Appendix

Evaluating the CARE Act: Implications of a Proposal to Repeal and Replace the Affordable Care Act

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Overview of COMPARE

We used the COMPARE microsimulation model to estimate how the Affordable Care Act (ACA) and the Patient CARE Act would affect health insurance enrollment, individual market premiums, federal spending, individual out-of-pocket spending, and several other outcomes. A complete description of the methods underlying COMPARE can be found in Cordova et al. (2013). Briefly, we create a synthetic population of individuals, families, health expenditures, and firms using data from the April 2010 cross-section of the 2008 Survey of Income and Program Participation (SIPP), the 2010 and 2011 Medical Expenditure Panel Survey (MEPS), and the 2010 Kaiser Family Foundation Annual Survey of Employer Benefits. These datasets are linked together using statistical matching on key demographic characteristics, such as self-reported health status and income. We assign each individual in the SIPP a spending amount using the spending of a similar individual from the MEPS; we then augment spending imputations with data on aggregate spending levels from the National Health Expenditures Accounts (NHEA), as well as data on high-cost claims from the Society of Actuaries (SOA). The NHEA adjustment accounts for the fact that the MEPS underestimates total medical spending levels, while the SOA adjustment corrects the underrepresentation of individuals with high spending in the MEPS data.

We calibrate COMPARE to approximate the pre-ACA health insurance market that existed in 2010 as a basis for estimating the impact of health reforms, including the ACA and the Patient CARE Act. Calibration is a process by which we adjust the algorithms in the model so that estimates of pre-ACA health insurance enrollment and premiums match actual health insurance enrollment data collected before the provisions of the law took effect. We calibrate the model to reflect enrollment data by insurance type, age group, income group, and self-reported health status from the SIPP, with additional adjustment to account for pre-ACA individual market enrollment levels reported to the Centers for Medicare and Medicaid Services (CMS) as

part of regulatory requirements. We simulate coverage denial rates based on market survey data from America's Health Insurance Plans. In addition, we calibrate the model to match average premiums observed in the pre-ACA individual market, according to data from the Kaiser Family Foundation. We developed pre-ACA individual market premium schedules using age rate bands based on pre-ACA premium data from eHealthInsurance.com. According to these data, 64-year-olds in good health were charged approximately 3.75 times what 21-year-olds were charged under pre-ACA rating regimes averaged across all states. We also incorporate a health status factor of 2.25 into the model, which allows insurers in pre-ACA scenarios to charge people in poor or fair health (according to their self-reported health status) up to 2.25 times as much as people in excellent or very good health. Hence, under pre-ACA rules, an older, unhealthy individual in our model could have been charged up to 8.4 times what a young healthy individual was charged.

A key feature of the model is that premiums are calculated dynamically. Premiums in the model are computed endogenously using the imputed expenditure of modeled enrollees. Individuals sort into health insurance plans by choosing their preferred option. Next, premiums are recalculated based on the profile of the enrolled pool. If premiums are too high, some enrollees will opt to drop an insurance option, while if premiums are low, additional individuals may enroll. This iterative process continues until the model achieves equilibrium, defined such that premiums and enrollment decisions are sufficiently stable between model iterations. The model can detect a "death spiral" if enrollment approaches zero while premiums rise to a very large number. A "death spiral" is an extreme manifestation of adverse selection, in which younger and healthier enrollees may respond to high premiums by dropping out of the risk pool, leaving older and sicker enrollees who have higher medical spending in the pool.

Below, we describe how we use COMPARE to model the ACA. We then describe the changes that we implemented to model the Patient CARE Act.

Approach to Modeling the Affordable Care Act

To model individual and family health insurance enrollment decisions under the ACA, COMPARE uses a utility maximization approach, in which decision-makers weigh the costs and benefits of available options. The utility-maximization framework accounts for the tax penalty

for not purchasing insurance, the value of health care consumption, premium costs, expected out-of-pocket health care spending, and financial risk associated with out-of-pocket spending. We scale each of these components of utility to dollars and assume that they are additively separable, following Goldman, Buchanan, and Keeler (2000). We further assume that individuals' utilities are separable in consumption and health. The health-related component of the utility function is modeled as follows:

$$(1) \qquad U_{ij} = u(H_{ij}) - \mathrm{E}[OOP_{ij}] - p^{(H)}{}_{ij} - \frac{1}{2} r\mathrm{VAR}[OOP_{ij}] - penalty_j$$

where $u(H_{ij})$ is the utility associated with consuming health care services for individual i under insurance option j, OOP_{ij} is the out-of-pocket spending expected, $p^{(H)}$ is the premium and r is the coefficient of risk aversion. Possible health insurance enrollment choices (j) under the ACA may include employer coverage, Medicaid or CHIP, an ACA-compliant individual market plan (including plans available on and off the Marketplaces), or another source of coverage.[1] Individuals can also choose to forego insurance. Not all individuals will have access to all forms of coverage. For example, access to Medicaid is contingent on eligibility, and individuals will only have access to employer coverage if they (or their spouse or parent) works for a business that offers insurance.

The penalty term represents the penalty associated with insurance status j, and is 0 for all but the uninsured insurance status. We assume that consumers will pay the full amount of the penalty if they do not have insurance. The CBO, in contrast, assumes there will be some level of non-enforcement (Auerbach et al., 2010). At the same time, the CBO also assumes that some individuals will enroll in insurance out of a "taste" for complying with the law. The CBO's assumptions about enforcement reduce the likelihood that individuals will enroll in insurance, while the assumptions about a taste for compliance increase the likelihood of enrollment. We make neither assumption, in part because the two assumptions influence enrollment in opposite directions, and the magnitudes of the effects are uncertain.

Specific modeling strategies for each source of coverage j are given below:

[1] Other sources of coverage include Medicare for the nonelderly with qualifying conditions and military-related sources of coverage such as TRICARE.

Small Group Employer Coverage: Small employers in the model choose whether to offer coverage based on workers preferences and a small set of other factors including industry and whether workers are unionized. Under the ACA, all small firms are part of a single risk pool with guaranteed issue, 3-to-1 rate banding on age, and restrictions that preclude insurers from charging different premiums to different groups other than based on geography, family size, tobacco use status, and the generosity of the plan. Initially, these regulations apply only to firms with fewer than 50 employees, but the cap rises to 100 employees in 2016. Small firms in the model are permitted to purchase a 60 percent, 70 percent, 80 percent or 90 percent actuarial value plan on the ACA's regulated small group market, which includes the Small Business Health Insurance Options (SHOP) marketplaces. Small firms in the model may retain grandfathered status, which exempts them from the ACA's rating regulations, although we assume that a certain percentage of small firms will lose grandfathered status each year.

The ACA also offers a small business tax credit to small firms with low-wage workers who obtain coverage through the SHOP marketplaces. Because firms can take advantage of these credits for only 2 years, we assume all small firms will have exhausted their tax credit eligibility by 2018 (the year modeled in this analysis).

