an additional increase in premiums is expected in 2019 as the penalty for the individual mandate is set to $0.

PLAN CHOICE

H&E assumes an underlying health insurance cost growth of 5 percent throughout the rest of the ten-year window even as premium increases were above 5 percent in 2017 and 2018.[4] Actual year-over-year premium growth estimates vary because of changes in the enrollment mix and other factors. After 2018, premiums in the individual market are projected to grow annually at rates closer to the underlying growth rate of 5 percent. Due to growing applicable

income contribution rates, subsidized premium growth for some plan designs is expected to exceed the underlying health insurance growth rate.

Table 5. Plan Choice Distribution in the Individual Market[1]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Platinum	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gold	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	3%
Silver[2]	61%	61%	60%	59%	58%	56%	55%	53%	53%	52%	51%	50%
Bronze	31%	32%	33%	33%	34%	36%	37%	38%	39%	39%	41%	41%
Catastrophic	4%	4%	4%	4%	4%	4%	4%	4%	5%	5%	5%	5%
Total Enrollment (millions)	**18**	**16**	**16**	**15**	**15**	**14**	**14**	**14**	**13**	**13**	**12**	**12**

[1] The Individual Market refers to the commercial, non-group market and includes sales of insurance within the Marketplace and direct sales by insurers.

[2] Silver plans include plans that receive cost-sharing assistance.

H&E uses the subsidized and unsubsidized Marketplace enrollment in each metal level after the first year to calibrate plan preferences in the individual market and estimate plan choices throughout the ten-year analysis window.

H&E estimates that the large enrollment in Silver plans among subsidized insurance plans in 2018 will give way to higher enrollment in Bronze plans as premiums rise and consumers with less generous subsidy amounts adjust to higher premiums. Most Silver plan enrollment is estimated to be largely comprised of households eligible for extra cost-sharing benefits. As the market grows to include more households that are eligible for premium credits but not cost sharing assistance (earning between 250 and 400 percent of FPL), the distribution of subsidized enrollment among the four metal levels is expected to become less evenly distributed later in the budget window.

Table 6. Plan Choice Distribution in the Health Insurance Marketplace

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Platinum	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gold	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
Silver[2]	75%	72%	71%	70%	69%	67%	66%	65%	64%	64%	62%	62%
Bronze	22%	25%	26%	27%	28%	30%	31%	32%	33%	33%	34%	35%
Total Enrollment (millions)	**10**	**10**	**11**	**11**	**10**	**9**	**9**	**8**	**8**	**7**	**7**	**6**

[1] The Individual Market refers to the commercial, non-group market and includes sales of insurance within the Marketplace and direct sales by insurers.

[2] Silver plans include plans that receive cost-sharing assistance.

Beyond 2018, lower-cost insurance plans are estimated to gain market share, as consumers shift away from more generous plans in response to the steadily rising cost of health insurance. Throughout the budget window, Silver plan enrollment is expected to dominate the marketplace as cost-sharing benefits are only available for Silver plans in the Health Insurance Marketplace. However, as time passes and premiums rise, enrollment in Bronze plans is expected to increase.

BUDGET

H&E estimates how the major health insurance coverage provisions in current law (with regards to the non-elderly population) will impact the federal budget. Budget impact estimates do not include estimates for non-ACA tax expenditures in current law, such as the employer-sponsored health insurance tax expenditure.[5,6]

Table 7. Cost of Current Law Coverage Provisions (billions)[1]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-2028
Source of Funds[2]													
Individual and Employer Mandate Taxes	3	3	0	0	0	0	0	0	0	0	0	0	0
Uses of Funds[3]													
Health Insurance Marketplace													
Cost-Sharing Benefits	8	0	0	0	0	0	0	0	0	0	0	0	0
Premium Tax Credits	48	67	69	71	72	74	74	75	75	75	76	75	737
Medicaid	279	290	301	312	324	337	350	363	377	392	407	423	3,588
Other	60	63	67	70	74	79	83	87	92	97	103	109	862
Subtotal	**395**	**420**	**437**	**454**	**471**	**489**	**507**	**526**	**545**	**565**	**586**	**607**	**5,186**
Net Budgetary Impact[4]	**-392**	**-417**	**-437**	**-454**	**-471**	**-489**	**-507**	**-526**	**-545**	**-565**	**-586**	**-607**	**-5186**

[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.

Medicaid coverage and expenditure estimates are calculated based on the number of states that had chosen to implement Medicaid expansion by January 1, 2018. These predictions are sensitive to future state-level decisions on expansion as well as new program waivers that alter the design of a state's Medicaid program.

Between 2019 and 2028, non-elderly coverage provisions under current law will cost $5.02 trillion, H&E estimates. The ACA introduced a number of taxes that are not directly related to the health insurance coverage of the non-elderly population and are therefore not included in this report. H&E has the capability to calculate the budgetary effects of the individual

mandate; however, there is no tax penalty for the uninsured beginning in 2019, resulting in $46 billion less in source funds from 2019 through 2028. In 2012, The Congressional Budget Office estimated non-coverage provisions of the ACA to reduce the deficit by $1.28 trillion by 2014.[7]

PRODUCTIVITY AND ACCESS

In an effort to shed light on how health care policy and consumer choices affect health care quality, H&E estimates two measures: 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.

