

# The Health Care Choices Proposal

October 2, 2018

In June, the Health Policy Consensus Group released a health care reform plan called “The Health Care Choices Proposal.”<sup>1</sup> The stated purpose of this plan, referred to in this report as the Proposal, is the expansion of choice and lowering of costs. The Proposal’s key feature is a block grant allocated to the states beginning in 2020, giving states resources and authority to design their own programs aimed at making insurance more affordable. All impacts projected in this report are relative to H&E’s March 2018 baseline.<sup>2</sup> As with all projections, the estimates are associated with some degree of uncertainty.

## Key Findings:

- **Premium Impact:** The Proposal is projected to decrease the cost of premiums for private individual market health insurance coverage. Silver plans would see the largest impact, as premiums would decrease by 15 to 32 percent beginning in 2020 relative to the baseline.
- **Coverage Impact:** The Proposal is projected to result in nearly 1 million fewer people purchasing insurance by 2028, with enrollment holding steady earlier in the 10-year window.
- **Medical Productivity Index:** The Proposal would lead to a 12 percent increase in the medical productivity index by 2028.<sup>3</sup>
- **Provider Access Index:** The Proposal would lead to a 20 percent decrease in the provider access index by 2028.<sup>4</sup>
- **Budget Impact:** When the H&E baseline is used to determine the yearly block grant, the Proposal would decrease federal spending by \$22 billion from 2020 to 2028.

## Analysis

This analysis uses 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.

The Proposal’s provisions would take effect on January 1, 2020. Where the Proposal lacks the necessary details, H&E used details found in the H.R. 1628 amendment LYN17744 to make assumptions because of its similarities with the Proposal.<sup>5</sup> The

following provisions from the Proposal and subsequent assumptions are included in this score.

- A single block grant of a fixed amount will be set aside for the states.

**Table 1. Block Grant Amount by Year (Billions)\***

<b>Year</b>	<b>Amount</b>
2020	\$139
2021	\$141
2022	\$144
2023	\$145
2024	\$146
2025	\$147
2026	\$149
2027	\$152
2028	\$153

\*Amounts use H&E's 2018 baseline estimates for the Medicaid expansion population, exchange subsidies, and basic health program.

- The Proposal does not assign allotments for each state, but it does indicate that that early in implementation the allotments will be based on each state's ACA-related spending. Over time, the allotment will be increasingly based on the states' proportion of low-income residents.
- ACA-related spending is any spending related to the individual market (subsidies, basic health program, etc.) and the spending on the Medicaid expansion population.
- In the first year of implementation, the allocation of the block grant is based entirely on the proportion of ACA spending in each state.

Table 2. Allocation Formula of Block Grant

Year	Percent of Block Grant Received
2020	= 2019 proportion of ACA-Related Spending
2021	=90% of 2020 proportion + 10% of low-income proportion
2022	=80% of 2021 proportion + 20% of low-income proportion
2023	=70% of 2022 proportion + 30% of low-income proportion
2024	=60% of 2023 proportion + 40% of low-income proportion
2025	=50% of 2024 proportion + 50% of low-income proportion
2026	=40% of 2025 proportion + 60% of low-income proportion
2027	=30% of 2026 proportion + 70% of low-income proportion
2028	=20% of 2027 proportion + 80% of low-income proportion

- The three-to-one age-based community rating requirement on premiums is removed. All states that did not have age-based community rating prior to the enactment of the ACA were assumed to have a new age-rating of five to one reflecting how health costs vary by age.<sup>6</sup> States that currently have more restrictive age-rating ratios were assumed to retain them.
- The single risk pool requirement for the individual market is removed.
- Individuals receiving subsidies can apply them to any private coverage option of their choice, including short-term, limited-duration insurance (STLDI) plans. H&E assumed these plans are defined, per current federal rules, as having a duration of 364 days.
- A five-percent premium discount for those continuously enrolled in health insurance is implemented in the year 2020.
- The Proposal gives the states a certain amount of freedom in the way block grant funds can be used. H&E made assumptions on how states would use these funds based on the laws in the states at the time of H&E’s March 2018 baseline. Table 3 below illustrates this.
  - It was assumed that states that both have a state exchange and expanded Medicaid under the ACA would seek to retain their current law as much as possible.
  - States that have only expanded Medicaid would seek to retain their Medicaid expansion while utilizing the rest of their block grant funds through a combination of tax credits and reinsurance. While the proposal stipulates that a variety of risk mitigation strategies are eligible for use

with state allotments, the model assumes that all states employ reinsurance as a risk mitigation strategy.