Large Group Employer Coverage: Like small employers, large employers choose whether to offer coverage based on worker preferences and several other characteristics including union status and industry. We allow large firms that offer coverage to choose between four different plans, which are distinguished by plan generosity and rated based on enrollees' expected health expenditures. We estimate premiums for the large group market based on a regression The firm's decision to offer is modeled using structural econometric techniques; more details are provided in the appendix of Eibner et al. (2011).

Medicaid: We model state Medicaid expansion decisions as of June 22, 2015 (Kaiser Family Foundation, 2015). We assume that, under the ACA, states with Medicaid eligibility thresholds that exceed 138 percent of the federal poverty level roll back their Medicaid eligibility thresholds to 138 percent FPL due to federally-funded tax credits and cost sharing subsidies that become available to this group. In states that did not expand Medicaid, individuals who would have qualified for Medicaid expansion and have income above the federal poverty line can obtain tax credits on the marketplaces. However, those with incomes below the federal poverty

line are ineligible for tax credits. Through our calibration process (described in more above), the model accounts for the fact that not all Medicaid-eligible individuals chose to enroll, perhaps due to stigma, lack of information, or transaction costs associated with enrolling.

Individual Market: Under the ACA, the individual market consists of two components: (1) the insurance marketplaces where individual can receive tax credits, (2) off-marketplace plans that comply with the ACA's rating requirements. We do not account for transitional plans in this analysis because we are modeling outcomes for 2018 (and transitional plans are only available through October 1, 2017). Because the ACA requires all plans in the individual market to be rated together, we model on- and off-marketplace plans that are ACA-compliant as a single risk pool. Hence, we do not distinguish between enrollment in on-marketplace plans and in off-marketplace plans that comply with the ACA. In the ACA-compliant individual market, modeled individuals and families can purchase plans with a 60 percent, 70 percent, 80 percent, or 90 percent actuarial value corresponding to bronze, silver, gold, and platinum plans on the marketplaces. We do not model catastrophic plans, which are available only to those who are under 30 or who qualify for a hardship exemption from the individual mandate. According to a 2015 fact sheet published by the Centers for Medicare and Medicaid Services (CMS), less than 1 percent of all marketplace enrollees have selected catastrophic coverage (Centers for Medicare & Medicaid Services, 2015a).

ACA-compliant individual market premiums are calculated endogenously in the model based on the health expenditure profile of those who choose to enroll. The total, unsubsidized premium is based on enrollees' age, smoking status, and the market rating reforms implemented under the ACA (Centers for Medicare & Medicaid Services, 2015b). We model 3-to-1 rate banding on age for adults ages 21 and over, with a separate age-band for children and young adults under the age of 21. We also account for the ACA's risk adjustment requirements, which transfer funds from plans with lower than average actuarial risk to plans with higher than average actuarial risk. We found that COMPARE, which uses average enrollee spending to compute premiums, slightly overestimated premiums relative to prices actually reported in the marketplaces for 2015. These differences may be due to factors that influence premiums but cannot be modeled, such as cross-subsidization among an insurer's plans, competitive market forces between insurers, and imprecise insurer forecasting. To account for this issue, we apply a

ratio adjustment to modeled premiums based on the ratio of actual-to-modeled premiums in 2015.

Under the ACA, the actual premium that an enrollee pays is adjusted to account for tax credits available to qualifying individuals with incomes between 100 and 400 percent of the federal poverty level (FPL) who do not have affordable offers of insurance from another source (e.g., employer coverage, Medicaid). We apply the ACA's subsidy formula using the benchmark silver premium and the individual's income. Eligible individuals who have income between 100 and 250 percent of the FPL can also receive cost-sharing subsidies (CSRs) that help to lower out-of-pocket spending. As required in the ACA, individuals receiving CSRs in COMPARE must purchase a silver plan (70 percent actuarial value), and out-of-pocket spending is reduced to what it would be under a 94 percent, 87 percent, or 73 percent actuarial value plan if the individual's income is between 100 and 150 percent, 150 and 200 percent, or 200 and 250 percent of FPL, respectively. Note that out-of-pocket spending enters the individual's utility function, and hence individuals receiving CSRs are more likely to purchase coverage.

Approach to modeling the CARE Act

The CARE Act, written by Senator Richard Burr (R-NC), Senator Orrin Hatch (R-UT), and Representative Fred Upton (R-MI), calls for repealing the ACA and replacing it with a combination of alternative reforms. Below we list the major reforms and note which ones are modeled in this report.

Modeled in our analysis

- **Replacing the ACA's 3:1 age rating requirement, now in effect in the small group and individual health insurance markets, with a 5:1 age rating requirement**. The ACA's 3:1 age band requires that insurance companies can charge older individuals no more than three times the premium charged to a young adult. Under the CARE Act, older adults can be charged up to five times as much as young adults.
- **Creating a "continuous coverage" provision.** The ACA requires health insurers to offer plans to all willing buyers in the individual and small group markets, and prohibits insurers from charging different premiums based on health status and gender. Such rating

requirements could discourage consumers from enrolling in insurance until they have an expensive health condition, leading to high premiums (because enrollees would be disproportionately sick and expensive). To guard against such delays in enrollment, the ACA instituted an "individual mandate" requiring most people to obtain insurance or pay a tax penalty. The CARE Act repeals the ACA's individual mandate, and requires that insurers offer coverage at standard rates to all applicants who have maintained continuous insurance coverage. The CARE Act would allow a one-time open enrollment period during which all individuals would be eligible to purchase insurance at standard rates. After this time period, insurers would be free to charge higher premiums or deny coverage to individuals who had not maintained continuous enrollment. In theory, the continuous enrollment provisions serve a similar function as the individual mandate, creating an incentive for people to enroll even if they are healthy and currently anticipate low health spending.

- **New tax credits for small business workers and low-income individuals.** The CARE Act establishes tax credits that vary by age for individuals with incomes below 300 percent of the federal poverty level. People are eligible for these credits if they work for small business, or if they lack access to other health insurance and do not work for a large business. Those with incomes below 200 percent of the FPL are eligible for the full credit, and the value of the credit declines as income rises from 200 to 300 percent of the FPL. Those with incomes over 300 percent of FPL are not eligible for the credit.
- **High risk pools.** The CARE Act enables states to set up high-risk insurance pools for patients with costly conditions. These pools would be eligible for targeted federal funding, although the amount and details of this funding arrangement are not specified in the proposal.
- **Capped allotment for Medicaid.** Federal Medicaid funding under the CARE Act would be based on federal costs as estimated for 2010 (assuming no Medicaid expansion), with adjustments for inflation, demographic characteristics such as health status and age, and other population characteristics. While states would have the flexibility to use this funding in a variety of ways, the proposal does not provide details on the exact parameters that states would need to adhere to (such as whether there are limits on patient cost sharing, or whether states could make changes to eligibility limits).