The Medical Productivity Index is designed to reflect the expected gains in health status in return for medical expenditures. Plan designs that encourage patients to consider the price of treatment when making health care decisions, such as high deductible plans, are ascribed high MPI scores, while plans with low cost-sharing requirements or first dollar coverage are ascribed low scores. The index ranges from a low of 1.0 to a high of 4.0.

The Provider Access Index is designed to reflect the availability of primary and specialty physicians and facilities. Plans with large networks, such as Platinum plans offered in the individual market, are given high scores for providing exceptional access. Bronze and other low-cost plans that afford access only to limited networks are ascribed low PAI scores. The index ranges from a low of 1.0 to a high of 5.0.[4]

Table 8. Individual Market Medical Productivity Index[1]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Individual Market	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**
Marketplace	2.2	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.4
Other Non-Group Insurance	2.6	2.6	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.8	2.8	2.8

Table 9. Individual Market Provider Access Index[1]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Individual Market	**2.9**	**2.9**	**3.0**	**3.0**	**3.0**	**3.1**	**3.1**	**3.1**	**3.1**	**3.2**	**3.2**	**3.2**
Marketplace	2.6	2.7	2.7	2.7	2.8	2.8	2.8	2.9	2.9	2.9	2.9	2.9
Other Non-Group Insurance	3.3	3.4	3.5	3.5	3.5	3.6	3.6	3.6	3.6	3.7	3.7	3.7

[1] Productivity and access estimates refer only to the Individual Market, Medicaid, and under-65, non-disabled population

CHANGES FROM PREVIOUS BASELINE ESTIMATES

As an organization, H&E is constantly reevaluating the assumptions and technical methods that are used to create baseline and proposed estimates of health insurance coverage provisions under current law. This publication is the seventh comprehensive baseline report, and the fifth to include detailed estimates on the net health-related federal budgetary impact of the ACA and Medicaid policy affecting individuals under 65.

For this baseline, H&E updated the under-65 microsimulation model. Just like the model used in previous estimates, the new under-65 model employs micro-data available through the Medical Expenditure Panel Survey. These data allows H&E to analyze the effects of health policies on the health insurance plan choices of the under-65 population and to interpret the resulting impact on national coverage, average insurance premiums, the federal budget, and the accessibility and efficiency of health care. The updated model applies recent integrated private health insurance choice data that allows H&E to make improved predictions regarding the individual marketplace. While the new data may not result in significant changes in H&E's baseline estimates of the individual market, it will affect the way the model projects future policy.

UNCERTAINTY IN PROJECTIONS

The Center for Health and Economy uses a peer-reviewed micro-simulation model of the health insurance market to analyze various aspects of the health care system.[5] And as with all economic forecasting, H&E estimates are associated with substantial uncertainty. While the estimates provide good indication on the nation's health care outlook, there are a wide range of possible scenarios that can result from policy changes, and current assumptions are unlikely to remain accurate over the course of the next ten years.

Aside from the potential policy changes, premium increases in the individual market are a substantial area of uncertainty in this report. From 2017 to 2018, it was reported by the Centers for Medicare and Medicaid Services that Silver benchmark premiums increased by 37 percent. Accordingly, 2018 premium increases were included in this report, yet double digit year-over-year premium increases were not assumed for any of the subsequent years—largely because of a lack of evidence. Future premium increases at a similar scale as 2018's increases would create major implications for individual market enrollment and federal spending and revenue. Premiums could also decrease if Congress appropriates the funds that the law requires to assist insurers with the burden of offering plans with increased cost-sharing assistance.

H&E projects that the change in the individual mandate penalty in 2019 will lead to modest decreases in enrollment for the Health Insurance Marketplace. However, H&E does not account for any effect of changing the current mandate penalty to $0 on Medicaid enrollment. Medicaid spending is also unaffected as a result.

[1] Center for Medicare and Medicaid Services. First Half of 2017 Average Effectuated Enrollment Report. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-13-2.html

[2] H&E's method for estimating Medicaid enrollment was also part of the under-65 model update. As a result, Medicaid enrollment is higher than in previous baselines, accounting for all of the under-65 Medicaid population with the exception of those that are dually eligible for Medicare and Medicaid.
[3] Accessed at: https://www.hixcompare.org/
[4] Centers for Medicare and Medicaid Services. National Health Expenditure Data. Accessed at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/
[5] The CBO estimates that the tax exclusion for employer sponsored insurance will cost $3.4 trillion over 10 years. See *Distribution of Major Tax Expenditures in the Individual Income Tax System*, Congressional Budget Office, May 2013, at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf
[6] In past baselines, H&E has included various estimates related to the employer sponsored insurance market that included: the excise tax on high cost employer sponsored plans, Medical Productivity in the employer marketplace, and Provider Access in the employer marketplace. These were left out of this baseline do to the update of the under-65 model.
[7] 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