The American Health Care Act

April 21, 2017

On March 16th, the House Budget Committee passed the American Health Care Act (AHCA). The AHCA, referred to in this paper as "the bill," replaces portions of the Affordable Care Act (ACA) through budget reconciliation. Some of the key provisions include an age adjusted tax credit available to consumers in the individual market, federal funds to help with consumer cost sharing on the individual market, and per capita caps for Medicaid or a state option to block grant Medicaid.[1,2] This report details the findings of the Center for Health and Economy (H&E) analysis – relying heavily on its Under-65 Microsimulation Model – of the proposal's impact on health insurance coverage, provider access, medical productivity, and the federal budget. All impacts projected in this report are relative to H&E's April 2017 baseline.[3] As with all projections, the estimates are associated with some degree of uncertainty. The summary of our findings is as follows.

KEY FINDINGS:

- **Premium Impact:** The AHCA is projected to decrease the premium cost of private individual market health insurance coverage, with the largest impact on Silver, Gold, and Bronze coverage plans.
- **Coverage Impact:** The AHCA is projected to lead to 10 million more insured individuals in 2020 relative to the current law baseline. By 2027, this number is expected be 3 million more than current law.
- **Medical Productivity:** Under the AHCA, medical productivity is projected to increase by 5 percent by the year 2027 relative to the current baseline.
- **Provider Access:** Provider access under the bill is projected to increase by 11 percent by 2027 relative to the current baseline.
- **Budget Impact:** H&E does not undertake a comprehensive federal budget analysis. Compared to the H&E baseline, those provisions in the bill considered by this analysis are estimated to contribute $246 billion to larger federal deficits between 2017 and 2027.

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.[4]

The bill's provisions would take effect in a staggered manner with some starting immediately upon passage, and others coming into effect throughout a transition period. All provisions would be in effect by January 1, 2020. The following provisions from the bill and subsequent assumptions are included in this score:

o Individuals and families who are not offered employer sponsored insurance are eligible for an age-adjusted premium tax credit, increased annually by Consumer Price Index (CPI) inflation plus one percentage point. The following table shows the tax credit values:

Table 1. Assumed Annual Premium Tax Credits Under the Bill

Age	Credit
29 and under	$2,000
30 to 39	$2,500
40 to 49	$3,000
50 to 59	$3,500
60 and over	$4,000

o Tax credits are advanceable and refundable.
o Tax credits are available in the full amount to single filers with incomes of $75,000 and under ($150,000 for joint filers). Tax credits are reduced for households with incomes above those thresholds by 10 percent of the difference of their income and corresponding thresholds.
o If the premium of a plan purchased in the individual market is less than the tax credit, then the difference is rescinded.
o HSA contribution limits are increased to reflect plan deductibles and max out-of-pocket.
o 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 with the exception of states with more unique rating restrictions.
o Continuous coverage protections instituted so that anyone with a qualifying life event would not be medically underwritten according to pre-existing conditions. Those who do not maintain continuous coverage will be charged a 30 percent surcharge on their premiums for 12 months after reentering the individual market.
o Income threshold for determining Medical Care Deduction reduced from 10 percent to 5.8 percent.
o The Essential Health Benefits (EHB) requirement ends in 2019.
o The excise tax on high-cost employer sponsored health insurance is delayed until 2025.
o A Patient and State Stability Fund will provide funds to the states from 2018 through 2026 totaling $115 billion. It is assumed that a portion of these funds go to creating an invisible high risk pool.
o $10 billion in safety net funding is provided to the states from 2018 through 2022.

- o Medicaid is transitioned to a per capita allotment beginning in the year 2020. States have the option to receive the money in the form of a block grant. This analysis assumes all states receive the per capita allotment.
- o After 2020, new Medicaid expansion enrollees are no longer eligible to receive the enhanced FMAP.

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 $7,150 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 bill 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

		2018	2019	2020	2021	2022	2027
Single Coverage	Platinum	$6,200	$7,000	$6,700	$7,000	$7,400	$9,600
	Gold	$4,900	$5,300	$5,200	$5,400	$5,700	$7,800
	Silver[2]	$4,700	$4,900	-	-	-	-
	Silver	$3,700	$4,200	$4,000	$4,200	$4,400	$5,700
	Bronze	$3,300	$3,800	$3,200	$3,200	$3,300	$3,700
	Catastrophic	$2,200	$2,400	$2,300	$2,300	$2,400	$2,700
Family Coverage[1]	Platinum	$27,500	$29,100	$26,500	$27,900	$29,400	$38,400
	Gold	$20,800	$22,000	$20,100	$21,200	$22,400	$31,300
	Silver[2]	$18,200	$19,300	-	-	-	-
	Silver	$15,400	$16,400	$16,200	$17,100	$18,000	$23,400
	Bronze	$13,300	$13,700	$13,500	$13,800	$14,200	$16,000
	Catastrophic	$7,600	$8,300	$9,400	$9,800	$10,000	$11,300

[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 bill will eventually lead to lower health insurance premiums in most plan categories for both single and family coverage. The primary policy mechanism that influences health insurance premiums is the repeal of actuarial rating restrictions.