- **Medical malpractice reform.** The proposal includes several medical malpractice reforms, including capping non-economic damage awards and limiting attorney's fees.
- **Capping the employer tax exclusion.** Historically, employer (and often employee) spending on health insurance has been excluded from employees' taxable income. Critics have argued that this exclusion distorts the health insurance market by encouraging workers and firms to choose high cost health plans with relatively generous benefits. The ACA attempted to address this issue by imposing an excise tax, commonly known as the "Cadillac tax," on insurance plans with premiums exceeding $10,000 for an individual or $27,500 for a family. However, this change has been delayed, and will not take effect until 2020. While the CARE Act would repeal this excise tax, the proposal would treat total employer premium spending in excess of $12,000 for single-coverage and $30,000 for family-coverage as taxable income.
- **Autoenrollment.** States would be permitted to automatically enroll individuals who are eligible for tax credits into health insurance plans. Individuals automatically assigned to plans would be free to drop out if they wished.
- **Repeal of ACA's Revenue Generating Provisions.** Because the CARE Act would repeal the ACA, it would eliminate many of the revenue-generating provisions in the law, including the section 9010 tax on group health insurers, an excise tax on indoor tanning services, a medical device excise tax, a fee on branded prescription drugs, the Patient Centered Outcomes Institute (PCORI) research fee, and several other taxes and fees. One exception to the broad-based repeal of revenue-generating provisions is that the CARE Act retains the ACA's Medicare reforms. These reforms include reductions in and changes to payment rates for many Medicare services, and have been scored by the CBO as deficit-reducing.

Not modeled in our analysis

- **Small business health plans and interstate compacts.** The CARE act allows small businesses to group together to negotiate insurance contracts. In addition, the proposal would allow states to negotiate interstate compacts, which would enable consumers to shop for insurance across state lines.

- **Reauthorization of Health Opportunity Accounts.** This provision would reauthorize a demonstration program that allowed states to change the Medicaid benefits package, while simultaneously allowing enrollees to establish a health savings account that that could be funded with federal and state contributions.
- **Targeted expansions of consumer-directed health care.** The CARE act relaxes certain restrictions on flexible spending accounts (FSAs), health savings accounts (HSAs), health reimbursement arrangements (HRAs), and Archer Medical Savings Accounts (MSAs). In general, these changes expand access to these accounts to a broader groups of people, and enable the accounts to be used for a larger number of services (e.g., for over-the-counter medications).
- **Transparency in health care.** The CARE Act would require insurers to report covered benefits, including drugs and services covered, plan limitations and restrictions, processes for appealing claims denials, and provider participation lists. Hospitals would be required to report amounts paid by insured and uninsured patients, and details about their charity care policies. States with Medicaid grants would also be incentivized to publicly report hospital charges, and to provide individuals with information about estimated out-of-pocket costs.

Our modeling focused on the provisions that were likely to have the biggest effects on enrollment, coverage, and spending, and those which were explained in sufficient detail to enable us to model. A challenge that we faced, however, was that because there is not yet legislative language for the proposal, in many cases the specific details of how policies would be implemented was unclear. To address this issue, we have made assumptions and, in many cases, conducted sensitivity analyses to understand whether these assumptions have a meaningful impact on results.

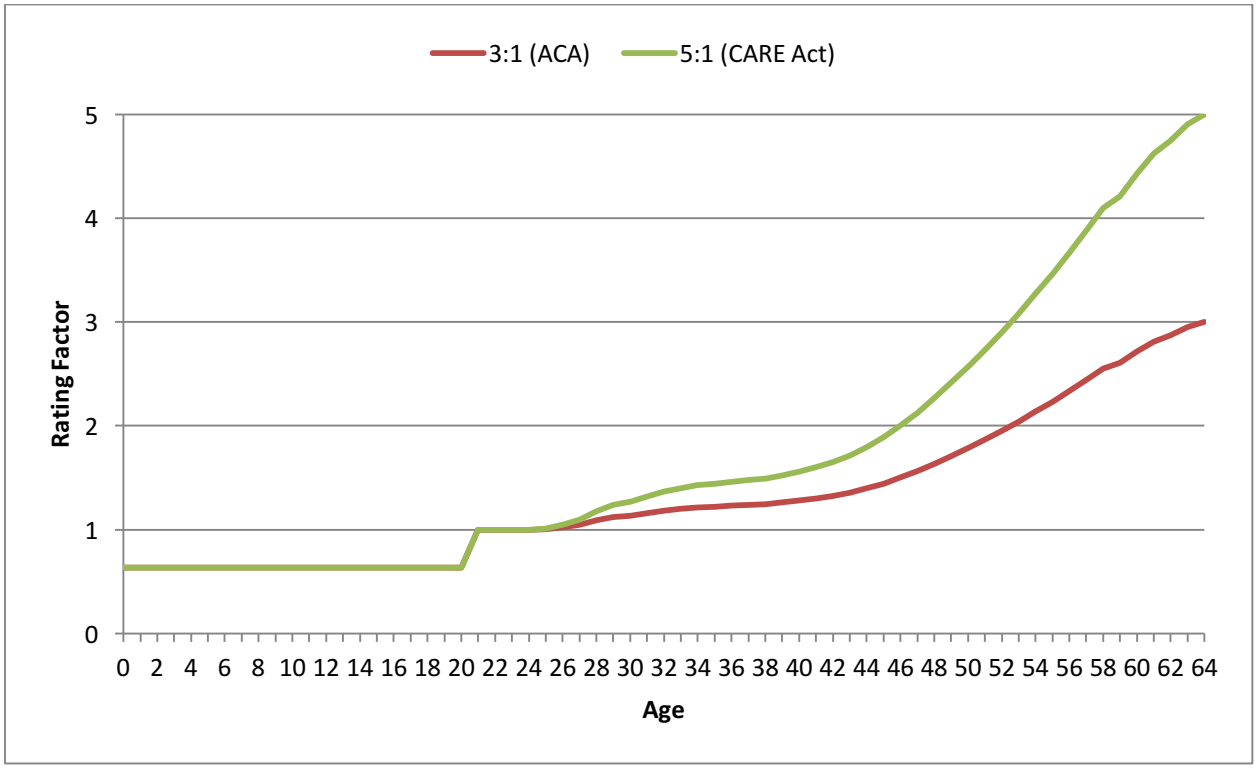
Below, we describe our methodological approach to address the reforms that we included in our analysis. We then briefly discuss the unmodeled reforms. In the final section of the appendix, we present results from our sensitivity analyses.

CARE Act Provisions Modeled in this Report

5:1 Age Rating

Under the ACA, insurers can charge a 64-year-old up to three times as much as a 21-year-old, a policy known as 3-to-1 rate banding. To implement this policy, CMS has suggested a default rating curve that increases with age, as shown by the red curve in Figure A.1 (Centers for Medicare & Medicaid Services, 2013). Under the CMS default curve, premiums are held constant for 21- to 24-year-olds, and then gradually increase with age. The rating factor indicates the multiple of the premium for a 21-year-old that is charged for a given age. For instance, a 40-year-old has a rating factor of 1.278, and hence is charged a premium that is 1.278 times the premium for a 21-year-old. A 64-year-old has a rating factor of 3, implying a premium that is three times as much as the premium for a 21-year-old. Individuals under age 21 are charged only 63.5 percent of the premium that a 21-year-old is charged. Hence, if children are included, premiums can vary by a factor of 4.7 across the full age distribution. The CARE Act relaxes the ACA's rating band so that a 64-year-old can be charged as much as five times what a 21-year-old is charged.

