Center for Health and Economy

Healthcare Reform to Make America Great Again

July 7, 2016

Presidential candidate Donald Trump has released a plan on his website to replace the Affordable Care Act (ACA).[1] The replacement, referred to in this report as the Proposal, would remove barriers to allow the sale of health insurance across state lines, and permit households to deduct premiums from their taxable income, among other changes. 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 coverage, provider access, medical productivity, and the federal budget.

A key aspect of the Proposal is adjusting existing laws impeding sale of health insurance across state lines. The effects of such an adjustment will vary greatly depending on the details; unfortunately, the Proposal is vague on the specifics of this provision. The central estimates in this report reflect a moderate approach to promoting the sale of insurance across state lines, and as such reflect moderate reductions in premiums due to the provision. The sensitivity of these results will be discussed in greater detail later in this report. More generally, the impacts of the Proposal are associated with some degree of uncertainty. A summary of our findings is as follows:

KEY FINDINGS:

- **Coverage Impact:** The Proposal is projected to lead to 18 million fewer insured individuals in 2017 relative to the current baseline, with the decrease in enrollment due to the repeal of the ACA along with the premium tax credits and Medicaid expansion that came with it. By 2026, this number is expected to be 13 million fewer than under current law.
- **Premium Impact:** The Proposal is projected to decrease the total premium cost of private health insurance coverage, with the largest impact on Silver, Gold, and catastrophic coverage plans.
- **Medical Productivity:** Under the Proposal, medical productivity is projected to increase by 2 percent by the year 2026 relative to the current baseline.
- **Provider Access:** Provider access under the Proposal is projected to increase by 11 percent by 2026 relative to the current baseline.
- **Budget Impact:** Compared to current law, the Proposal is estimated to decrease the federal deficit by $583 billion between 2017 and 2026.

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 Proposal, which is scored in this report as taking effect on January 1, 2017, is a plan to repeal and replace the ACA. However, many provisions that the ACA implemented would not be replaced with something comparable by the Proposal. Also, many provisions in the Proposal would not have any effect on H&E's scoring, or are not scoreable using the H&E model. Included among those that do not affect the score are provisions on health savings accounts, requirements of price transparency for health care providers, and drug importation. The following provisions are those included in the Proposal that were scoreable by H&E:

- The Affordable Care Act is fully repealed.
- Individual states' regulatory structures rewind to pre-ACA regulations. States that had guaranteed issue and community rating regulations on insurance without the ACA will still have those regulations.
- Individuals are allowed to fully deduct health insurance premium payments from their tax returns.
- Barriers preventing the sale of insurance across state lines are removed, allowing consumers in the Individual Market to purchase out-of-state insurance.
- Medicaid funding to the states is block-granted. For modeling purposes, H&E assumes historical Medicaid spending as the base amount of the block grant.

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.

H&E estimates that the Proposal 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.

Table 1. Average Premiums in the Individual Market under the Proposal

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

[1]Family coverage estimates are based on a family size of four people.

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 Proposal 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 Proposal 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. 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 Proposal.

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.

The Proposal also suggests removing barriers that impede the sale of health insurance across state lines. While the Proposal remains unclear about the mechanisms that will be used to create interstate insurance sales, H&E's assumptions of what this might look like are discussed below. Whatever policy is implemented to create this type of marketplace, H&E expects the interstate sale of insurance to have some sort of downward effect on premiums to varying degrees ranging from minimal to significant effects. Our estimates in this study reflect a scenario where such policies would exert noticeable downward pressure on premiums.

Table 2. Percent Change in Premiums From Current Law

		2017	2018	2019	2020	2021	2026
Single Coverage	Platinum	-23%	-24%	-24%	-25%	-25%	-28%
	Gold	-22%	-23%	-24%	-27%	-27%	-32%
	Silver	-21%	-22%	-24%	-27%	-26%	-32%
	Bronze	-20%	-22%	-25%	-24%	-23%	-24%
	Catastrophic	-28%	-26%	-30%	-29%	-29%	-32%
Family Coverage[1]	Platinum	-26%	-26%	-27%	-28%	-28%	-31%
	Gold	-28%	-28%	-30%	-31%	-31%	-36%
	Silver	-28%	-30%	-30%	-32%	-33%	-37%
	Bronze	-29%	-30%	-31%	-31%	-30%	-30%
	Catastrophic	-27%	-24%	-24%	-24%	-24%	-24%

[1]Family coverage estimates are based on a family size of four people.