- The ACA tax-credit structure remained in place for each state with a state-based exchange.
- It was assumed that states that did not create an exchange or expand Medicaid would only use their allotment for reinsurance and tax credits.

**Table 3. State Policies as of March 2018 Baseline**

<b>State</b>	<b>State Exchange and Expansion</b>	<b>Medicaid Expansion Only</b>	<b>State Exchange Only</b>	<b>Neither</b>
Alabama				X
Alaska		X		
Arizona		X		
Arkansas		X		
California	X			
Colorado	X			
Connecticut	X			
Delaware		X		
District of Columbia	X			
Florida				X
Georgia				X
Hawaii		X		
Idaho			X	
Illinois		X		
Indiana		X		
Iowa		X		
Kansas				X
Kentucky		X		
Louisiana		X		
Maine		X		
Maryland	X			
Massachusetts	X			
Michigan		X		
Minnesota	X			
Mississippi				X
Missouri				X
Montana		X		
Nebraska				X
Nevada		X		
New Hampshire		X		
New Jersey		X		
New Mexico		X		
New York	X			

North Carolina				X
North Dakota		X		
Ohio		X		
Oklahoma				X
Oregon		X		
Pennsylvania		X		
Rhode Island	X			
South Carolina				X
South Dakota				X
Tennessee				X
Texas				X
Utah				X
Vermont	X			
Virginia				X
Washington	X			
West Virginia		X		
Wisconsin				X
Wyoming				X

- The Proposal states that 50 percent of a state’s allotment must be spent on the population between 50 and 300 percent of the Federal Poverty Level (FPL). For states that do not currently have a state-based exchange, an income-adjusted tax credit was used for consumers between 0 and 150 percent FPL. For consumers above 150 percent FPL, a tax credit adjusted by age and income was provided. It was also assumed that for these states, tax credits could be used on non-Qualified Health Plans.
- The Proposal requires that states use a portion of the block grant for a risk-mitigation program. In accordance with this requirement, a reinsurance program was implemented for every state. H&E assumes that the government would make reinsurance payments to insurers for all the claims per beneficiary incurred above a specific threshold. The threshold would be equal to the 90<sup>th</sup> percentile of beneficiaries ranked by total claims.

## Premium Impact

H&E health insurance premium estimates are based on five plan design categories offered in the individual market exchanges: 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 \$7,350 for an individual under current law. Under current law, catastrophic plans have roughly a 50 percent actuarial value. This report also includes STLDI plans in the catastrophic category, however, so the catastrophic category represents a range of

actuarial values and plan designs. All premium estimates reflect average health insurance prices paid, without regard to federal subsidies.

Table 4 below presents the estimated premiums for each category between 2020 and 2028.

Table 4. Average Annual Premiums in the Individual Market

		2020	2021	2022	2023	2024	2028
Single Coverage	Platinum	7,200	7,400	7,700	7,900	8,200	9,500
	Gold	6,700	6,900	7,100	7,300	7,600	8,700
	Silver <sup>2</sup>	6,300	6,500	6,700	6,900	7,100	8,000
	Bronze	5,900	6,100	6,300	6,600	6,900	7,900
	Catastrophic	3,100	3,100	3,200	3,300	3,300	4,200
Family Coverage <sup>1</sup>	Platinum	14,400	14,800	15,300	15,800	16,300	18,600
	Gold	13,400	13,900	14,300	14,700	15,200	17,300
	Silver <sup>2</sup>	11,900	12,100	12,700	13,100	13,700	15,800
	Bronze	11,400	11,600	11,900	12,200	12,500	14,000
	Catastrophic	6,600	6,700	7,000	7,200	7,500	8,300

<sup>1</sup>Family coverage estimates are based on a family size of four persons.