Figure A.1. Age Rating Curves



Notes: The 3-to-1 rating curve is based on the curve proposed by CMS, and the 5-to-1 rating curve is derived by the authors, using equation 2 described below.

The CMS default rating curve was developed by the Center for Consumer Information and Insurance Oversight (CCIIO) Office of the Actuary in consultation with the National Association of Insurance Commissioners (see 78 FR 13405).[2] The ACA allows states to tighten the age rating bands (and propose adjustments to the rating curve to CMS), but states cannot relax the bands. For example, Massachusetts uses a 2 to 1 rate band (i.e., a 64-year-old can be charged up to two times as much as a 21-year-old).

To model the rate band, we first compute the average spending level in the risk pool and apply an administrative loading factor to obtain the average enrollee premium. In the baseline ACA scenario, we use the weights of the enrolled population and the rating factors on the red curve of Figure 1 to calculate premiums by age to model 3-to-1 rate banding. The final premium

[2] Available at: https://www.federalregister.gov/articles/2013/02/27/2013-04335/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review#h-19

schedule satisfies two conditions: (1) 3-to-1 rate banding and (2) the linear combination of the population weights and the premium schedule equals the average enrollee premium.

In the CARE Act scenario, we relax the rate banding to 5-to-1 as depicted by the green curve in Figure 1. The rating factors from the default ACA rating curve are scaled using the following formula:

$$5\ to\ 1\ rating\ factor = \left(2\times(3{:}1\ rating\ factor)\right) - 1 \quad (2)$$

Hence, for a 40-year-old, the rating factor increases from 1.278 to 1.556 under 5-to-1 rate banding. For a 64-year-old the rating factor increases from 3 from 5. We continue to assume that children and young adults under the age of 21 will be charged 63.5 percent of the premium charged to a 21-year-old under 5-to-1 rate banding. The formula in equation 1 is designed to preserve the general shape of CMS's standard default rating curve, while steepening the gradient so that a 64-year-old is now charged five times as much as a 21-year-old.

Continuous Coverage Provision

As an alternative to the individual mandate, which would be repealed under the proposal, the CARE Act enacts a "continuous coverage" provision to motivate individuals to enroll in insurance even if they are healthy. The CARE Act allows for a one-time open enrollment period, during which time all individuals would be eligible to enroll in coverage at standard rates that vary only by age and place of residence. Individuals would maintain eligibility to enroll at standard rates in the future, as long as they have been continuously enrolled in coverage for at least 18 months without a significant break. Insurers would not be able to deny coverage, fail to renew policies, upcharge based on health status, or exclude pre-existing conditions from coverage for the population that maintains continuous enrollment.

Those who do not enroll during the one-time open enrollment period, or who fail to maintain continuous coverage, could face denial or higher plan premiums if they attempt to enroll in the future. In theory, the possibility of facing higher premiums or coverage denial should motivate some individuals to enroll in coverage even if they are currently healthy and anticipate low medical bills. To account for the continuous coverage provision, we modify the

penalty calculation in the COMPARE utility function (shown in equation 1) using the following equation:

$$(3) \quad \text{Penalty}=(1/(1+d))*\text{Prob}(\text{Sick}_{t+1})*[(1-\delta)(\text{Premium}_{u(t+1)}-\text{Premium}_{s(t+1)})+ \delta *(E[Util_{\text{sick,nongroup}(t+1)}]-E[Util_{\text{sick,uninsured}(t+1)}])]$$

Where d is the discount rate, $\text{Prob}(\text{Sick}_{t+1})$ is the probability that the individual transitions to fair or poor health status between year t and year t+1, δ is the probability of being denied coverage given that the individual is in fair or poor health, $\text{premium}_{u(t+1)}$ represents the premiums the individual would face if upcharged based on health status, and $\text{premium}_{s(t+1)}$ is the standard premium. The term $E[Util_{\text{sick,nongroup}(t+1)}]$ is the expected utility, as defined in equation 1, that the individual has if he or she is sick and insured on nongroup coverage at time t+1. The term $E[Util_{\text{sick,uninsured}(t+1)}]$ is the expected utility that the individual has if he or she is sick and uninsured at time t+1. Hence, the term $\{\delta *(E[Util_{\text{sick,nongroup}(t+1)}]-E[Util_{\text{sick,uninsured}(t+1)}])\}$ accounts for the decrement to utility stemming from the possibility of being uninsured and subject to coverage denial in year t+1. Individuals in the model continue to choose from the same set of options that were available in the ACA case, and—if they enroll in individual market coverage—they have the option to choose among plans with 60 percent, 70 percent, 80 percent, and 90 percent actuarial values.

To estimate the probability that an individual transitions from good, very good, or excellent health status to fair or poor health status, we calculated transition rates using 2012 and 2013 data from the Medicaid Expenditure Panel Survey. These transition rates are shown in Table A.1. For people in fair or poor health at time t, we estimate as similar penalty, but we set the probability of being sick ($\text{Prob}(\text{Sick}_{t+1})$) equal to 1.

Table A.1. Probability of Transitioning from Good, Very Good, or Excellent Health Status to Fair or Poor Health Status, 2012-2013 MEPS Data

	Males	Females
<18	2.9%	2.6%
18-34	5.4%	6.2%
35-49	7.2%	8.8%
50-65	9.9%	9.4%

We model a separate premium pool for individuals who experience a lapse in coverage, and who are in fair or poor health when they choose to enroll in the nongroup market. We assume that this market follows the same 5:1 rate band as the continuous coverage market. Overall, we estimate premiums in this market to be 25 percent higher than premiums in the protected, continuous coverage market. We estimate this difference based on the observed difference in spending between privately-insured MEPS respondents in poor or fair health and privately-insured MEPS respondents in good, very good, or excellent health. We assume that individuals in good, very good, or excellent health who experience a lapse in coverage would face the same premiums as individuals who are protected under the continuous coverage provision.

Because the CARE act authorizes a one-time-only open enrollment period, behavior and incentives in this initial period may be different from behavior and incentives in subsequent years. To account for this issue, we run the model on a one time basis using the penalty in equation (3), and estimate the share of people by age, sex, and health status who would opt to be uninsured. Then, for later years in which there is no open enrollment period but the denial and upcharge is in effect, we select a fraction of uninsured people in each age, sex, and health status group to face upcharge or denial if they attempt to enroll in insurance. We assume that individuals who are uninsured in time t will attempt to obtain insurance through the individual market in time t+1 if they transition from good, very good, or excellent health to fair or poor health between time t and time t+1. We estimate the number of people who face higher nongroup premiums due to a break in coverage and who face denial on the nongroup market as follows by age and gender:

A. (Number Seeking Nongroup Coverage Without Continuous Care at time t+1) =

   Prob($Sick_{t+1}$)*(Number Uninsured Without Access to Alternative Coverage at time t)

B. (Number Denied Coverage on Nongroup Market) =

   δ*(Number Seeking Nongroup Coverage Without Continuous Care at time t+1)

C. (Number Facing Higher Premiums on Nongroup Market) =

   (1-δ)*(Number Seeking Nongroup Coverage Without Continuous Care at time t+1)

We randomly assign individuals in the model to be denied coverage and to face higher premiums on the nongroup market from the individuals who have fair and poor health status in the model and do not have access to any form of insurance other than nongroup. Denial rates are based on pre-ACA denial rates reported by America's Health Insurance Plans (America's Health Insurance Plans, 2007), and vary by age group.