The net effect of these provisions is to decrease the average insurance premiums in all categories between 24 and 37 percent relative to current law by 2026. 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.[3] H&E estimates that the Proposal will lead to an additional 13 million uninsured individuals in 2026, relative to baseline estimates.

Under the ACA, premium subsidies declining with income are made available to households that earn between 100 and 400 percent of the Federal Poverty Level (FPL) for the aid in purchasing health insurance. The subsidies are based on a formula that allows a household to purchase a medium PPO plan—a Silver plan—for a specified percent of their income.

Table 3. Health Insurance Coverage Under the Proposal (millions)[1]

	2017	2018	2019	2020	2021	2022	2026
Individual Market	34	34	33	32	32	31	30
Employer Sponsored Insurance	145	145	146	146	146	147	146
Medicaid	33	33	33	34	34	34	35
Other Public Insurance[2]	11	12	12	13	13	14	17
Total Population[3]	**273**	**274**	**275**	**277**	**278**	**280**	**285**
Total Insured[3]	**223**	**224**	**224**	**225**	**225**	**226**	**227**
Uninsured	**49**	**50**	**51**	**52**	**53**	**54**	**58**

Table 4. Change in Insurance Coverage Under the Proposal (millions)[1]

	2017	2018	2019	2020	2021	2022	2026
Individual Market	-2	1	1	1	3	3	3
Employer Sponsored Insurance	-1	-1	0	0	1	1	3
Medicaid	-18	-18	-18	-18	-18	-18	-18
Other Public Insurance[2]	1	1	0	1	0	1	1
Total Insured[3]	**-18**	**-16**	**-16**	**-14**	**-14**	**-13**	**-13**

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

[2]Estimates of Other Public Insurance includes Medicare for disabled individuals

[3]Total enrolment estimates may not equal the sum of all other enrollment due to rounding.

The ACA's subsidy structure would not be replaced by the Proposal; however, it would allow individuals that buy insurance in the Individual Marketplace to deduct their insurance premiums from their taxes. This provision along with repealing the regulatory burden of the ACA would allow more households to have the option of purchasing catastrophic health plans. This is also reflected in higher enrollment in the Individual Marketplace.

H&E estimates that the Proposal will lead to a slight decrease in enrollment in employer sponsored insurance. While the Proposal eliminates 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.

Medicaid enrollment is also projected to decrease, mainly due to the repeal of the ACA and the Medicaid expansion that comes with it. Some losses in Medicaid enrollment are also expected due to the block-granting of Medicaid.

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. Medical Productivity Index Under the Proposal[1]

	2017	2018	2019	2020	2021	2026
Individual Market	2.5	2.5	2.5	2.5	2.5	2.5
Employer Sponsored Insurance	2.3	2.3	2.4	2.4	2.4	2.5
Private Insurance	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**	**2.5**
Medicaid	1.5	1.5	1.5	1.5	1.5	1.5
Total Insured	**2.2**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**

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

H&E expects medical productivity to slightly increase under the Proposal. The marginal shift from beneficiaries in employer sponsored plans and public insurance 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 patients. These gains are bolstered by high deductible enrollment in the Individual Market.