<sup>2</sup>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 Proposal would eventually lead to lower health insurance premiums in all categories for both single and family coverage relative to the March 2018 baseline projection, with the largest decreases occurring among Silver plans.

The decrease in premiums is expected to be the result of many things. Current law mandates that insurers offer a Silver plan with reduced cost-sharing for consumers with incomes at or below 250 percent of the federal poverty level. In exchange for offering plans with reduced cost-sharing, insurers were to receive cost-sharing reduction payments (CSRs) from the federal government to ease the burden of providing extra benefits; they are currently not receiving CSRs, however, resulting in upward pressure on premiums (especially Silver premiums). Reintroducing CSRs or removing the requirement on insurers to sell plans with cost-sharing reductions would lead to significant downward pressure on Silver premiums.<sup>7</sup> H&E assumes that states either fund CSRs to benchmark Silver plans or remove the requirement to offer Silver plans with CSRs.

Under current law, health insurance plans are only able to alter rates 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 insuring 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 Proposal is projected to lower average premiums compared with current law when states loosen these restrictions.

H&E estimates reinsurance would also relieve upward pressure on premiums. The proposal requires states to use a portion of their allotment to establish a risk-mitigation program (e.g., high-risk pools, “invisible” high-risk pools, risk adjustment, reinsurance). Reinsurance, for example, would provide payments to insurers that enroll high-cost beneficiaries, thereby offsetting some of the risk that insurers take on for enrolling such beneficiaries. In this analysis, it is assumed that states would establish reinsurance programs through which insurers would receive payments for the costs they incur for beneficiaries in the 90<sup>th</sup> percentile of expenses. H&E expects this reinsurance to be another provision that puts downward pressure on premiums for states.

The introduction of STLDI plans would also affect premiums.<sup>8</sup> As STLDI plans pull younger and healthier consumers out of traditional health insurance plans, they would bifurcate the marketplace, putting upward pressure on the premiums of other plans as insurers seek to mitigate the costs of a less healthy risk pool. The premium effects of STLDI plans would be marginal, however, as the loosening of age bands, reinsurance, and tax credits reduce the cost of traditional insurance, thus making STLDI plans less appealing.

Table 5. Change in Average Premiums in the Individual Market

		2020	2021	2022	2023	2024	2028
Single Coverage	Platinum	-15%	-16%	-15%	-17%	-16%	-16%
	Gold	-12%	-14%	-14%	-15%	-16%	-17%
	Silver <sup>2</sup>	-15%	-17%	-18%	-19%	-20%	-24%
	Bronze	-1%	-2%	-2%	-1%	-1%	-2%
	Catastrophic	-2%	-3%	-6%	-8%	-11%	-7%
Family Coverage <sup>1</sup>	Platinum	-16%	-16%	-16%	-17%	-17%	-18%
	Gold	-19%	-20%	-20%	-21%	-21%	-23%
	Silver <sup>2</sup>	-27%	-30%	-29%	-30%	-30%	-32%
	Bronze	-18%	-19%	-20%	-20%	-20%	-22%
	Catastrophic	-1%	-6%	-5%	-8%	-7%	-14%

<sup>1</sup>Family coverage estimates are based on a family size of four persons.

<sup>2</sup>Silver plans offered to low income households receive cost-sharing benefits that alter the effective premium relative to un-assisted Silver plans.

## Coverage Impact

H&E insurance coverage estimates reflect health insurance choices for the under-65 population. H&E estimates that the Proposal would result in slight decreases in the insured population, with less than one million fewer insured in the year 2028 relative to the March 2018 baseline projection. Table 6 below shows the overall projected insurance levels.