It is unclear from the CARE Act proposal what type of insurance would be considered sufficient to meet the continuous coverage requirements. We assume that individuals would need to enroll in a plan with at least a 60 percent actuarial value, as currently required under the ACA.

Tax Credits for Consumers

The CARE Act authorizes a targeted tax credit to help certain individuals obtain health insurance. The text of the Act lists the following groups as being tax-credit eligible:

- Individuals working for a small business with 100 or fewer employees
- Individuals who do not work for such a small business *or a large employer*, and who do not have an offer of health insurance coverage.

In addition, the tax-credit is means-tested and the allotted amount varies with age and family status. Those with incomes up to 200 percent of the FPL are eligible for the full amount of the tax credit, with the value of the credit declining to zero as income increases between 201 and 300 percent of the FPL. The proposed amounts (in 2014 dollars) are shown in Table A.2.

Table A.2. Proposed Tax Credit Amounts as Reported in the CARE Act for Calendar Year 2014

Age	Individual	Family
18-34	$1,970	$4,290
35-49	$3,190	$8,330
50-64	$4,690	$11,110

To model these tax credits, we needed to make assumptions about the exact meaning of the proposal language. Our literal reading of the proposal is that individuals who work for an employer with more than 100 workers are never eligible for tax credits, regardless of income. However, such an interpretation could leave some very low-income workers without access to tax credits, and creates ambiguities for part-time workers who are unlikely to qualify for a large employer's health plan. There are also ambiguities that arise when one spouse works for a small employer and one works for a large employer. Based on a very literal reading of the language, the spouse who works for a small employer would be eligible for the credit, and potentially could get a family credit to apply towards small group or individual market coverage. A similar ambiguity arises if one spouse works for a large employer that does not offer coverage, and the second spouse is not employed. In this case, a literal reading of the language might imply that the non-working spouse is eligible for the tax credits, and potentially could have access to credits for family coverage.

To deal with these ambiguities, we model a base case derived from our most literal reading of the proposal, and two alternative cases that apply a more-restrictive and a less-restrictive approach. Table A.3 shows how the three cases differ in terms of the assumptions.

Table A.3. Assumptions for Sensitivity Analysis Regarding Tax Credit Eligibility

Employment Status		Tax Credit Eligibility		
Individual	**Spouse**	**Baseline**	**More Restrictive Alternative**	**Less Restrictive Alternative**
Married Individuals				
Small Group	Small Group	Eligible	Eligible	Eligible
Small Group	Large Group	Eligible	Ineligible	Eligible
Large Group	Large Group	Ineligible	Ineligible	Eligible if neither firm offers coverage
Small Group	Not Working	Eligible	Eligible	Eligible
Large Group	Not Working	Eligible if large firm does not offer	Ineligible	Eligible if large firm does not offer
Not Working	Not Working	Eligible	Eligible	Eligible
Single Individuals				
Small Group	NA	Eligible	Eligible	Eligible
Large Group	NA	Ineligible	Ineligible	Eligible if firm does not offer coverage
Not Working	NA	Eligible	Eligible	Eligible

We assume individuals who are eligible for Medicaid are eligible for the tax credits, because the proposal specifically states that Medicaid-eligible individuals would have the choice to take-up tax credits if they wish. We further assume that the value of the family tax credit is based on the age of the oldest family member, excluding family members over the age of 65.

The proposal specifies only a single distinction in the tax credit amount between individuals and families. However, under current regulations, premiums in the individual and small group markets increase with each additional family member. We assume that family premiums in the individual and small group markets will continue to reflect the sum of individual premiums for each member given his or her age. We model the tax credit, in contrast, as a fixed amount that is invariant to family size. We make this assumption based on our most literal reading of the proposal, and also because the ratio of the family to single tax credit is

highest for those ages 34 to 49, the age group most likely to have children living at home. We treat married couples as being eligible for the family tax credit.

We assume that small business workers can take advantage of the full amount of the credit, even if the credit exceeds their required premium contribution. Effectively, this assumption implies that credits in excess of the premium contribution amount will reduce the employer's cost of providing insurance. Because the CARE Act largely preserves the current tax exclusion for employer sponsored health insurance (other than a tax exclusion cap, discussed below), the proposal leads to a double benefit for small business workers—they are eligible for both the employer-sponsored insurance tax exclusion and the small business tax credit. We believe this interpretation is in keeping with the intent of the proposal, which focuses on empowering small businesses. Although the CARE Act does not specify what types of plans would be eligible for the credit, we assume plans would need to have at least a 60 percent actuarial value.

Because the ACA and the CARE Act tax credits are structured very differently, their relative generosity will vary depending on an individual's age, family size, and income level. Table A.4 shows the estimated difference between CARE Act and ACA premiums after tax credits for people who enroll in a 70 percent actuarial value plan. We consider three family structures: single adults, married couples, and a family of four. In general, the CARE Act favors younger enrollees, and is more favorable for single adults and married couples than for families. For some income levels, 40 year old adults fare better than 30 year old adults under the CARE Act. This is because of the stepwise nature of the CARE Act credits. A 30 year old individual is close to the top of the age eligibility range for the 18 to 34 year old tax credit, while a 40 year old is near to the bottom of the age eligibility range for the 35 to 49 year old tax credit. Because premiums increase steadily with age, those at the bottom of the tax credit age range get a bigger discount relative to the cost of the premium than those at the top.

Table A.4. Difference between ACA and CARE Act Premiums Paid After Subsidies, by Age, Income, and Family Type, 2018

Age	100%	150%	200%	250%	300%	350%	400%
Single							
21	$10	-$527	-$1,412	-$1,320	-$1,343	-$1,061	-$1,061
30	$891	$355	-$520	-$1,103	-$461	-$808	-$808
40	$292	-$245	-$1,120	-$340	$303	-$334	-$590
50	$1,709	$1,172	$298	$1,916	$3,397	$2,760	$2,123
60	$6,243	$5,707	$4,832	$6,450	$7,931	$7,294	$6,657
Couple (both same age)							
21	-$199	-$923	-$2,123	-$1,091	-$214	-$1,076	-$1,938
30	$1,567	$841	-$345	$12,595	$1,550	$688	-$175
40	-$361	-$1,087	-$2,273	-$35	$3,078	$2,215	$1,353
50	$1,660	$933	-$253	$4,599	$9,266	$8,403	$7,541
60	$10,728	$10,002	$8,816	$13,668	$18,334	$17,472	$16,610
Family of Four (both parents same age)							
21	$2,761	$1,656	-$168	$150	$234	-$1,079	-$2,392
30	$4,529	$3,430	$1,618	$13,848	$2,047	$685	-$628
40	$2,600	$1,502	-$311	$1,219	$3,574	$2,212	$900
50	$4,621	$3,522	$1,710	$5,853	$9,762	$8,400	$7,088
60	$13,689	$12,591	$10,778	$14,922	$18,831	$17,469	$16,156

Notes: Negative values (in orange) imply that families pay less under the CARE act than under the ACA. Those with incomes above 300 percent FPL are eligible for ACA tax credits but not CARE Act credits.