Table 6. Provider Access Index Under the Proposal[1]

	2017	2018	2019	2020	2021	2026
Individual Market	3.2	3.2	3.2	3.2	3.2	3.1
Employer Sponsored Insurance	3.8	3.8	3.8	3.8	3.8	3.7
Private Insurance	**3.7**	**3.7**	**3.7**	**3.7**	**3.7**	**3.7**
Medicaid	1.0	1.0	1.0	1.0	1.0	1.0
Total Insured	**3.2**	**3.2**	**3.2**	**3.2**	**3.2**	**3.1**

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

Under the Proposal, average provider access is projected to increase relative to current law due to an increase of enrollment in catastrophic coverage plans that commonly offer a wide choice of providers relative to plans with lower cost-sharing but narrow networks. The decrease in Medicaid enrollment under the Proposal also contributes to the net increase in average provider access.

Table 7. Change in Medical Productivity Under the Proposal[4]

	2017	2018	2019	2020	2021	2026
Individual Market	4%	13%	13%	9%	9%	5%
Employer Sponsored Insurance	1%	2%	-2%	-1%	0%	-3%
Private Insurance	**2%**	**3%**	**3%**	**-1%**	**0%**	**-1%**
Medicaid	0%	0%	0%	0%	0%	0%
Total Insured	**7%**	**7%**	**8%**	**3%**	**4%**	**2%**

Table 8. Change in Provider Access Under the Proposal[4]

	2017	2018	2019	2020	2021	2026
Individual Market	7%	18%	23%	22%	27%	48%
Employer Sponsored Insurance	0%	-1%	-1%	2%	2%	4%
Private Insurance	**0%**	**3%**	**3%**	**2%**	**2%**	**4%**
Medicaid	0%	0%	0%	0%	0%	0%
Total Insured	**8%**	**8%**	**8%**	**11%**	**11%**	**11%**

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

Budget Impact

In its analysis of the Proposal'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 Proposal—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.

Table 9. Budgetary Impact of the Proposal (billions)[1]

	2017	2018	2019	2020	2021	2026	10-Year Total
Sources of Funds[2]							
Tax on Employer Sponsored Health Insurance	0	0	0	-19	-20	-16	-132
Individual and Employer Mandate Taxes	-11	-13	-15	-17	-19	-37	-219
Loss of Individual Market Tax Revenue	-45	-43	-41	-40	-38	-31	-377
Subtotal	**-56**	**-57**	**-57**	**-76**	**-77**	**-84**	**-728**
Uses of Funds[3]							
Cost Sharing Benefits	-15	-14	-14	-13	-12	-5	-105
Premium Tax Credits	-77	-79	-81	-81	-82	-93	-835
Medicaid	-47	-47	-48	-47	-48	-53	-488
Other Public Health Insurance	17	8	8	9	10	18	121
Subtotal	**-122**	**-132**	**-134**	**-132**	**-131**	**-133**	**-1,307**
Net Budgetary Impact	**-67**	**-76**	**-77**	**-58**	**-55**	**-49**	**-583**

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

[2]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.

[3]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.

H&E projects that the insurance coverage provisions of the Proposal will reduce the budget deficit by $583 billion 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 Proposal 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 household's 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.

H&E projects that the Proposal will lead to a gross reduction in Sources of Funds of $728 billion. The Proposal repeals the employer and individual mandates of the ACA without replacing them with any similar tax penalty, resulting in a cost of $219 billion from 2017

to 2026. The Proposal also repeals the excise tax on employer sponsored health plans from the ACA. H&E estimates that the repeal of the excise tax will cost $132 billion in revenue from 2017-2026, a net decrease of $351 billion relative to the current baseline. Since the Proposal also allows individuals to deduct the cost of insurance premiums from their taxes, H&E expects there to be a significant loss in revenue. H&E estimates that this provision will result in a decrease of $377 billion in revenue from 2017-2026.

With the Proposal's repeal of the ACA, premium tax credits, cost sharing reductions, and the Medicaid expansion are repealed along with it. Since none of these provisions are replaced, over the 10-year budget window of 2017 to 2026, the Proposal will lead to a gross decrease in Uses of Funds of $1.3 trillion. As a result of the elimination of premium tax credits and cost sharing reductions, H&E expects a decrease in the Uses of Funds of $940 billion from 2017-2026. Along with the repeal of the Medicaid expansion, H&E expects that block-granting Medicaid in the states will lead to additional savings. H&E projects that the cumulative decrease in use of Medicaid funds will be $488 billion from 2017-2026.