**Table 6. Health Insurance Coverage (Millions)**

	2020	2021	2022	2023	2024	2028
Individual Market*	17	16	16	16	16	15
Health Insurance Marketplace	10	10	9	9	9	8
Other Non-Group Insurance	7	7	7	6	6	6
Employer Sponsored Insurance	156	157	157	158	158	160
Medicaid	66	66	66	66	67	67
Other Public Insurance <sup>1</sup>	5	5	5	5	5	5
<b>Total Non-Elderly Population</b>	<b>277</b>	<b>278</b>	<b>279</b>	<b>280</b>	<b>280</b>	<b>284</b>
<b>Total Insured<sup>2</sup></b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>246</b>
<b>Uninsured<sup>2</sup></b>	<b>33</b>	<b>33</b>	<b>34</b>	<b>34</b>	<b>35</b>	<b>37</b>
<b>Percent Uninsured</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>	<b>13%</b>

<sup>1</sup> Other Public Insurance includes under-65 Medicare enrollment.

<sup>2</sup> 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 projected decrease in the number of insured individuals is primarily a result of a decrease in Medicaid enrollment of 2 million in 2028, largely because of funding constraints created by the block grant and the transition of the block grant allotments to being based on the share of the population between 50 and 300 percent FPL. The decrease in Medicaid enrollment would be mostly offset by increases in enrollment in the individual market. H&E expects a large increase in catastrophic coverage, as consumers could use tax credits to that end and could also purchase cheaper, STLDI plans. These changes combined with lower overall premium decreases would lead to 2 million more enrolled in the non-group marketplace by 2028.

Table 7. Change in Coverage Estimates (Millions)

	2020	2021	2022	2023	2024	2028
Individual Market	2	2	2	2	1	2
Health Insurance Marketplace	*	*	*	*	*	*
Other Non-Group Insurance	2	2	2	2	1	2
Employer Sponsored Insurance	*	*	*	*	*	*
Medicaid	-2	-2	-2	-2	-2	-2
Other Public Insurance	*	*	*	*	*	*
<b>Total Insured in March 2018</b>						
<b>Baseline<sup>1</sup></b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>246</b>
<b>Total Insured with the Proposal<sup>1,2</sup></b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>245</b>	<b>246</b>

<sup>1</sup> All insurance coverage estimates refer only to the under-65 population.

<sup>2</sup> Differences of enrollment between 0 and 1 million may not appear due to rounding. For example, the Proposal's enrollment in 2028 is 245.6 and rounds to 246 while the Baseline's enrollment in 2028 is 246.4 and rounds to 246.

\* Difference between baseline estimates is between 0 and 1 million.

## 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 (i.e. efficiency) and access scores to the range of plan designs available and then using the changes in plan choices to project the evolution of health care quality. These scores are provided in Tables 8 and 9 below.

Table 8. Medical Productivity Index

	2020	2021	2022	2023	2024	2028
<b>Individual Market</b>	<b>2.7</b>	<b>2.7</b>	<b>2.7</b>	<b>2.7</b>	<b>2.8</b>	<b>2.8</b>
Marketplace	2.6	2.6	2.6	2.7	2.7	2.8
Other Non-Group Insurance	2.8	2.8	2.8	2.8	2.9	2.9

<sup>1</sup> Productivity and access estimates refer only to the Individual Market, Medicaid, and under-65, non-disabled populations.

Table 9. Provider Access Index

	2020	2021	2022	2023	2024	2028
<b>Individual Market</b>	<b>2.5</b>	<b>2.5</b>	<b>2.5</b>	<b>2.5</b>	<b>2.5</b>	<b>2.6</b>
Marketplace	2.4	2.4	2.5	2.5	2.5	2.5
Other Non-Group Insurance	2.7	2.7	2.7	2.7	2.7	2.7

<sup>1</sup> Productivity and access estimates refer only to the Individual Market, Medicaid, and under-65, non-disabled populations.

H&E expects the medical productivity index to increase relative to the March 2018 baseline projection as a result of the Proposal, as Table 10 below demonstrates. The ability for consumers to use subsidies to enroll in catastrophic plans would substantially increase enrollment in those plans. H&E projects that a higher proportion of consumers would purchase higher cost-sharing plans, which drive higher medical productivity. By 2028, the medical productivity index would increase by 12 percent relative to conditions under current law.