High-Risk Pool

The CARE Act proposal allows states to set-up high-risk pools with targeted federal funding to provide coverage for patients with costly conditions. The ACA also authorized high-risk pools through the Pre-Existing Condition Insurance Plan (PCIP) program, but these high-risk pools expired after the Marketplaces became operational in early 2014. While past experience with high-risk pools has been mixed (Hall, 2014), such pools potentially serve two purposes in improving the function of insurance markets. First, high-risk pools may provide coverage of last resort for high-risk patients who would otherwise face denials, pre-existing condition exclusions, or upcharges in the standard insurance market. However, it is unclear that the high-risk pools envisioned under the CARE Act are meant to address these issues, because the CARE Act prevents insurers from denying coverage, failing to renew policies, or upcharging sick patients, as long as these individuals have been continuously enrolled in insurance.

Potentially, the high-risk pool could become an insurer of last resort for patients who fail to maintain continuous coverage and later find themselves unable to access insurance. However, allowing this type of stop-gap could undermine the intent of the continuous coverage provisions, which are meant to encourage people to enroll in insurance even if they are currently healthy and do not anticipate significant medical bills.

A second function of high-risk pools is to remove costly individuals from the standard risk pool, to keep premiums in the standard market more affordable. We assume this is the major role of the high-risk pools envisioned under the CARE Act.

Because the current proposal lacks detail on exactly how the high risk pools would operate, we make the following assumptions.

- Individuals with high expected expenditure are directed to the high risk pool rather than the standard risk pool if they apply for individual market coverage.
- High risk pool enrollees who are in compliance with the CARE Act's continuous coverage provisions face the same premiums on the high-risk pool as they would in the standard risk pool.
- The federal government pays for the costs of the high-risk pool in excess of premiums.
- Individuals who violate the continuous coverage requirements face upcharge and denial regardless of whether they are directed to the high-risk pool.

To determine which individuals will be directed to the high-risk pool, we estimate expenditure and select those with expected expenditure in the top 1 percent of the distribution as high-risk pool candidates. Both the costs of the high risk pool and the impact on premiums in the standard risk pool will depend on how accurately the criteria for selecting high-risk pool candidates reflect actual expenditure. In our baseline estimates, we assume that expenditure is estimated with imprecision, and thus those in the top 1 percent of expected expenditure may not actually have expenditures in the top 1 percent. To model this uncertainty, we sample individuals to be selected for the high risk pool with a probability that is proportional to $(\text{total expenditures})^p$ where the parameter p takes on some positive value. When p is very small, individuals are selected for the high risk pool with a nearly uniform probability, representing a scenario in which the selection criteria have a very poor ability to predict individuals' health care expenditures. When p is very large, the criteria by which individuals are selected for the high risk pool is

nearly perfect, and those selected for the high risk pool have the highest expenditures. In our base case scenario, we use $p = 0.3$, which represents criteria for selection into the high risk pool that is moderately good at predicting which individuals will have high expenditures. We use a similar approach to model denials in the pre-ACA nongroup market, and have found that values of p around 0.3 reproduce enrollment and premiums in the pre-ACA nongroup market well (more selective denial and higher values of p lead to lower premiums and higher enrollment compared to what we observed in the pre-ACA markets).

While criteria for selecting high-risk pool enrollees are not discussed in the CARE proposal, it is possible that enrollees would be selected based on health conditions rather than on expected expenditures. In fact, the PCIP program authorized by the ACA used high-risk conditions as the basis for assigning individuals to the high risk pool. In the case of PCIP, however, there was no hard-and-fast list of qualifying conditions, and enrollment assignments were instead based on a doctor's note or proof of coverage denial from an insurer (National Conference of State Legislatures, 2011). Due to the uncertainty regarding who would be eligible for the high-risk pool and how accurately the selection criteria would reflect underlying costs, we conduct sensitivity analyses in which we vary the precision with which expenditure is estimated in selecting high-risk pool candidates.

Medicaid Assumptions and Capped Allotment

Because the CARE Act repeals the ACA, we assume that Medicaid eligibility criteria revert to pre-2014 levels in all states. Many individuals with incomes under 138 percent of the federal poverty level who lose access to Medicaid as a result of this change will become eligible for the tax credits offered under the proposal (although those who work for a large employer are not eligible). Low-income individuals in states that did not expand their Medicaid programs may become eligible for the CARE Act's tax credits as well.

Under the CARE Act, Medicaid-eligible individuals are in general permitted to enroll in individual or small group coverage using tax credits. We allow low income individuals in the model to choose between Medicaid and subsidized individual or small group coverage based on the utility maximization procedure outlined above. However, we preclude Medicaid enrollees with extremely high spending from opting for individual or small group coverage, to account for

the fact that disabled and medically-needy Medicaid enrollees have special health needs and may be unlikely to switch to private coverage. To do this, we assume that individuals who report being enrolled in Medicaid in the 2010 SIPP despite not appearing eligible based on the state's pre-ACA income thresholds are medically needy or disabled. For these individuals, we ensure that their utility for Medicaid is higher than their utility for any other form of health insurance coverage.

The CARE act changes the federal approach to funding Medicaid, moving to a capped allotment in which federal funding is based on the prior year's spending, with adjustments for enrollee demographics, population growth, and inflation based on the consumer price index (CPI) plus 1 percentage point. To account for this change, we inflate Medicaid spending over time using CPI+1 rather than health care cost inflation factors. We assume that initial allotments are based on 2016 enrollment and spending patterns. Because health care costs in the model grow at rates that exceed CPI+1, the effective funding level for Medicaid in inflation-adjusted dollars declines over time under this approach. We do not address cost-saving strategies that states might implement to adapt to the declines in federal funding amounts. Because we model outcomes for 2018 (only two years past 2016), the amount of divergence between Medicaid funding levels and actual program costs will be relatively minor over this window.

Malpractice Reform

To model medical malpractice reform, we rely on a previous analysis conducted by the CBO in response to a request from Senator Hatch (Elmendorf, 2009). The reforms modeled by the CBO include capping noneconomic and punitive damages, modifying the "collateral source" rule to require that compensatory income obtained from other types of insurance (e.g., life insurance, worker's compensation) be subtracted from jury awards, imposing a statute of limitations on malpractice claims, and adopting a "fair share" rule which would make providers liable only for a portion of claims if multiple parties were found at fault. The CBO estimates that these reforms would save money for the federal government by enabling the government to reduce payment rates for Medicare and Medicaid (because providers now face lower malpractice premiums), and by reducing spending on defensive medicine in these programs. In addition, the CBO assumes the reforms raise tax revenue because employers will increase spending on taxable

wages as health insurance cost fall. The reforms modeled by the CBO are not identical to the suggested policy proposed in the CARE Act. However, because the CARE Act is relatively non-specific about which malpractice reforms would be implemented, and because the CBO analysis was conducted for one of the CARE Act authors, we assume that the CARE Act would ultimately adopt malpractice reforms that are at least as effective as those scored in the CBO's analysis.