Uncertainty in H&E Projections

As with all forecasting, H&E estimates are associated with substantial uncertainty. While our estimates provide good indication on the nation's health care outlook, it is unlikely that the policy environment will remain unchanged throughout our ten-year analysis period. 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.

Interstate Sale of Insurance

One portion of this analysis that is particularly sensitive to uncertainty is our examination of the Proposal's plan to adjust existing laws impeding sale of health insurance across state lines. Since there is substantial uncertainty about the magnitude of the effects of such a plan, the minimum and maximum effects that such a plan's regulatory structure may have on premiums and uninsured were considered.

Currently individual states can decide whether or not to allow insurers to sell plans from another state in their state. However, even where this is allowed, various barriers such as the difficulty of building a network and attracting enough customers to create a large enough risk pool make it unappealing to insurers to pursue this option. It was assumed for this analysis that the Proposal would remove the state's ability to block the entry of out-of-state plans into the local insurance market, or require out-of-state plans to meet any state requirements.

Table 10 and Table 11 represent the enrollment impact for the maximum and the minimum premium effects of an interstate regulatory structure. Table 10 represents the

enrollment in the scenario where premiums were the cheapest while Table 11 represents the enrollment in the scenario where premiums are the most expensive.[4]

Table 10. Insurance Coverage Under the Proposal in the Case of Maximum Premium Impact (millions)[1]

	2017	2018	2019	2020	2021	2022	2026
Individual Market	2	4	5	5	7	7	7
Employer Sponsored Insurance	-2	-2	-2	-1	-1	-1	-1
Medicaid	-18	-18	-18	-18	-18	-18	-18
Other Public Insurance	1	0	0	0	0	1	1
Total Insured[2]	**-17**	**-15**	**-15**	**-14**	**-12**	**-11**	**-11**

Table 11. Insurance Coverage Under the Proposal in the Case of Minimum Premium Impact (millions)[1]

	2017	2018	2019	2020	2021	2022	2026
Individual Market	-4	-1	-1	0	1	2	1
Employer Sponsored Insurance	1	1	1	2	2	2	3
Medicaid	-18	-18	-18	-18	-18	-18	-18
Other Public Insurance	2	1	1	1	1	1	1
Total Insured[2]	**-19**	**-17**	**-17**	**-16**	**-15**	**-13**	**-14**

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

[2]Total enrollment estimates may not equal the sum of all other enrollment due to rounding.

In general, as premiums go down, more people are insured through the Individual Market; however, much of the enrollment gained in the Individual Market is due to people opting to forgo employer sponsored insurance coverage for a cheaper plan in the Individual Market. Also, regardless of the effects on premiums, the change in Medicaid enrollment remains virtually unchanged throughout the simulation.

There are many different issues with the scenarios considered, the first of which would be implementation. Regulatory conflicts between the state where the policy holder resides and the state where they are buying their insurance would need to be resolved. Networks would also need to be developed in states where the "exported" plan would be sold; furthermore, jurisdictional issues regarding legal disputes between in-state residents and out-of-state insurers would likely need to be addressed by Congress and the Federal courts.

After implementation, the effect that such a scenario may have on premiums is unclear. The cost of health care varies across different regions of the country in ways that may not

be related to the insurance market. As an "exported" plan is sold in various areas, it is possible that the rates of that plan may increase to deal with the cost of insuring people in more expensive markets. These types of variables are not accounted for in the score above.

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[1] Healthcare Reform to Make America Great Again. (n.d.). Retrieved June 21, 2016, from https://www.donaldjtrump.com/positions/healthcare-reform

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

[3] 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.

[4] Parente, S., Feldman, R., Abraham, J.M., and Xu, Wendy. "Consumer Response to a National Marketplace for Individual Insurance". Journal of Risk and Insurance, Volume 78, Issue 2, pages 389–411, June 2011.