H&E expects upward pressure on premiums as a result of repealing the individual mandate. The AHCA's continuous coverage provision is meant to replace the individual mandate, however, H&E does not expect this provision to offset the projected increase because of the inclusion of the 30 percent surcharge for previously unenrolled individuals.

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 bill is projected to lower average premiums compared with current law by loosening these restrictions.

There are certain states with individual market age-related regulations that are unique to the state and also have a direct impact on premiums. This analysis assumes those states retain their state-specific regulations. New York and Vermont retain their 1:1 age-rating ratio, and Massachusetts retains its 2:1 age-rating ratio.

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 so that a person with low expected medical costs have the option to buy less generous, lower-premium plans. 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.

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 AHCA also provides a Patient and State Stability Fund that is meant to promote more stable risk pools, and also gives CMS the ability to set up an invisible high risk pool.[5] States are given freedom to use the money as they see fit to lower premiums and encourage Individual Market enrollment. In this analysis, H&E assumed that the bulk of the fund would be used to help with the creation of an invisible high risk pool while remaining funds would be allocated to consumer cost-sharing for anyone between 100 and 150 percent FPL, similar to the cost sharing benefits available through the ACA. The use of both of these mechanisms resulted in increased downward pressure on premiums, especially the allocation of funds to high risk individuals. The assumption of supplemental cost-sharing is particularly uncertain because the bill gives states a certain degree of freedom to use different mechanisms that suit their needs. A couple of these mechanisms are discussed below.

Table 3. Average Premiums in the Individual Market

		2018	2019	2020	2021	2022	2027
Single Coverage	Platinum	-5%	1%	-9%	-10%	-11%	-13%
	Gold	-6%	-5%	-12%	-13%	-14%	-12%
	Silver[2]	-6%	-8%	-	-	-	-
	Silver	-5%	0%	-9%	-11%	-10%	-14%
	Bronze	-3%	9%	-11%	-14%	-15%	-18%
	Catastrophic	5%	-4%	-12%	-12%	-11%	-13%
Family Coverage[1]	Platinum	-5%	-7%	-21%	-22%	-23%	-25%
	Gold	-8%	-9%	-21%	-22%	-22%	-18%
	Silver[2]	-9%	-9%	-	-	-	-
	Silver	-9%	-9%	-16%	-16%	-17%	-19%
	Bronze	-8%	-9%	-12%	-13%	-13%	-15%
	Catastrophic	6%	-1%	8%	10%	9%	6%

[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.

Coverage Impact

H&E insurance coverage estimates reflect health insurance choices for the under-65 population. H&E estimates that the AHCA will lead to 10 million more insured individuals in 2020 and 3 million more insured individuals by 2027. Under the bill, the

2027 uninsured rate among the under-65 population will be 20 percent—a slight drop from the projected uninsured rate of 21 percent under current law.

The principle reason for the increased coverage is lower premiums and greater coverage flexibility in the Individual Market. The bill adjusts the ACA's premium subsidy structure for age beginning in 2019. And then, in 2020, the ACA's subsidies are completely phased out and replaced by an age-adjusted tax credit. Individual Market enrollment is also buoyed by the $115 billion through the Patient and State Stability Fund.

Table 4. Health Insurance Coverage (millions)

	2018	2019	2020	2021	2022	2027
Individual Market	24	25	40	39	39	35
Health Insurance Marketplace	12	17	0	0	0	0
Other Non-group Insurance	12	8	40	39	39	35
Employer Sponsored Insurance	145	145	145	145	145	144
Medicaid	51	51	48	46	43	37
Other Public Insurance[2]	11	11	10	11	12	14
Total Non-Elderly Population	**274**	**275**	**277**	**278**	**280**	**287**
Total Insured[1]	**231**	**232**	**243**	**241**	**239**	**231**
Uninsured[1]	**43**	**43**	**34**	**37**	**41**	**56**
Uninsured Rate	**16%**	**16%**	**12%**	**13%**	**15%**	**20%**

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

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

The increase in individual market enrollment is partially offset by decreases in Medicaid enrollment. In 2020, the bill transitions Medicaid funding to a per capita cap and removes the enhanced FMAP for any Medicaid expansion enrollees above 100 percent of federal poverty level (FPL) —those already enrolled at the higher match will be grandfathered in as long as they maintain continuous Medicaid coverage. By 2027, H&E expects Medicaid enrollment to decrease by 18 million relative to current law. This decrease largely comes as states adjust for decreased federal funding due to new enrollees being ineligible for the enhanced FMAP.