Simultaneously, H&E expects the provider access index to decrease as a result of the regulation changes. Many consumers would switch to catastrophic and STLDI plans, which have a lower actuarial value. The higher cost sharing of lower actuarial value plans means that consumers have less incentive to access health care. Both of these characteristics lead to a lower provider access index, broadly defined as the ability (due to cost or other insurance-driven factors) of patients to seek out desired doctors and specialists. A 20 percent decrease in the provider access index is expected by 2028, as Table 11 shows.

Table 10. Medical Productivity Index

	2020	2021	2022	2023	2024	2028
<b>Individual Market</b>	<b>11%</b>	<b>11%</b>	<b>11%</b>	<b>11%</b>	<b>12%</b>	<b>12%</b>
Marketplace	12%	14%	14%	15%	16%	17%
Other Non-Group Insurance	5%	5%	5%	5%	4%	4%

<sup>1</sup> Productivity and access estimates refer only to the Individual Market, Medicaid, and under-65, non-disabled populations.

Table 11. Provider Access Index

	2020	2021	2022	2023	2024	2028
<b>Individual Market</b>	<b>-18%</b>	<b>-18%</b>	<b>-19%</b>	<b>-19%</b>	<b>-19%</b>	<b>-20%</b>
Marketplace	-12%	-11%	-13%	-13%	-13%	-14%
Other Non-Group Insurance	-23%	-24%	-24%	-25%	-25%	-27%

<sup>1</sup> Productivity and access estimates refer only to the Individual Market, Medicaid, and under-65, non-disabled populations.

## Budgetary Impact

H&E projects that the Proposal would lead to a net increase in the budget surplus of \$22 billion dollars relative to the current H&E baseline from 2020 to 2028. While the block grant to the states is meant to be budget neutral, H&E expects actual state spending to be less than the block grant as a result of state caution and the difficulty involved in making enrollment projections. The decrease in Medicaid enrollment discussed above would lead to decreases in Medicaid spending, which further decreases net spending relative to H&E’s March 2018 baseline.

Table 12. Change in Budgetary Impact Estimates Relative to March 2018 Baseline (Billions)<sup>1</sup>

	2020	2021	2022	2023	2024	2028	2010- 2028
<b>Change in Sources of Funds Baseline Estimates<sup>2</sup></b>							
Individual and Employer Mandate Taxes	0	0	0	0	0	0	0
<b>Subtotal</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Change in Uses of Funds Baseline Estimates<sup>3</sup></b>							
Cost-Sharing Benefits	1	1	1	1	1	1	6
Premium Tax Credits	7	8	2	2	1	-1	21
Reinsurance	11	10	11	11	11	11	99
Medicaid	-23	-21	-19	-16	-15	-12	-148
Other	*	*	*	*	*	*	*
<b>Subtotal</b>	<b>-5</b>	<b>-1</b>	<b>-4</b>	<b>-2</b>	<b>-2</b>	<b>-2</b>	<b>-22</b>
<b>Change in Budgetary Impact<sup>4</sup></b>	<b>5</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>22</b>

<sup>1</sup> Cost estimates refer only for the under-65 population and are relative to H&E's March 2018 baseline.

<sup>2</sup> Positive values denote increases in revenue; negative values denote decreases in revenue.

<sup>3</sup> Positive values denote increases in spending; negative values denote decreases in spending.

<sup>4</sup> Positive values denote surplus; negative values denote deficit.

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

It should be noted that the example allotment amounts used in this analysis are based on H&E spending projections, thus resulting in significant budgetary impacts. This is discussed further in the “Uncertainty in Projections” section below.

## 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.<sup>5</sup> As with all economic forecasting, H&E estimates are associated with substantial uncertainty. While the estimates provide a 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. The Proposal presents many unique challenges that produces substantial uncertainty.