ESI Tax Exclusion

Following our earlier work (White et al., 2015), we assume that firms reduce the generosity of the health plan benefits that they offer, and simultaneously increase the amount of compensation they provide as wages, in response to an exclusion cap on employer-sponsored coverage. We use elasticities from Gruber and Lettau (2004) to estimate the degree to which firms might reduce health insurance benefits and pass wages back to workers. Our estimates account for the federal tax revenues that would result from wages passed back to workers, plus the payroll and income taxes that individuals and firms would be responsible for on health insurance benefits that exceeded the exclusion cap.

Because our analysis focuses on the year 2018 and the Cadillac tax has now been delayed until 2020, we do not model the Cadillac tax in the current report. However, in unreported sensitivity analyses, we found that including the Cadillac tax did not affect our major conclusions. If implemented in 2018, we estimate that the Cadillac tax would raise $1.4 billion in revenue. This would slightly reduce the net deficit impact of the ACA, and narrow the cost difference between the two plans. However, compared to the ACA, the CARE Act would continue to insure fewer people at a lower cost to the federal government.

Autoenrollment

The CARE Act allows states to automatically enroll individuals who are eligible for tax credits into health insurance plans. Enrollees can then opt-out of coverage if they wish. Because it is unclear how many states would enact autoenrollment policies and who would be targeted for

autoenrollment if enacted, we do not model autoenrollment in our main report.[3] However, in sensitivity analyses presented in this appendix, we consider a case in which people are autoenrolled in plans if the tax credit they are eligible for would exceed the cost of the health insurance premium for a 60 percent actuarial value (i.e. bronze) plan. For this sensitivity analysis, we assume that all states enact autoenrollment, and that no one opts out of coverage once autoenrolled.

ACA Revenue-Generating Provisions

We estimate the revenue generated through the ACA's taxes, fees, and other measures using the Congressional Budget Office's (CBO's) analysis of the budgetary and economic effects of repealing the ACA (Congressional Budget Office, 2015a). The CBO estimates that, in 2018, fees on health insurance providers, branded prescription drugs, and medical devices will lead to $19 billion in revenue, with an additional $8 billion in revenue coming from other provisions ($27 billion total). Because most of the fees, taxes, and other revenue-generating provisions affect health care expenditure, we assume that repealing these measures will lead to a proportional reduction in health care costs.[4] We assume most of this reduction in cost comes in the form of lower premiums; however we assume that changes that limit tax deductions available through health savings accounts (HSAs), medical savings accounts (MSAs), and flexible spending accounts (MSAs) will affect consumer out-of-pocket spending on health care. We use a table reported by the Joint Committee on Taxation (Joint Committee on Taxation, 2012) to estimate the cost of specific revenue provisions such as the change in the tax treatment of MSAs, HSAs, and FSAs.

Medical Inflation

We used assumptions about medical spending growth from the CBO to project how medical spending, including premiums, would increase in time (Congressional Budget Office 2015a). We

[3] Autoenrollment is also a feature of the ACA_-for example, the federally facilitated marketplaces automatically reenroll individuals into plans each year. We do not model the ACA's autoenrollment provisions either.
[4] We exclude the cost of the tanning tax when estimating increases in health spending because the tanning tax falls outside of the health care system.

also used CBO estimates of CPI to estimate how per capita income would increase with time (Congressional Budget Office 2015b). To model the capped allotment provision in the CARE Act for Medicaid, we assumed that, starting in 2016, Medicaid costs would grow at CPI+1 rather than at medical cost growth rates. We additionally assumed that premium tax credits under the CARE Act would be indexed to increase at CPI+1 starting in 2014.

CARE Act Provisions Not Modeled in this Report

There are several provisions of the CARE Act that we were unable to model. These provisions include small business health plan compacts, interstate compacts, targeted expansion of CDHPs, reauthorization of HOAs (health savings accounts for Medicaid enrollees), and efforts to increase transparency. In general, we did not model these provisions because the implementation details provided in the CARE Act proposal were slim, and because—in many cases—these provisions depend on state implementation decisions that are difficult to anticipate. For example, it is unclear whether the proposal would re-authorize HOAs as a small demonstration program (as originally enacted under the Deficit Reduction Act) or as a larger scale program, whether states would be required to offer HOAs to Medicaid enrollees, or whether enrollees would be required to accept these policies in lieu of traditional Medicaid. In the case of the small business health plan and interstate compacts, it is also difficult to predict which states and small businesses would chose to ban together, and how this would ultimately affect bargaining power and costs.

Model Limitations

The model has several important limitations. First, COMPARE is a partial equilibrium model that does not consider the impacts of health reform on the broader economy. For example, we do not account for changes in employment that might occur due to health reform policies, such as individuals retiring early or becoming self-employed because they now have the opportunity to get tax credits if they no longer work for a large employer. Similarly, the model does not account for the possibility that businesses may break into smaller pieces, or fail to grow over time, in response to the tax advantages offered to small businesses. In addition, there is no single data source that links individuals, firms, and health spending. As a result, we need to

impute information from several data sources to generate a synthetic population of the United States. These imputations could cause error; for example, we may not fully capture correlations in health spending among workers at a given firm. Finally, to validate the model, we ensure that the model accurately predicts outcomes under pre-ACA policy. But, because we have limited data on post-ACA outcomes, we have few opportunities to ensure that the model accurately predicts outcomes in the post-ACA policy environment.

Sensitivity Analysis

A challenge that we faced in estimating the impact of the CARE Act was that, unlike the ACA, there is no legislative language that describes the CARE Act in specific terms, and there are no regulations spelling out detailed implementation rules. As a result, we were forced to make assumptions about several key issues. Areas of particular uncertainty include the effectiveness of the continuous coverage provisions, implementation of the high risk pools, the implementation of the tax credits, the potential impact of autoenrollment, and the degree to which the CARE Act will repeal the ACA's revenue-generating provisions.

In modeling the continuous coverage provisions, our approach assumes that individuals weigh the costs and benefits of available insurance options, and consider how this year's enrollment decisions could affect next year's costs if they fail to maintain continuous coverage. While according to economic theory rational actors should consider the cost of future upcharges and denials in making health insurance decisions, it is not clear that individuals act rationally when making insurance decisions. Some people may think only about costs and benefits in the current year, without considering future spending. Alternatively, some people may look ahead for more than one year in determining whether or not to enroll in coverage.

In the case of the high-risk pools, the proposal lacks detail on which individuals will be eligible to enroll in the pool, how federal funding will be allocated to support the pool, and whether high-risk pool enrollees will face different premiums than other individuals. In addition, states have discretion over whether to implement the high risk pool, and some may choose not to do so.