By 2027, 35 million people are expected to have insurance in the individual market—17 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 bill redefines qualified health plans (QHP) the tax credits provided by the bill may be used to purchase a wider range of health plans that leads to an increase in coverage. For example, under the bill, 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 QHPs that meet the Essential Health Benefits prescribed. As a result of the bill's increased tax credit eligibility and lower premiums in the Individual Market, H&E expects to see a slight drop in consumers that obtain insurance through their employer.

Table 5. Change in Coverage Estimates (millions)

	2018	2019	2020	2021	2022	2027
Individual Market	1	2	19	19	19	17
Health Insurance Marketplace	1	6	-10	-10	-9	-7
Other Non-group Insurance	*	-4	29	29	28	24
Employer Sponsored Insurance	-1	-1	-1	-1	*	*
Medicaid	-1	-1	-5	-7	-10	-18
Other Public Insurance	*	1	-1	-1	*	2
April 2017 Baseline[1]	**232**	**232**	**231**	**230**	**229**	**228**
AHCA	**231**	**232**	**243**	**241**	**239**	**230**

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

* 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 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.

Table 6. Medical Productivity Index

	2018	2019	2020	2021	2022	2023	2027
Individual Market	2.1	2.3	2.8	2.9	2.9	3.0	3.2
Employer Sponsored Insurance	2.3	2.3	2.4	2.4	2.4	2.4	2.6
Private Insurance	**2.3**	**2.3**	**2.5**	**2.5**	**2.5**	**2.5**	**2.7**
Medicaid	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total Insured[1]	**2.1**	**2.1**	**2.2**	**2.3**	**2.3**	**2.3**	**2.5**

Table 7. Provider Access Index

	2018	2019	2020	2021	2022	2023	2027
Individual Market	2.6	2.5	3.1	3.1	3.2	3.2	3.3
Employer Sponsored Insurance	3.9	3.9	3.9	3.9	3.9	3.9	3.8
Private Insurance	**3.7**	**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	1.0
Total Insured[1]	**3.0**	**3.0**	**3.1**	**3.1**	**3.1**	**3.2**	**3.1**

H&E expects medical productivity to ultimately increase as a result of the bill. 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. By 2027, the total change Medical productivity is expected to increase by 5 percent relative to current law.

Under the AHCA, average provider access is projected to increase relative to current law by 11 percent in 2027 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 AHCA'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.

Table 8. Change in Medical Productivity Index

	2018	2019	2020	2021	2022	2027
Individual Market	-8%	-16%	-18%	-4%	18%	16%
Employer Sponsored Insurance	1%	1%	-3%	-2%	-2%	-2%
Private Insurance	**-1%**	**-2%**	**2%**	**-1%**	**1%**	**2%**
Medicaid	0%	0%	0%	0%	0%	0%
Total Insured[1]	**1%**	**-4%**	**-5%**	**-3%**	**2%**	**5%**

Table 9. Change in Provider Access

	2018	2019	2020	2021	2022	2027
Individual Market	-19%	-15%	-13%	-6%	17%	41%
Employer Sponsored Insurance	-1%	-1%	5%	5%	4%	5%
Private Insurance	**-3%**	**-1%**	**3%**	**3%**	**6%**	**8%**
Medicaid	0%	0%	0%	0%	0%	0%
Total Insured[1]	**-4%**	**-4%**	**1%**	**1%**	**3%**	**11%**

Budget Impact

H&E does not attempt a comprehensive budgetary analysis. In its analysis of the bill'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 AHCA—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 and for which, therefore, budgetary impact is not addressed.

It projects that those provisions of the AHCA included in the analysis will lead to a net increase in the budget deficit of $246 billion dollars relative to the current H&E baseline over the next decade. H&E estimates that the AHCA will lead to a gross reduction in sources of funds of $260 billion. The bill repeals both the individual and employer mandates without replacing them without any similar tax penalty, which H&E estimates will cost $156 billion over the next decade. The bill also delays the implementation of the excise tax on high cost employer sponsored insurance, which leads to a $104 billion loss in revenue.