The most significant source of uncertainty stems from state behavior. For simplicity, and based on past behavior, H&E assumed four different state scenarios, but presumably states would employ a wider range of policy combinations. As the number of possible policies implemented at the state level are various, so are the number of possible outcomes, as it is likely that states implement their policies with varying levels of success. For example, the Proposal states that a portion of the block grant money must be used to offset the costs of high-risk individuals. H&E assumed that each state would implement a reinsurance program to this end, but states could also seek to achieve the same goal through the use of high-risk pools, risk corridors, or some other risk-mitigation mechanism.

H&E did not make assumptions about whether states would craft policies that would require additional state funding. It is possible that states would use their own funds to supplement the block grant in order to implement the non-group market policies they design. Some states did so before the ACA, and some currently are pursuing this avenue with various proposed and approved 1332 waivers.<sup>9</sup> It is likely that states that choose to do this would further decrease premiums and increase enrollment.

The block grant amount is another source of uncertainty. The Proposal uses current projections of ACA-related spending in order to budget the next ten years of the block grant. Presumably, Congress would use the baseline estimates of the Congressional Budget Office (CBO) in order to set the budget. H&E makes different assumptions in its baseline, however, that would lead to significantly less federal funding for state block grant spending.<sup>10</sup> This report presents the scenario where H&E's baseline estimates of ACA spending are used to budget the block grant amounts. The main reason for using the H&E baseline is that the Proposal seeks to be budget neutral by matching the block grant amount with projected spending. If CBO's current baseline were to be used for this report, the Proposal would increase spending relative to H&E's baseline and enrollment levels would likely be higher under such a scenario.

Aside from the assumptions made with regard to the block grant amount, the Proposal would likely be implemented under a future CBO baseline that differs from CBO's current baseline. The block grant amounts for such proposal would be a moving target until the time of its implementation.

The Proposal also includes the administration's final rule on STLDIs. The largest source of uncertainty with regard to STLDIs stems from state behavior. Currently six states have laws in place that would negate the effects of the proposed rule in their states. It is possible that other states would follow suit, and more regulations at the state level could further suppress STLDI enrollment, which would have implications for marketplace premiums and enrollment. A more thorough discussion of the uncertainties surrounding STLDI's can be found at [healthandeconomy.org](http://healthandeconomy.org).<sup>6</sup>

Finally, the national effects on premiums are a substantial source of uncertainty. As discussed above, many policy assumptions in this report combine to put significant

downward pressure on premiums. The magnitude of the premium changes, however, is largely determined by state-specific policy decisions. H&E's assumptions on age-based community rating, premium discounts for continuously enrolled individuals, and reinsurance programs are all likely to differ from state to state with various premium effects. Also, states with poorly written and implemented policies could produce premium increases relative to current law.

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<sup>1</sup> [https://galen.org/assets/Consensus\\_Group\\_HealthCareChoicesProposal-2.pdf](https://galen.org/assets/Consensus_Group_HealthCareChoicesProposal-2.pdf)

<sup>2</sup> <http://healthandeconomy.org/health-and-economy-baseline-estimates-6/>

<sup>3</sup> <http://dev-health-economy.pantheonsite.io/models/medical-productivity-index/>

<sup>4</sup> <http://dev-health-economy.pantheonsite.io/models/provider-access-index/>

<sup>5</sup> <https://www.cassidy.senate.gov/imo/media/doc/LYN17752.pdf>

<sup>6</sup> [https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health\\_Insurance\\_Premiums.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf)

<sup>7</sup> <http://healthandeconomy.org/reinsurance-and-cost-sharing-reductions-estimates/>

<sup>8</sup> <http://healthandeconomy.org/the-proposed-modifications-to-short-term-limited-duration-insurance-plans/>

<sup>9</sup> A list of these waivers can be found at: [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section\\_1332\\_State\\_Innovation\\_Waivers-.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html)

<sup>10</sup> H&E does not assume Medicaid expansion take-up by the states in its baseline. Therefore, Medicaid spending and enrollment projected by H&E is noticeably less than that of CBO, roughly \$160 billion over the ten-year budget window.