Much of the uncertainty related to the CARE Act's tax credits stems from language in the proposal that makes tax credits unavailable to individuals who work for a large employer, regardless of whether the worker has access to a health insurance offer. If interpreted literally, this language could preclude many low-income workers with no access to employer coverage from obtaining tax credits. In addition, the language creates ambiguities for married couples in cases in which one spouse is eligible for tax credits and the other spouse is ineligible.

For autoenrollment, it is unclear how many states will choose to autoenroll people, what criteria will be used to flag autoenrollment candidates, or how many people will drop-out after being autoenrolled (an outcome that will be sensitive to additional state policies, such as how autoenrollees are notified about their status, and what administrative processes must be followed to opt-out).

There is also uncertainty regarding whether the CARE Act would repeal revenue-generating provisions that have already taken effect, such as the section 9010 tax on health insurance plans. Many of these provisions are unpopular, and the CARE Act makes no mention of preserving them. However, by repealing the revenue-generating provisions, a plan such as the CARE Act would be scored by the CBO as deficit-increasing. Arguably, legislators might attempt to retain some of the revenue-generating provisions, or enact similar measures to generate revenue, if the CARE Act were turned into a bill.

In Table A.5, we conduct sensitivity analyses in which we alter assumptions about the high risk pool, workers' eligibility for tax credits, autoenrollment, response to the continuous coverage provisions relative to the baseline CARE Act scenario, and the elimination of revenue-generators. Below, we describe the details of the scenarios modeled:

- **ACA:** This scenario focuses on the ACA as implemented based on current federal regulations. It includes the individual and employer mandates, Medicaid expansion in participating states, tax credits and cost-sharing subsidies for qualified individual market enrollees, and individual market rating reforms such as guaranteed issue and 3 to 1 rate banding. The ACA scenario is included in the main report.
- **CARE Act, Baseline:** This scenario represents the interpretation of the CARE Act presented in the main report and described in this appendix.

- **More targeted high risk pool eligibility:** In this scenario we amend the CARE Act baseline scenario by assuming that insurers can predict with certainty which individuals will have spending in the top 1 percent of the distribution. Such precise targeting would likely make premiums on the standard individual market less expensive, because the highest-cost enrollees would be removed from the risk pool. However, this targeting also increases costs to the federal government, which we assume funds any high-risk pool spending in excess of premiums collected.
- **No High Risk Pool:** Here, we eliminate the high risk pool entirely, effectively assuming that no states take-up the option under the CARE Act.
- **Less Restrictive Tax Credit Eligibility:** In this scenario, we broaden eligibility for premium tax credits based on the assumptions presented in Table A.3. Importantly, we assume that large firm employees without access to employer-sponsored coverage are eligible for tax credits.
- **More Restrictive Tax Credit Eligibility:** Here, we tighten assumptions about tax credit eligibility using the criteria described in Table A.3.
- **Autoenrollment:** We assume that all states opt to autoenroll individuals and families in a 60 percent actuarial value plan if that plan would be free to the enrollee after accounting for the premium tax credits. We further assume that no enrollees proactively drop-out after being autoenrolled.
- **Continuous Coverage, Do Not Consider Future Costs:** We assume that people do not consider future health insurance costs when making decisions about whether to enroll in insurance. As a result, the continuous coverage provisions have no effect on behavior.
- **Continuous Coverage, Look Forward 2 Years:** We assume people look forward for two years when making enrollment decisions under the CARE Act.
- **Keep Revenue-Generating Provisions**: In this scenario we assume that the CARE Act will retain the ACA's revenue-generating taxes and fees, such as the 9010 tax, fees on branded prescription drugs, the medical device tax, the tanning tax, and provisions related to the tax treatment of FSAs, HSAs, and MSAs.

Table A.5. Sensitivity Analysis Related to Key CARE Act Assumptions

	(1) ACA	(2) CARE Act, Baseline	(3) More Targeted High-Risk Pool Eligibility	(4) No High Risk Pool	(5) Less Restrictive Tax Credit Eligibility	(6) More Restrictive Tax Credit Eligibility	(7) Auto-enrollment	(8) Continuous Coverage: Do Not Consider Future Costs	(9) Continuous Coverage: Look Forward 2 Years	(10) Keep Revenue Provisions
Number Insured Under Age 65 (Millions)	251.5	242.5	252.6	241.2	245.8	241.7	251.5	239.2	244.5	240.1
Net Deficit Impact (Relative to "No Reform") (Billions)	$72	$89	$154	$85	$101	$82	$113	$83	$93	$53

Notes: the net deficit impact represents the cost of the insurance coverage provisions of the modeled reforms net of any revenue generating provisions of the reforms (such as the ACA's individual mandate penalty or the CARE Act's exclusion cap on high-cost employer-sponsored health plans). We model the coverage-related spending and revenue effects only, and do not consider the effects of repealing other ACA provisions such as the tanning tax or excise taxes on medical devices. All analyses are for the calendar year 2018.

None of the CARE Act scenarios modeled in Table A.5 insure more people at a lower net cost (measured based on the net impact on the federal deficit) than the ACA. The scenario in which the high-risk pool is highly-targeted to perfectly enroll the costliest spenders (column 3) leads to slightly higher enrollment than the ACA—252.6 million enrollees under the highly-targeted scenario versus 251.5 million enrollees under the ACA. The increase in insurance occurs because, by siphoning the highest-risk people from the individual market, the highly-targeted risk pool scenario reduces premiums in the standard risk pool and encourages enrollment. However, the federal deficit impact under this scenario is more than twice the impact under the ACA, because the government now subsidizes the excess health care utilization of the highest spenders in society.

The autoenrollment scenario (column 7) roughly matches the ACA in terms of the number of people covered; however, with a net deficit impact of $113 billion, the autoenrollment scenario adds $41 billion more to the federal deficit than the ACA. Autoenrollment dramatically increases federal spending because, based on the text of the CARE Act proposal, we assume everyone targeted for autoenrollment would be tax-credit eligible.

When we assume the CARE Act retains the ACA's revenue-generating provisions (column 10), we find that the CARE Act reduces the federal deficit impact in 2018 by $21 billion relative to the ACA. However, the CARE Act insures 11.4 billion fewer people than the ACA. The CARE Act scenario with the revenue-generating provisions (column 10) insurers fewer people than the CARE Act scenario without the revenue-generating provisions (column 2) because the revenue-generating taxes and fees fall predominately on insurers and medical services, leading to higher premiums and lower enrollment.

In the remaining cases, including the "no risk pool" scenario (column 4), the "less restrictive tax credits" scenario (column 5), the "more restrictive tax credits" scenario (column 6), and both sensitivity analyses related to the continuous coverage provisions (columns 8 and 9), the CARE Act insures fewer people than the ACA, while at the same time increasing the deficit. Qualitatively, these results are similar to what we find in the baseline scenario.

These results are consistent with a prior COMPARE study (McGlynn et al., 2010), which analyzed over 2000 policy options to increase coverage that varied in terms of mandate penalties, Medicaid expansion assumptions, subsidy amounts, and age-banding assumptions. The study

found that only a small number of scenarios would insure more people at a lower net federal cost than the ACA, and most of these scenarios involved increasing (rather than eliminating) the individual mandate penalty.

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