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	0	0	-18	-20	-3	-104
Individual and Employer Mandate Taxes	-4	-8	-9	-11	-12	-29	-156
Subtotal	**-4**	**-8**	**-9**	**-29**	**-32**	**-32**	**-260**
Change in Uses of Funds Baseline Estimates[3]							
Cost Sharing Benefits/ Stability Fund	0	14	14	-5	-4	-3	3
Premium Tax Credits	0	*	14	81	78	60	508
Medicaid	0	-5	-95	-39	-48	-91	-582
Other Public Insurance	0	8	9	-12	-7	15	53
Safety Net Funding	0	2	2	2	2	0	10
Subtotal	**0**	**18**	**-57**	**27**	**21**	**-19**	**-8**
April 2017 Baseline	**-333**	**-347**	**-358**	**-348**	**-357**	**-404**	**-3,659**
AHCA	**-337**	**-371**	**-308**	**-402**	**-408**	**-416**	**-3,905**
Net Budgetary Impact[4]	**-4**	**-24**	**48**	**-56**	**-53**	**-12**	**-246**

[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 AHCA will lead to a gross decrease in uses of funds of $8 billion. The bill includes three new sources of spending: the universal premium tax credits, the Patient and State Stability Fund, and Safety Net Funding for the states. In Table 10, Safety Net Funding for the states is the only category broken out, as the other two are comparable to the ACA's premium subsidies and cost sharing reductions. The Safety Net Funding is set to last five years and $10 billion is allocated for it. Through the implementation of the per-capita cap and the repeal of the enhanced FMAP, the AHCA stands to reduce Medicaid spending by roughly $582 billion relative to the H&E baseline.

Notably, the H&E baseline assumes that there are no additional states that would take up the Medicaid expansion available under the ACA.

The AHCA and the ACA both implement premium tax credits to help insure people in the Individual Market. The AHCA's tax credits are available to all who are not offered employer sponsored insurance or eligible for public assistance, therefore H&E expects a wider take up of the bill's tax credits to lead to an increase in spending of $508 billion relative to current law. The AHCA also provides funding to the states through the Patient and State Stability Fund. $115 billion is allocated for the year 2018 through 2026. Despite it ending in 2016, the fund is expected to spend $3 billion more than the ACA's cost sharing benefits.

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. In this analysis, there are a few pieces related to individual states' reactions that merit particular attention.

First, as noted above, AHCA does not allow for states to receive the enhanced federal funding for new Medicaid expansion population enrollees starting in 2020. H&E expects many states to react to this decrease in funding by curbing Medicaid eligibility. For example, one state could decrease the threshold to 80 percent FPL while another state may only reduce their eligibility threshold to 110 percent FPL. To account for this, H&E assumed that as states curb eligibility, the national average FPL threshold would decrease to 91 percent. In this analysis, H&E assumed a transition period of five years beginning in 2020. It is important to point out these assumptions as budget and coverage numbers are sensitive to them. For example, if more states retain higher levels of Medicaid eligibility or if states react at a slower rate to the AHCA than assumed, there would likely be less Medicaid savings and more enrollment.

One more provision of the bill that is subject to uncertainty with regard to state behavior is the implementation of the Patient and State Stability Fund. States are given a certain degree of freedom to use the money as they see fit to lower premiums and encourage Individual Market enrollment. In this analysis, H&E assumed that the states might use excess funds to help with consumer cost-sharing for anyone between 100 and 150 percent FPL, similar to the cost sharing benefits available through the ACA. However, it is not likely that all states adopt this strategy, and as strategies for the funding vary, the speed and magnitude of effects on coverage and premiums are likely to vary also. A state could decide to use this funding cover individuals through a traditional high-risk pool or could set up a stop-loss program to help insurers stabilize premiums in the state. These are just

a few among a bevy of options available to the states for the use of this money and each has the potential to impact savings, enrollment, and premiums in various ways.

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[1] The text of the AHCA can be found at https://budget.house.gov/uploadedfiles/black_016_xml.pdf
[2] At the time of the release of this analysis, it was reported that a possible amendment is forthcoming. This analysis only reflects those amendments accepted by the House Rules Committee as of April 20, 2016.
[3] http://healthandeconomy.org/health-and-economy-baseline-estimates-5/
[4] More information on the H&E Under-65 Microsimulation Model can be found at http://healthandeconomy.org/models/under-65-microsimulation/
[5] Invisible High Risk Pools (IHRPs) are a risk-spreading mechanism that is a combination of reinsurance and a traditional high risk pool. Like a traditional high risk pool, IHRPs target an expensive population. Unlike a traditional high risk pool, the expensive population is not separated from the rest of the insurance pool. Like reinsurance, IHRP funding pays insurers for medical expenses over a certain threshold. But unlike reinsurance, only the targeted population can trigger the extra funding of the IHRP. Insurers are not helped by IHRP funding for any beneficiary not targeted for the risk pool regardless of their claims.